

POWERS

POWERS PYLES SUTTER & VERVILLE PC
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From: Diane Millman

Re: RFP for (Voluntary) Kidney Care Choices Model(s)

Date: October 29, 2019

The Centers for Medicare and Medicaid Innovation (CMMI) has issued the Request for Applications for the (voluntary) Kidney Care Choices Models. The following are the primary “takeaways”:

In General

- The deadline for applications for the voluntary models is January 22, 2020. This leaves little time for those interested in the direct contracting models to line up participants and put their applications together.
- The “performance period” upon which the benchmarks will be based will be 2020 (Implementation Period). The period during which the applicant will be financially accountable (Performance Period) will run from January 1, 2021, through December 31, 2023, with the option for a one-year or a two-year extension through December 31, 2024, or December 31, 2025.
- CMMI expects to issue another solicitation for applicants in 2020 or 2021 for participation starting in 2021 or 2022; however, new participants will not have an implementation period and their financial accountability under the Model would begin at the start of their first payment year in the Model.
- Under the terms of the applicable Participation Agreement(s), Model participants must make full electronic health data available to all patients within 24 hours of an encounter; support electronic, interoperable data exchange with other providers/suppliers and health systems; use 2015 edition certified EHR technology, including secure messaging, transition of care document exchange, and standards-based Application Programming Interfaces (APIs) to eliminate the use of faxes for health information exchange; and connect to regional and/or national/vendor-mediated health information exchange (HIE) to send and receive electronic alerts for patient transitions of care from hospitals or other providers for all patients.
- CMMI reserves the right to modify or terminate the Model or Models at any time if it is determined that the Model or Models is not improving the quality of care without increasing spending, is not reducing spending without reducing the quality of care, or is not otherwise achieving the goals and aims of the initiative.

- Both the Kidney Care First and the Comprehensive Kidney Care Contracting Models are intended to address a number of perceived deficiencies of the CEC Model by:
 - Including beneficiaries with CKD stages 4 and 5 before they progress to ESRD in the model to promote later and better starts on dialysis, or to avoid dialysis entirely.
 - Including beneficiaries after they receive a transplant and incorporating financial incentives to promote greater utilization of transplants.
 - Empowering nephrologists to take the lead in coordinating care for beneficiaries across the care spectrum.
 - Including Medicare Benefit Enhancements to support improved utilization of skilled nursing facilities (SNFs) and hospice care, telehealth services, and the kidney disease education (KDE) benefit.
 - Addressing nephrologist payment in order to better align payments with care.
- Under both the Kidney Care First and the Comprehensive Kidney Care Contracting Models, certain modifications will be made in the amounts generally paid under Medicare FFS for nephrology services and other ESRD/CKD-related services:
 - CKD Quarterly Capitation Payment (CKD QCP): Combines payment for several different outpatient Evaluation and Management (E/M) codes and other care management codes listed below into a single capitated payment for the care of CKD-aligned beneficiaries with CKD stage 4 or 5.
 - Adjusted Monthly Capitation Payment (AMCP): Modifies payments made to KCF practices based on specified performance measures under the current payment monthly capitation payment structure for management of patients on dialysis.
 - Kidney Transplant Bonus (KTB): \$15,000 for every aligned Medicare beneficiary who is transplanted, with \$2500 payable the first year, \$5000 the second, and \$7500 the third, assuming continued graft function.

Kidney Care First Model (KCF Model)

- The Kidney Care First (KCF) Model will only include nephrologists and nephrology practices as participants; however, the performance measures that will be used under the AMCP element of the model will have the potential to encourage nephrologists to educate their patients about the benefits of preemptive transplantation and to encourage their patients to pursue transplantation. In particular, the measures include one measure (“Optimal End Stage Renal Disease (ESRD) Starts; NQF #2594”) which focuses on the percentage of new ESRD patients who receive a preemptive kidney transplant, initiate home dialysis, or initiate outpatient in-center hemodialysis via arteriovenous fistula or arteriovenous graft.

Comprehensive Kidney Care Contracting Models (CKCC Models)

- Kidney Contracting Entities (KCEs) will be formed to participate in the CKCC Models.
 - Each KCE must be identified by a single TIN and be a separate and unique legal entity that is recognized and authorized to conduct business under applicable federal, state, or tribal law.

- Applicants will not be expected to have their legal entity formed until after application selection; however, KCE applicants should include their proposed participants and preferred providers in their application and must finalize the list prior to signing the CKCC Participation Agreement.
- KCE Participants
 - The KCE must not interfere with its KCE participants' ability to refer their Medicare beneficiaries to any dialysis facility or other Medicare-enrolled provider or supplier or otherwise prevent full beneficiary freedom of choice of providers and suppliers.
 - A nephrology practice that participates in a KCF Model may not also participate in a CKCC Model.
 - KCEs must include as participants at least one nephrologist or nephrology group practice and at least one transplant provider.
 - For this purpose, a transplant center, transplant surgeon, transplant nephrologist, and/or organ procurement organization (OPO) will "count" as a transplant "provider."
 - Nephrologists may only participate in one KCE, while transplant providers may participate in multiple KCEs. KCEs may also include dialysis facilities and other suppliers and providers as KCE "participants."
 - KCE participants must have at least 75% control of the KCE's governing body, and nephrologists or representatives of nephrology practices must represent at least 30% of the membership of the governing body. At least one governing body member must be an employee or executive of a transplant provider, and at least one governing body member must be an independent Medicare beneficiary with CKD or ESRD or a non-affiliated, independent consumer advocate.
 - All dialysis facilities in a single KCE must be owned by the same dialysis company to avoid anticompetitive practices. Additionally, if the KCE includes dialysis facilities as KCE participants, it must include greater than 85% of the dialysis facilities owned in whole or in part by the dialysis company in the KCE market area.
- Initial and continued alignment of Medicare beneficiaries with a KCE will depend on whether the beneficiary's nephrologist/nephrology practice is a participating provider (rather than on which dialysis facility the patient uses, as under the current CEC Model). In order to continue with participation in the Model, the KCE must maintain at least 1,000 late stage CKD and 350 ESRD-aligned beneficiaries throughout the life of the Model.
- When an aligned CKD or ESRD beneficiary receives a transplant, they will remain aligned to the KCE for 3 years from the month of transplant in order for the KCE to be eligible to receive Kidney Transplant Bonus (KTB) payments.

- At least 20% of KTB payments must be shared with KCE participants who are transplant providers (e.g., transplant surgeons, OPOs, etc.).
- An additional 20% of the KTB payment must be shared with KCE participants who are nephrologists/nephrology practices.
- The distribution of the remaining 60% of the KTB payments is at the discretion of the governing body of the KCE, subject to the requirements of applicable law.
- KCEs will be able to choose among three CKCC options:
 - Under the Graduated Option, the KCE will not have downside risk for the initial period of participation; however, this option is not available for Large Dialysis Organizations (LDOs).
 - Under the Professional Option, the KCE will bear 50% of the downside risk and share in 50% of the upside savings, as compared with an adjusted benchmark calculated by CMMI.
 - Under the Global Option, the KCE will bear 100% of the downside risk and will be entitled to 100% of the savings, as compared with an adjusted benchmark calculated by CMMI.
- While the payment methodology and degree of risk varies across CKCC options, a common benchmarking methodology will apply across all three models.
 - The benchmarks will be calculated prospectively and given to KCEs at the start of each performance year and may be adjusted to account for CKD progression.
 - The benchmark will be calculated separately for CKD and ESRD beneficiaries for each of the three payment options and cover all Medicare Part A and B costs including those not related to kidney disease, with specified exceptions.
 - Kidney transplant-related costs, such as evaluation of the recipient and donor, blood, and tissue typing of the recipient and donor, organ acquisition, execution of the transplant itself, and services following the transplant are specifically excluded from the CKCC benchmark.
 - The benchmark baseline will be determined based on historical costs, but a number of adjustments will be made to account for trending, geographic area, regional expenditures, and other factors, including a new risk adjustment. In addition, KCEs under the Global Model will be subject to a “discount factor” equal to at least 3% of the benchmark amount, and the discount factor will increase by 1% each year, thereby requiring KCEs operating under the Global Model to be increasingly efficient over time.
- KCEs participating in the Global PBP Option will be at risk for 100% of the total cost of care for all Medicare Part A and B services for aligned beneficiaries relative to a benchmark. This option will include the total care capitation (TCC) arrangements, which

offers a capitated, risk-adjusted monthly payment to KCEs for services that KCE participants furnish to aligned beneficiaries.

- KCE Participant Providers and Preferred Providers will have the option of participating in the capitated arrangement and reducing their claims amounts between 1% and 100% (while continuing to process claims) for services furnished to aligned beneficiaries.
- CMS will continue to pay claims for services furnished by providers and suppliers outside of the KCE and for any Participating or Preferred Providers who do not opt into FFS claims reductions; however, an amount will be withheld by CMS from any claims filed by Participating Providers and Preferred Providers who choose to continue to be paid by Medicare on a claims basis (rather than through the KCE capitated amount), to avoid the need for significant year end recoupments from KCEs for services rendered to aligned beneficiaries by non-participating providers.