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CMMI Streamlines Final Transplant Payment Model, Boosts Upside Reimbursement

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The final version of a new payment model designed to increase kidney transplant rates and transparency is more streamlined than the initially proposed model, has easier goals to achieve for growth, and incorporates larger payments for transplant centers that meet the model's goals.

The release of the final Increasing Organ Transplant Access (IOTA) Model (1) is the latest step toward meeting the goals of the 2019 Advancing American Kidney Health Initiative (2), which aims to reduce the number of patients on dialysis by increasing prevention and transplants.

The Center for Medicare and Medicaid Innovation (CMMI) first released a draft of the IOTA Model in May 2024 and requested public comments. The final model, released in November 2024, reflects compromises intended to address stakeholders' concerns about the model while still achieving the goal of boosting transplant access. Currently, approximately 1 in 13 patients on the kidney transplant waiting list dies before receiving a transplant, and as many as one-third of donated kidneys are discarded due to system inefficiencies.

"Kidney transplantation is the optimal therapy for most people with kidney failure," said ASN Past President Deidra C. Crews, MD, ScM, FASN, in a press release from ASN about the final model (3). "I am optimistic that IOTA's focus on increasing transplant rates will mean that more of the 550,000 Americans on dialysis can benefit, given the known survival and quality of life advantages that kidney transplantation confers."

Crews and other ASN leaders applauded the final model for its emphasis on increasing transplant rates, expanding the use of donor organs, increasing transparency in the process for patients and referring

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Show Me the Money: 2024 Nephrology Fellow Survey and Trends in Starting Salary

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In 2020, the COVID-19 pandemic took the world by storm, causing significant and acute changes to the global economy. It caused near-immediate reductions in product supply chains as well as in human capital, including nurses and physicians. Work-related hazards and caregiver challenges (precipitated by lockdowns and virtual education) caused many health care professionals to leave the workforce. Meanwhile, market forces led to a tremendous spike in inflation, sending consumer prices soaring over the next several years. How might these events have impacted the economy for new nephrology graduates, including their salaries, job descriptions, and perspectives on the job market? We turned to the 2024 ASN Nephrology Fellow Survey Report to hear what story it tells (1).

Incoming workforce

The 2024 survey was distributed in May 2024 to 962 current adult, pediatric, and adult-pediatric fellows in Accreditation Council for Graduate Medical Education (ACGME)-accredited US nephrology training programs. The response rate was 46% (n = 447), which was on par with previous years. Respondent demographics were generally consistent with those reported by

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nephrologists, and focusing more on improving longer-term transplant outcomes.

A model approach

The 6-year mandatory IOTA payment model pilot is designed as a randomized trial to test the model's ability to increase transplant rates. Eligible transplant programs in about half of the transplant service areas—approximately 230 in total—will be required to participate, and the other half of transplant centers will serve as a control group.

The model incentivizes transplant centers to increase the number of organs that they transplant annually and complements previous Centers for Medicare & Medicaid Services (CMS) payment models, like the 2021 End-Stage Renal Disease Treatment Choices (ETC) Model and the 2022 Kidney Care Choices (KCC) Model, which incentivize nephrologists and dialysis centers to refer patients for transplant.

"With the creation of the IOTA Model, CMMI is aiming to create value-based care models that support the continuum of kidney disease care, from KCC for patients with advanced chronic kidney disease to ETC for end-stage renal disease and now for patients who could receive a kidney transplant," said Mallika Mendu, MD, MBA, FASN, a nephrologist and vice president of Clinical Operations and Care Continuum at Brigham and Women's Hospital in Boston, MA, in an emailed statement. "Overall, the focus on creating value for patients with kidney [diseases] (improving quality while reducing cost) is positive, and related to IOTA, the opportunity to increase the number of transplants performed is potentially transformational."

The final IOTA model represents a more streamlined version. "It's an excellent model with some important changes from the proposed rule that are reasons for significant enthusiasm," said Sumit Mohan, MD, MPH, FASN, professor of medicine and epidemiology at Columbia University in New York City. He explained that the revised goals for increased transplant rates are more realistic, and achieving the criteria needed to earn the incentive payments is easier.

Eugene Lin, MD, MS, FASN, a health economics researcher and assistant professor of medicine at the University of Southern California in Los Angeles, also liked CMMI's steps to simplify the model. He noted that overly complex models can be confusing for clinicians and may set goals that are hard to achieve. It can also be difficult for patients to understand the goals of more complicated models. "It seems like CMMI has been moving toward more simplicity on these models, which I also think is a good thing for [practitioners]," he said. "They are literally just being incentivized to do more transplants."

Positive developments

Changes that ASN championed that were contained in the final model included pushing back the program's start date from January 1 to July 1, 2025, to give participating programs more time to prepare.

Another ASN-backed change was an increase in the Medicare fee-for-service beneficiary upside payments for centers that meet the model's goals from $8000 to $15,000. Many comments on the initial model raised concerns that the originally proposed $8000-plus side payment would not be enough to cover additional staff or services needed, particularly for the care of patients who have medical complexities.

Mendu, Mohan, and Lin were all appreciative of the decision to increase the reimbursement. "To succeed in this model, hospitals and [transplant centers] will need to make investments in infrastructure and staffing, particularly to support more complex patients," Mendu explained.

Centers that fail to meet the program goals must pay CMS $2000 per patient—the same as in the original proposal. Lin noted that centers have quite a bit of latitude; a center does not need to be performing at the highest level to avoid the penalty, and moderate performance is enough to avoid penalties.

Programs will be assessed on various factors, including growth in their overall transplant rate, donor organ acceptance rate, shared decision-making, and longer-term patient outcomes. Lin noted that the goals for growth were adjusted in the final proposal to be more sustainable and to rely on a 3-year average performance. He said that having a 3-year average is important because it will prevent centers from being penalized if something beyond their control happens, which temporarily lowers their annual transplant rate. "[Transplant centers] are not being held accountable to statistical noise," he said. "They're being held accountable to something that's more long-term and sustainable."

The IOTA Model also includes several measures to increase transparency in the transplant system. For example, transplant centers will be required to publicize their waitlist criteria, which may help patients find the right program. "One of the most challenging aspects of helping the patients [who] I have the privilege of serving get a kidney transplant is determining which program is the best fit for them," Crews added. "Being able to publicly access the criteria [that] each program uses when determining whether or not to add a patient to the kidney transplant waitlist will help me and the people with kidney failure that I care for navigate the system more efficiently and effectively."

The model also incentivizes centers to discard fewer organs. "There is a clear focus on improving efficiency and a center's organ offer acceptance rate," Mohan said. "As a result of the focus on organ acceptance rate, the model should help improve organ utilization and lower discard rates."

Room for future improvement

Although CMMI included many of the changes that ASN and individual nephrologists recommended in the model, there were a few notable omissions.

The final model did not include a requirement that centers inform patients if an organ declined on their behalf is successfully transplanted into someone else. On average, patients who die while on the waitlist have had 17 kidneys declined on their behalf that were successfully transplanted into someone else (4). Mohan called the omission unfortunate. The American Society of Transplant Surgeons recommended the change because it argued that the notifications would create an administrative burden (5).

Mohan and Lin agreed that adding patient notifications about declined kidney offers in the future might be beneficial. Lin noted that clinicians want to avoid overloading patients with information and carefully consider how to share information about declined offers. "We need to be moving in that direction long term but recognize that it may not be that simple to get there," he said. Mohan also hoped that tracking 6-year transplant outcomes, an exclusion in the revised model, may be added in later years to help bolster the emphasis on improving longer-term outcomes.

A health equity payment adjustment was also not included in the final model, and a requirement that centers create a health equity plan was made voluntary. "I am concerned that the health equity requirements were dropped from this proposed model, as that was a novel and important aspect of the initial proposed model," Mendu said. "The challenge is that there are already significant, long-standing disparities among under-represented minorities with respect to receiving kidney transplantation. A model like this that [strives] to increase kidney transplantation, without addressing the drivers of inequity, could exacerbate existing disparities."

Still, Mendu was optimistic that the model would help improve transplant quality, efficiency, and rates. However, she noted that it would be essential to track patient outcomes, including those related to disparities; monitor the effects on clinicians and centers; and provide feedback to CMMI. ■

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