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RE CMMI Voluntary Demonstration Models

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On July 10, the CMS Innovation Center (CMMI) announced four voluntary demonstration models intended to improve the quality and lower the cost of Medicare beneficiaries with ESRD and late stage (stages 4 and 5) Chronic Kidney Failure (CKF). These models are:

Kidney Care First (KCF) Model
Comprehensive Kidney Care Contracting (CKCC) Graduated Model
Comprehensive Kidney Care Contracting (CKCC) Professional Model
Comprehensive Kidney Care Contracting (CKCC) Global Model

Unfortunately, at this stage, only very broad descriptions of these voluntary models are publicly available. For this reason, and in light of CMMI's outreach to ASTS requesting ASTS' views of the CMMI initiatives in this area, this memo focuses on identifying the questions that ASTS may wish to consider asking during its upcoming call with CMMI with respect to the voluntary models.

KCF Model

In the KCF Model, participating nephrology practices will receive adjusted fixed payments on a per-patient basis for managing the care of patients with late-stage chronic kidney disease and patients with ESRD. The payments will be adjusted based on health outcomes and utilization compared to the participating practice's own experience and national standards, as well as performance on quality measures. In addition, participating practices will receive a bonus payment for every patient aligned to them that receives a kidney transplant based on the transplant remaining healthy for up to three years after the surgery.

Comprehensive Kidney Care Contracting (CKCC) Models

The CKCC Models include adjusted capitated payments similar to those payable under the KCF model as well as kidney transplant bonus payments similar to those payable under the KCF model. However, there are two major conceptual differences between the KCF Model and the

CKCC Models: First, under the CKCC Models, the demonstration participant will be a Kidney Contracting Entity (KCE) rather than an individual nephrologist or nephrology practice. (KCEs are required to include nephrologists or nephrology practices and transplant providers, while dialysis facilities and other providers and suppliers are optional participants in KCEs.) Second, in addition to receiving adjusted capitated patient management payments and transplant bonus payments that will depend on KCE performance, a KCE may share in savings or losses, with the savings/loss share determined based on the extent of the risk the KCE is willing to take on:

- Under the **CKCC Graduated Model** the KCE contracts with CMS under an arrangement that is modeled on that currently in effect for smaller dialysis facilities under the Comprehensive ESRD Care (ESCO) model. Under this model, the KCE will share in savings (but not losses) for the first year, until it transitions to the **CKCC Professional Model**.

- Under the **CKCC Professional Model,** the KCE will contract directly with the Medicare Program and will earn 50% of shared savings or be liable for 50% of shared losses based on the total cost of care for Part A and B services, subject to various adjustments, including quality of care adjustments.

- Under the **CKCC Global Model**, the KCE will contract directly with the Medicare Program and will earn 100% of the savings or be liable for 100% of the losses on the total cost of care for Part A and Part B services. Essentially, this is a full risk model not dissimilar to the model outlined in the PATIENTS Act: Payment presumably would be made either based on full capitation (similar to the methodology used to pay Medicare Advantage plans) or based on a percentage of Part A and Part B premiums. However, unlike the model outlined in the PATIENTS Act, the CKCC Global Model, the entity at risk would consist of a KCE that is formed by nephrologists and transplant centers (rather than an entity formed by a dialysis center, as under the PATIENTS Act).

These CKCC models mirror direct contracting primary care demonstration models previously proposed by CMMI. See https://innovation.cms.gov/initiatives/direct-contracting-model-options/.

Observations: First, it is well known that the ESRD/CKD Stage 4 and 5 patient population is significantly more resource intensive than Medicare beneficiaries generally: In fact, as we have discussed in the past, because of the resource intensive nature of this patient population, the Medicare Advantage capitated payments for Medicare beneficiaries on dialysis are 9-10 times the capitated amounts for age/disabled Medicare beneficiaries. Under the CKCC Direct Contracting Models (other than the CKCC Graduated Model), the KCE would take on substantial risk for managing this patient population (50% of the risk in the case of the CKCC Professional Model and 100% of the risk in the case of the CKCC Global Model). The Direct Contracting Models anticipate that KCEs will consist of nephrology practices and transplant centers; however, it is unclear whether and to what extent networks that include only nephrology practices and transplant centers will be in a position to take on this degree of financial and

clinical risk, without the involvement of a "deep pocket"—for example, an insurer, a large health system (ideally one that also functions as an insurer), or one of the large dialysis companies.

> ***Recommendation:*** *We recommend that ASTS consider whether and to what extent the KCEs formed exclusively by nephrologists and Transplant Centers will be in a position to take on substantial financial risk for the provision of all Part A and Part B services to ESRD and stage 4/5 CKD patients.*

Second, under the Demonstration Program proposed by ASTS, a Collaborative involving area Transplant Center(s), nephrologists, dialysis facilities, the OPO, donor hospitals and others would be formed to increase transplantation rates, with the Collaborative paid a portion of the savings attributable to increasing transplantation. The Innovation Center evidently has decided not to pursue this concept. However, it may be worth considering whether a Collaborative of the kind envisioned by the Proposed ASTS Demonstration might be able to qualify as a KCE under any of the Direct Contracting Models proposed by CMMI.

The questions/comments that ASTS may wish to consider with respect to this model include:

(1) How will the amount of the kidney transplant bonus payment payable under these models be determined?
(2) What efforts are going to be made to remove the disincentives to transplantation arising from current CMS/ OPTN/SRTR outcomes requirements, which run counter to these models' objective of increasing transplantation?
(3) How will CMMI ensure that the incentive payments made under these models to increase transplantation does not result in undue pressure on potential living donors? More generally, how will CMMI ensure coordination between participating nephrologists and TC living donor programs and potential conflict between LDAs and nephrologists?
(4) In light of the amount of financial risk that KCEs will assume under the CKCC Professional and Global Models, has CMMI explored the feasibility of these models with potential health system participants?
(5) Is CMMI open to the possibility of waiving outcomes requirements or other CMS requirements for Transplant Center participants in these models? Would suspension of the OPTN outcomes requirements or SRTR five star ratings be possible?
(6) Could a Collaborative of the type envisioned by the proposed ASTS Demonstration Project qualify as a KCE under the CKCC Model(s).