CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11553	**Date: August 11, 2022**
	Change Request 12802

SUBJECT: Automatic Reprocessing of Claims for Kidney Care Choices (KCC) Model- Implementation

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to include automatic reprocessing into claims processed for the Kidney Care Choices (KCC) model. CRs 11914, 11915, and 12362 process claims as per the KCC model related payment adjustments, benefit enhancements and other adjustments. These CRs specifically removed automatic reprocessing due to the limitations at the time, hence, this CR is reintroducing automatic reprocessing to avoid multiple issuances of Technical Direction Letters (TDLs).

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Demonstrations

Attachment - Demonstrations

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I. GENERAL INFORMATION

A. Background: The Kidney Care Choices (KCC) Model includes two options, each with its own demo code: Comprehensive Kidney Care Contracting (CKCC) (demo code: 93) and CMS Kidney Care First (KCF) (demo code: 97). The KCC Model begins on January 1, 2022, and ends on December 31, 2024, or optionally, December 31, 2026.

For the CKCC Options, nephrologists and nephrology practices must partner with transplant providers, and may partner with dialysis facilities and other providers and suppliers to become Kidney Contracting Entities (KCEs). KCE nephrologists will receive adjusted capitated payments for managing beneficiaries with CKD stages 4 and 5. KCEs will also have access to Benefit Enhancements (BEs) to strengthen care coordination for aligned beneficiaries and alternative payment mechanisms to manage cash flow.

- Payment Mechanisms (PMs) allow providers to elect 100% reduced (i.e., "zeroed out") Fee-for-Service (FFS) claim payments in return for their KCE practice receiving predictable prospective payments. In the first Performance Year of CKCC, there will be one PM: Chronic Kidney Disease Quarterly Capitation Payment (CKD QCP).
- Benefit Enhancements (BEs) are waivers to Medicare payment rules that offer flexibility for care coordination and delivery. They allow beneficiaries to receive services and providers to receive payments for those services that are not otherwise covered by Medicare. There are six BEs included in Change Request (CR) 11915.

For the CMS Kidney Care First (KCF) Option, nephrologists and nephrology practices will receive adjusted capitated payments for managing beneficiaries with Chronic Kidney Disease (CKD) stages 4 and 5 and ESRD (End State Renal Disease), and will be eligible for upward or downward payment adjustments based on the quality of their performance and improvements in their performance over time. This model is designed to emulate the basic design of the Primary Care First (PCF) Model, in which participating practices will be accountable for managing the care of attributed Medicare beneficiaries. The KCF option will include Benefit Enhancements to enable nephrologists to strengthen care coordination for beneficiaries with CKD stages 4 and 5, as well as new financial mechanisms to enable participants to manage cash flow.

- Payment Mechanisms (PMs) allow Providers to elect 100% reduced (i.e., "zeroed out") Fee-for-Service (FFS) claim payments in return for their KCF Practice receiving predictable prospective payments. These mechanisms function similarly to Population Based Payment (PBP) and AIPBP (All-inclusive) in the Next Generation Accountable Care Organization (NGACO). In the first Performance Year of KCF, there will be one PM: <u>Chronic Kidney Disease Quarterly Capitation Payment</u> (CKD QCP).

- Benefit Enhancements (BEs) are waivers to Medicare payment rules that offer flexibility for care coordination and delivery. They allow beneficiaries to receive services and providers to receive

payments for those services that are not otherwise covered by Medicare. There are three BEs included in Change Request (CR) 11914.

The performance period between the participant and CMS begins on January 1, 2022 (the "Start Date") and ends at 11:59 PM ET on December 31, 2026, unless terminated by either party, in which case the agreement ends on the effective date of termination. If the agreement is terminated by CMS, as noted below, the Agreement Performance Period ends immediately on the effective date of termination of the Agreement.

CMS may terminate the participant immediately or with advance notice if:

- CMS determines that the participant no longer has the funds to support the Model;
- CMS modifies or terminates the Model pursuant to section 1115A(b)(3)(B) of the Act;
- CMS determines that any grounds for remedial action exist.
- CMS has denied, suspended, or terminated the KCE's participation in the CKD QCP for a Performance Year;
- CMS determines that one or more of the KCE's KCE Participants or Preferred Providers has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the Model; or
- The state in which the participant operates enters into an arrangement with CMS that is based on a statewide global or per-capita Medicare payment.

The practice may terminate the agreement performance period as well under the below circumstances:

- The KCE may terminate the Agreement Performance Period upon advance written notice to CMS. Such notice must specify the effective date of the termination, and such date may be no sooner than 30 Days following the date of that notice.
- For KCF:
    - Practices have certain deadlines they have to notify CMS by in order to terminate from the model. Meeting these deadlines allows for them to have a certain date of termination. For example, if a Practice sends a written notice of termination to CMS on or before September 30, 2023, the effective date of termination of this Participation Agreement is December 31, 2023.

Other types of termination are:

- Retroactive participant drops: This is when an individual participant is removed from a KCE's participant list with a retroactive drop date. Claims for that individual participant that were adjusted would be reprocessed.
- Midyear dealignment: This is when we discover a prohibited overlap, and the resolution to the negotiation is that we have to give up the beneficiary. We could dealign retroactively which would mean the claims for the beneficiary need to be reprocessed as the beneficiary would have never been part of the model.

Depending on the type of termination and the termination timeline claims could have been processed under the model and need to be reprocessed. As the volume of claims that are processed for the model is large, if a situation were to arise, then automatic reprocessing is necessary to avoid any and all manual reprocessing for this model. The claims that would be reprocessed would be those adjusted under the demo codes 93 or 97 for the different PMs and BEs, if any processed, as mentioned above.

The beneficiary file provides the active beneficiaries whose claims are adjusted based on their alignment to the providers on the provider list (who are part of the model). Any changes that occur on either of the beneficiary or

provider file should trigger an automatic reprocessing of the claims as this would mean the details that were provided to process the claims originally have changed and need to be reprocessed with the new set of details.

B. Policy: Section 1115A of the Social Security Act (added by section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) authorizes the CMS Innovation Center to test innovative payment and service delivery models that have the potential to lower Medicare, Medicaid, and Children's Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care. Under the law, preference is to be given to selecting models that also improve coordination, efficiency and quality of health care services furnished to beneficiaries. Section 1899 of the Social Security Act establishes the Medicare Shared Savings Program, and authorizes CMS to share Medicare savings with participating accountable care organizations under certain circumstances.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12802.1	Effective with beneficiary alignment files processed on or after the implementation of the CR, contractors shall trigger an Informational Unsolicited Response (IUR) edit '7125' that apply to Part A and Part B claims for the following benefit enhancement indicators: • Demo 93 BEs - '2', '3', '4', '9', 'B', 'C', 'F' • Demo 97 BEs - '2', '3', 'C', 'F', 'G' when the following criteria are met for beneficiary changes (demo code 93 and demo code 97) • When there is a change in the beneficiary's alignment date. **NOTE: The quarterly full replacement file will also serve as the reprocessing file.**								X	
12802.1.1	Contractors shall initiate the adjustment process when an IUR is received from CWF.					X				
12802.2	Effective with provider alignment files processed on or after the implementation of the CR, contractors shall create and set up logic to allow claims (demo					X	X			

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	code 93 and demo code 97) to automatically reprocess claims from the beginning of the provider's start date when the following criteria are met: • When a provider is added on to the quarterly replacement file • When a provider is dropped from the quarterly replacement file • When there is a change to the provider's alignment period on the replacement file **NOTE: The quarterly full replacement file will also serve as the reprocessing file.**									
12802.2.1	FISS shall create a process to identify 'dropped' records in the Provider Participation file and create adjustments accordingly per BR 12802.2.					X				
12802.3	Contractors shall use existing IURs, MCS reason code "O" and MCS discovery code "C." Note: The IURs are not eligible for 935 appeal rights.		X							
12802.4	The contractor shall not generate IUR '7125' for claims that process within 90 days after the beneficiary termination date.								X	
12802.5	Contractors and SSMs shall participate in a single, one-hour long teleconference with CMS during the MIST testing period to discuss problems identified during testing at a date to-be-determined by CMS. This date will be communicated on a future Functional Workgroup (FWG) call. Note. • Please send the email addresses where the invites should be sent to manasa.peddy@cms.hhs.gov within 5 business days of the CR issuance. • MIST invitations should be sent to MIST_Systems@sparksoftcorp.com.					X	X		X	MIST

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• CWF does not regularly attend FWGs and must be informed of the time/date of the UAT call separately									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Heather Maldonado, heather.maldonado@cms.hhs.gov , Manasa Peddy, manasa.peddy@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

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ATTACHMENTS: 0