



## Guidance for Nephrology Practices on Kidney Care First

### Issues to Consider

RPA has conducted a careful review of the Kidney Care First (KCF) provisions in the Request for Applications (RFA) disseminated by CMS on October 24 and has developed the following list of questions for nephrology practices to consider before deciding whether to participate in the KCF. Several, if not most, of these issues will apply to the Comprehensive Kidney Care Contracting (CKCC) Option as well, but topics related to financing of the CKCC entities are not addressed below.

Accordingly, RPA recommends that nephrology practices carefully consider the following questions to determine whether participation in the KCF/CKCC voluntary models is appropriate for them.

- **Patient Composition:** Is the practice's census of patients sufficient to support the minimum of 500 late stage CKD and 200 ESRD aligned Medicare beneficiaries necessary to participate in the model, taking into account the categories of patients excluded from the minimum number, and the impending policy change allowing ESRD patients into Medicare Advantage (and thus being excluded from participation) in 2021?-
- **CKD Patient Encounters:** Will the requirement for the practice to have at least two interactions with 500 CKD patients every six months affect the ability of the practice to satisfy the 500-patient minimum?
- **MCP Payment:** For practices that typically see their ESRD patients four times monthly, will the de facto 25% reduction in payment for treating those persons be adequately offset given some of the other beneficial features of the payment model (such as the transplant bonus and the presumed designation as an advanced alternate payment model)?
- **CKD Payment:** For late stage CKD patients, will the quarterly capitated payment for that care (approximately \$240 quarterly/\$80 monthly) account for the staff and other expenses associated with providing those services?
- **E&M Services:** Will the quarterly capitated CKD MCP payment be more or less than the practice currently bills for E&M services which would no longer be separately billed?
- **E&M Claims:** For late stage CKD patients, does the practice have the capacity to administer the requirement to submit claims for E&M services (for data collection and quality purposes) that will not be reimbursed?

- **Data Reporting:** Does the nephrology practice have the data reporting and ‘wrangling’ capabilities necessary to submit required quality metrics to CMS? Since the practice will need to begin administering and tracking the patient activation survey for late stage CKD and ESRD patients and for depression remission for CKD patients (which are not typically part of a nephrology practice’s workflow), does the practice have the capacity to absorb the administrative overhead necessary to capture the new quality data?
- **Benefit Enhancements:** Does the practice have the resources necessary to effectively administer the benefit enhancements such as those pertaining to KDE services and telehealth?
- **Payment Penalties:** Given that under the Performance-Based Adjustment (PBA) a certain percentage of practices will experience payment penalties, does the practice have the financial wherewithal to absorb such penalties if necessary?

As RPA learns more about the voluntary KCF/CKCC payment models, RPA membership will be apprised of key developments.