Accountable for HEALTH

C+TAC COALITION TO TRANSFORM ADVANCED CARE

REGULATORY AND LEGISLATIVE RECOMMENDATIONS

COMPREHENSIVE KIDNEY CARE CONTRACTING: IMPROVEMENTS FOR INDIVIDUALS WITH SERIOUS ILLNESS

Accountable for Health and the Coalition to Transform Advanced Care submitted recommendations to the Center for Medicare and Medicaid Innovation that would strengthen the Comprehensive Kidney Care Contracting model and offer a broader roadmap for advancing care for people with serious and chronic illnesses. These recommendations reflect a growing need to better align care delivery and payment with the realities facing patients living with complex, long-term conditions, ensuring care is more coordinated, supportive, and responsive to what matters most to patients and families.

1. Model Permanence, Stability, and Transparency

Model stability and transparency are essential to sustaining provider participation—particularly among small and mid-sized organizations. Current retrospective trend adjustments have introduced financial unpredictability, undermining confidence in the model and limiting long-term investment.

Recommendations

- Establish a clear pathway to model permanence by releasing a public summary of CKCC evaluation findings, including evidence of cost neutrality and quality improvement.
- Reduce financial volatility by convening a technical workgroup (CMMI + CKCC participants) to review and refine retrospective trend methodologies.
- Improve metric clarity and alignment by simplifying and standardizing quality measures to reduce administrative burden and increase actionable use.
- Provide prospective guidance on benchmarking and trend assumptions to allow participants to plan and manage risk more effectively.

2. Beneficiary Choice, Information, and Engagement

Beneficiaries currently lack visibility into CKCC-participating entities and are not consistently equipped to make informed decisions about their kidney care options across the continuum.

Recommendations

- Develop a beneficiary-facing directory of CKCC participants that includes standardized information on quality, patient experience, and available services.
- Advance shared decision-making infrastructure by embedding tools that clearly present dialysis modalities, transplant pathways, conservative management, and palliative care options.
- Strengthen caregiver integration by:
  - Requiring meaningful caregiver engagement in care planning, where appropriate.
  - Clarifying and expanding regulatory flexibilities for caregiver supports through supplemental benefits and care coordination services.
- Ensure equity in access to information by making tools culturally competent and accessible across literacy levels.

3. Integration of Palliative and Hospice Care

There remains a significant gap in integrating palliative and hospice services within CKCC, with limited utilization of existing concurrent care flexibilities and insufficient transparency into outcomes.

Recommendations

- Increase transparency and accountability by publishing data on utilization, outcomes, and disparities related to the concurrent hospice waiver.
- Test a dedicated palliative care track within CKCC, focused on community-based palliative care delivery, care coordination, and symptom management.
- Expand the quality framework to include:
  - Symptom burden
  - Patient-reported distress
  - Goal-concordant care indicators
- Advance broader policy alignment by exploring expansion of concurrent hospice and disease-directed care flexibilities beyond current demonstration limitations, including consideration for Medicare Advantage populations.

4. Upstream and Patient-Centered Kidney Care Pathways

There is a critical opportunity to better support patients across the kidney disease continuum by prioritizing quality of life, goal-concordant care, and earlier integration of supportive services.

Recommendations

- Pilot a “Palliative Dialysis” quality measure to better capture care aligned with patient goals, particularly for those prioritizing comfort over life prolongation.
- Develop care pathways for patients who forgo or discontinue dialysis, including:
  - Standardized clinical protocols
  - Care coordination supports
  - Family and caregiver resources
- Invest in workforce capabilities by promoting training for nephrology teams in:
  - Serious illness communication
  - Early goals-of-care discussions
  - Advance care planning
- Encourage earlier upstream engagement through incentives for timely referral to supportive and palliative services.