CLIENT ALERTS & INSIGHTS

CMS Terminates KCF Model and Finalizes Significant Revisions to CKCC Participation and Payment Framework

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On May 28, 2025, the Centers for Medicare & Medicaid Services ("CMS") Innovation Center formally announced the early termination of the Kidney Care First ("KCF") model effective December 31, 2025, and issued a suite of substantial revisions to the remaining tracks within the Kidney Care Choices ("KCC") model. These developments mark a significant policy pivot aimed at reducing model-related Medicare losses, promoting financial sustainability, and transitioning value-based kidney care toward more scalable, entity-based structures.

The KCF model, which was originally scheduled to conclude at the end of PY 2026, will sunset one year earlier than planned. Simultaneously, the Graduated, Professional, and Global tracks under the Comprehensive Kidney Care Contracting ("CKCC") umbrella will be extended through PY 2027, but with material changes to benchmark discounting, capitation payments, transplant incentives, and geographic eligibility.

Termination of the Kidney Care First (KCF) Model

CMS's decision to discontinue the KCF model stems from mounting operational and fiscal concerns. Launched as a practice-level demonstration designed to accommodate smaller nephrology groups, the KCF model faced persistent barriers to adoption and implementation, including:

- **Limited Scale:** Only 15 practices enrolled, covering approximately 6,000 attributed beneficiaries nationwide.
- **Administrative Complexity:** Participants consistently raised concerns about onerous reporting obligations, limited analytics access, and a lack of real-time CMS engagement.
- **Financial Underperformance:** The model produced approximately $304 million in net Medicare losses during PY 2023.

KCF participants will be required to complete a model close-out process in accordance with forthcoming CMS instructions. This process will include data destruction requirements, provider/supplier notifications, and final reconciliations. Participants seeking to continue within a value-based nephrology care framework must affiliate with an approved KCE under the CKCC framework no later than **June 20, 2025**, or explore other Accountable Care Organization (ACO) opportunities.

Major Reforms to CKCC Model Effective Performance Year 2026

CMS concurrently finalized a set of financial, operational, and eligibility-based reforms to the CKCC tracks-applicable to all existing and prospective KCEs. These changes are intended to balance the pursuit of improved care outcomes with CMS' cost containment goals and simplified model mechanics.

1. **New Benchmark Discounting**

- Professional and Global Track KCEs will now be subject to a 1% discount applied to both Chronic Kidney Disease ("CKD") and End-Stage Renal Disease ("ESRD") benchmarks beginning in PY 2026.
- These discounts reduce baseline expenditure benchmarks, effectively raising the hurdle that participants must surpass to generate shared savings.

2. **50% Reduction in CKD Quarterly Capitation Payments ("QCPs")**

- CKD QCPs-used to fund care coordination and early intervention-will be cut in half.
- KCEs that rely heavily on capitation payments for non-dialysis patient management may face significant cash flow constraints and must reassess staffing, case management, and telehealth infrastructure tied to these funds.

3. **Elimination of the Kidney Transplant Bonus**

- CMS will eliminate the $15,000 transplant bonus for all qualifying transplants performed on or after January 1, 2026.
- This change removes a longstanding incentive intended to offset the upfront clinical and administrative costs of transplant referrals and care coordination, particularly impactful for KCEs with high-performing transplant referral pipelines.

4. **Expanded Geographic Eligibility**

- CMS will broaden the definition of "contiguous CBSA" areas to include U.S. Territories, thereby increasing eligibility for KCE participation.
- This policy change enables providers in Hawaii, Guam, Northern Mariana Islands, American Samoa, Puerto Rico, U.S. Virgin Islands, and select adjacent mainland CBSAs to join or expand KCE coverage zones.

5. **One-Year Extension of the CKCC Tracks**

- The Graduated, Professional, and Global CKCC tracks are officially extended through December 31, 2027, giving participants additional time to adapt to revised model rules and continue earning shared savings under new methodologies.

Strategic Implications for KCEs and Nephrology Practices

These reforms reflect CMS's strategic departure from individual-practice models toward larger, integrated care frameworks. The policy trajectory indicates that future kidney care demonstrations will prioritize organizational scalability, standardized operations, and measurable fiscal impact over niche or boutique program designs. Participating KCEs should carefully evaluate the downstream effects of these changes across financial, operational, and compliance dimensions.

Key Next Steps:

- **Confirm KCE Affiliations:** Ensure that nephrology practices, dialysis providers, and transplant networks are listed as official KCE participants by **June 20, 2025**, to remain eligible for PY 2026 participation.
- **Reforecast Financial Models:** Update internal budgets to reflect reduced CKD QCPs, elimination of transplant bonuses, and tighter benchmark targets. The new structure may significantly affect net operating margins.
- **Evaluate Quality Strategy and Attribution:** Reassess performance improvement plans and benchmark management, particularly in light of discounting and potential changes to attribution logic and risk adjustment.
- **Assess Care Coordination Capabilities:** With reduced capitation funding, practices must determine whether existing infrastructure is financially sustainable or if downsizing and outsourcing may be necessary.

Conclusion: Navigating a More Demanding Model Environment

The combination of incentive reductions and heightened performance expectations under the updated CKCC framework will make it increasingly difficult for KCEs to generate shared savings unless they achieve material improvements in care efficiency and cost management. The model is shifting toward a leaner, outcomes-based structure, where only the most operationally disciplined entities are likely to thrive.

The Benesch Healthcare+ team monitors developments in this area of the law and may provide additional updates as they become available. Please contact the authors of this article for additional information or if you have any questions or would like assistance with affiliation planning, risk model recalibrations, and strategy alignment under the new policy landscape.

Please contact the authors below for additional guidance or model-specific consultations.

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