Transcript of Webinar: Overview of the CEC RFA
Recorded on May 31, 2016
Centers for Medicare and Medicaid Innovation

Jennifer: Hello, everyone and thank you for joining us. I would like to welcome each of you to today's learning event titled, Overview of the CEC RFA. My name is Jennifer Brock and I will be moderating today's learning event. During today's event presenters will provide an overview of the goal of the CEC Model, discuss terms of the award, and the eligibility criteria for model applicant, and describe any changes from the first public solicitation.

Today's event is open to dialysis facilities including large dialysis organizations or LDOs and non-large dialysis organizations or non-LDOs. Nephrologists and all other clinical and non-clinical ESRD care providers and stakeholders interested in learning about the second solicitation for the CEC Model.

I would like to take a moment to inform today's learning event participants that all comments made on this call are offered only for general informational and educational purposes. As always, the agency positions on matters may be subject to change. CMS's comments are not offered as, and, do not constitute legal advice or legal opinion, and no statement made on this call will preclude the agency and/or its law enforcement partners from enforcing any and all applicable laws, rules, and regulations. ACO's are responsible for ensuring that their actions fully comply with applicable laws, rules, and regulations, and we encourage you to consult with your own legal counsel to ensure such compliance.

Furthermore, to the extent that we may seek to gather facts and information from you during this call, we intend to gather your individual opinion only. CMS is not seeking group advice.

Before we begin I would like to point out a few tips so that we can have a successful learning event today. First, since we are recording this event, all attendees online has been placed in a Listen Only Mode. The recording from today's event will be e-mailed to registered attendees following today's event. It may also be accessed via the Center for Medicare and Medicaid Innovation Comprehensive ESRD Care Model Webpage, within two weeks following today's event.

Second, there will be a formal question and answer period at the end of this event. Attendees are encouraged to submit any questions they might have into the Q and A pod to the right of your webinar screen, either during the event or during the Q and A period. During the Q and A period I will attempt to address all questions entered into the pod to the CEC Model Team Member. However, in the instance all questions cannot be addressed attendees are encouraged to e-mail their questions to ESRD-CMMI@cms.hhs.gov following this event. If you have any technical questions or issues during today's event please submit a question to Caitlyn McTague, who is our producer in the Q and A pod. Caitlyn will be happy to assist you.

Finally, a PDF copy of today's slides along with a copy of the RFA fact sheet can be accessed by clicking on the link under the download presentation pod located to the bottom right corner of your webinar screen. There is also an opportunity for you to provide feedback on this event by clicking on the link in the feedback survey pod to the right of your screen.

Let's get started. I would like to begin by conducting a brief poll to get a sense of the audience joining us during today's event. Caitlyn, would you please open the poll.

Caitlyn: The poll is now open, everyone on the line please click on the title that best describes you under Question 1 and click on the number of people currently in the room viewing today's event with you under Question 2. All right, looks like we've got a lot of activity.

Jennifer: Should we close the poll, Caitlyn?

Caitlyn: Yes, I'm going to close the poll now. Thank you for participating.

Jennifer: All right, looks like we have a majority of hospital administrator facility staff. Let's see the result. We also have a lot of Others, if you don't mind. For anyone who selected Others, if you don't mind entering in the Q and A pod, on the right of your screen. All right, let's head back to the main meeting room, shall we.

All right, I would like to now turn the presentation over to our first presenter today. Starting the discussion today will be Dr. Mai Pham, who is the Chief Innovation Officer at CMMI, Mai.

Dr. Pham: Good afternoon, thanks so very much, and thanks very much for all of you who are attending this webinar. We are very excited to be able to talk with you about the second solicitation for the Comprehensive ESRD Care Model. I'm speaking on quite a personal level having used to run the Seamless Care Models Group where the CEC Model was first, and which I remember from several years ago beginning the thought work on and engaging many of you in thinking through design elements. We have, as our current model participants know, continue that engagement. The team has been very open to hearing important feedback on an on-going basis and it is in no small part due to all of those conversations that we are coming back to you today, and out in public again with another solicitation with what we think are design elements that are responsive to a lot of the feedback that you gave.

I really am excited to hear from the team that they've already began having conversations with a number of organizations, some of whom we're not engaged at all in the first solicitation round, others of whom maybe be considered the first solicitation or giving the model a second look and very excited to hear that we have a good and healthy mix of large and small organizations, experienced and less experienced organizations and organizations from different geographies. All of those factors, we think will make for a stronger model tests, as well as a stronger and richer learning experience for the organizations that do come in.

Again, I really want to extend my welcome and my thanks to you all for your interests and my hope that you will see through this application process despite the very compressed timeline. We are hopeful that you will continue to engage with us. I'm going to turn it over now to Tom Duvall.

Tom: Thanks Mai. Next slide. My name is Tom Duvall. I know I've met a lot of you but I'm the Team Lead for the CEC Model here at CMMI. We have a few goals here really with this presentation today. Again, we're very excited to have so many of you on here. One goal is to talk about the current status of the CEC Model, so that you all understand where we are right now. Another goal is to really provide an overview of the model, hit some of the key design elements and especially focus on some of the changes that are happening with round two here. Then we're going to talk about the proposed solicitation, some of the key details, what the process looks like, and then finally answer questions from you all. Next slide.

Our main principle with this model is really about trying to move dialysis care, dialysis facilities and nephrologists beyond just dialysis care and really holding you all responsible for the total cost of care for beneficiaries. What this chart shows is that for the average dialysis patient approximately 1/3 of the spending comes from the dialysis PPS bundle, the other 2/3's though is outside of dialysis. We know that there's already a lot of CMS programs and efforts around the dialysis side, with the QIP Program and including the PPS bundle.

What our real goal is to expand the responsibilities of the nephrologists and dialysis facilities already have for the dialysis services and really allow them, allow you all to coordinate care for the other 2/3's of spending, and across the full spectrum of care for beneficiaries. Next slide.

What the CEC Model is, it's developed by the Center for Medicare and Medicaid Innovation within CMS and our real goal is that it's a coordinated care effort where three key groups come together to coordinate the ESCO, to coordinate the care for the beneficiaries within an ESCO. An ESCO is an ESRD Seamless Care Organization which is our term for an ACO. What that is made up of, that's a legal entity that you I'll hope will be applying for, and that there's three key providers in an ESCO.

One of them is the dialysis facilities, that's obviously where patients get the day to day care. That's where we take the beneficiary toward visiting those relevant dialysis facilities. The nephrologist, who we view as co-equal partners during this process and service the primary care providers for these patients, and finally just the other providers, these includes all the relevant specialists, long-term care providers, hospitals, and all of the providers. You really need to form a network to coordinate care, all of the care for these beneficiaries. Next slide.

I want to put the CEC Model in the context of the larger accountable care organization ecosystem at CMS, because one view of the CEC Model is that it's an expansion of the existing CMS Dialysis Focus Programs like the QIP and like the PPS Bundle, but on another view we are a test a of the ACO Model as applied explicitly to ESRD population. All these other ACO models that are being tested at CMS include

the entire Medicare fee for service population. This model is really testing whether or not a dialysis-focused model just for the ESRD population can really, kind of better care for beneficiaries and better save CMS money.

As you can see the pioneer ACO model and the Medicare Shared Savings Program both launched in 2012 and include the all Medicare fee for service population, with a mix of mostly one-sided risk on the Medicare Shared Savings Program and then two-sided risk for Pioneer and the next generation ACO model. The CEC Model, as we'll get to in a minute has a mix of one-sided and two-sided risks. Next slide.

This again is a certain outline of the three key types of providers in an ESCO. The model is divided and we'll get a little bit more into this later between LDOs and non-LDOs. The LDOs are the large dialysis organizations with over 200 facilities. The non-LDOs, and this is all used in the definition from the US Renal Data Survey, includes the facilities owned by the small dialysis organization, the hospital-based facilities, and the independently-owned dialysis facilities. Any organization that has an LDO dialysis facility that is owned in whole or in part by a large dialysis organization would be on the LDO track for this model. Any ESCO that has any dialysis facilities owned by a small dialysis organization, a hospital-based facility or an independent-based facility, they would be in the non-LDO track.

One of the key things to think about as you're putting together any applications or thinking about any potential ESCOs, is that we only allow a single dialysis company per ESCO. What that means is that two, say small dialysis chains could not work together as part of the same ESCO. We'll talk about aggregation a little bit later on but I just wanted to put that part out there. One important fact on that is for joint ventures those count as still being owned in whole or in part of the same company. We don't treat joint ventures separately, so that if you want to include dialysis facilities wholly owned by your company and joint ventures that are owned in part by your company, that would be fine to include as part of the same ESCO. Next slide.

Our real goal is that once we have this organization and once we figure out who's exactly is in your ESCO there's three big goals that we really have. The first is increasing quality. We have a pretty rigorous way of measuring this with 26 quality measures around the five domains that are part of the overall CMS quality strategy. Around patient safety, patient experience, care coordination, clinical quality of care, and population health. We use some of the existing measures that are out there from the ESRD Quality Incentive Program and Dialysis Facility Compare, as well as using some of the ICH-CAHPS scores that you all get from your dialysis facilities.

Quality is a very important part of the model and in order to help bring that back into the financial savings, financial results are adjusted by the quality performance and we require that ESCOs must meet minimum quality thresholds in order to be eligible to achieve any shared savings. Next slide.

The quality part and really trying to improve quality is one of the key benchmarks of the model and model success. The other key part is on the financial side and the way that this works is virtually identical to the financial model for other accountable care

organization models, where what we do for an ESCO is that we measure your financial performance, which is the total Medicare A and B cost for all of your aligned beneficiaries relative to an annual benchmark. An annual benchmark is our term for what your cost target is. The cost target, the benchmark is based off of your historical cost in 2012, 2013, and 2014. Then to get from those average historical cost to your present, your benchmark we would trend it forward annually and risk adjust it using the CMS-HCC Risk Adjustment Model.

One key point about this model relative to other ACO models is that there is no rebasing that is currently a part of the model. Even as the years go on you will be judged relative to your 2012, 2013, and 2014 historical expenditures. There is not rebasing the way that there is in other ACO models. One of the key part, the key points and which pits them with the whole larger idea of the model is that the benchmark includes the cost of all the A and B benefits for beneficiaries not just dialysis costs. The real principle is holding all the patient's providers responsible for the cost that they're seeing.

As we talked about earlier there's different track here in the model for LDOs and for non-LDOs. The key divide is 200 dialysis facilities as we defined it, as is defined by the US Renal Data Survey, with separate financial models for each. The LDO side has a two-sided risk with upside and downside, as well as with sharing rates and higher caps overall. The non-LDO side currently has only a one-sided track with a 50% sharing rate, but there is not the potential downside of having to pay back shared losses to CMS.

However, as part of this solicitation and for the ESCOs currently in the model we're adding a two-sided track for the non-LDOs. What this means is that you will have the option of choosing whether or not you want to have one-sided risk at a 50% sharing rate or two-sided risk with the potential to pay back money to CMS, but also the potential to earn a higher level of savings at a much greater level of savings, as well as potential losses. This is one of the key differences and one of the key changes that we wanted to really point out to you all as part of this solicitation. Next slide.

One of the key features that we have for non-LDOs is the idea of aggregation. Based off of the actuarial work that was done by our partners here in CMS, LDO ESCOs are required to have a minimum of 350 beneficiaries, non-LDO ESCOs however can have fewer, kind of in recognition that some of you all are the independent or pretty small chains. However, if you have fewer than 300 beneficiaries what we do, we do an accounting mechanism at the end of the year called aggregation, and what that involves is adding together the aggregate financial performance of all of the ESCOs in the aggregation pool. We would add that together, add together all the benchmarks, add together all the performance to your expenditures and then see at the end of the year what the total savings are.

Financial performance would be evaluated on the aggregate level, whereas quality would be evaluated on the individual level. Each ESCO would still ultimately get an insured savings based off of their performance on individual quality measures.

Two other key factors here, one is that having more beneficiaries in the pool leads to a lower minimum savings rate. That's our term for the threshold of savings that the aggregation pool would have to meet in order to get any savings. You can think of it as a margin of error that's based on statistical numbers and designed to ensure that any savings that are actually paid out are statistically significant. The other key point is that there is going to be separate aggregation pools on the one-sided track and on the two-sided track.

The aggregation pools will be determined at CMS' discretion, it will ultimately depend on the number of applicants, the nature of all the applicants who apply, on the non-LDO side for what the final pools will look like. If you have specific preferences for who you might want to aggregate with, please let us know and I think we can take that into account, but ultimately we'll make choices based off of what the number and the nature of non-LDOs looks like for PY2 of the model. Next.

Then we get to Calculated Shared Savings. The first step is really comparing what the aggregate expenditures, the aggregate Medicare A and B expenditures were for each ESCO and then we compare it to what that cost target, what that benchmark was. We check to make sure that the quality performance mechanisms were met, and then if that number is less than the cost target then the ESCO would have the potential for savings. If the expenditures are greater than the benchmark then the ESCO would be required to pay back a portion of the losses to CMS. Again, if those losses would be outside of the margin of error, and that would be in the two-sided track only. For the LDOs and for those non-LDOs who choose a two-sided track.

One other key different here relates to the minimum loss and savings rate and this is a difference per PY2 of the model. For one-sided ESCOs the minimum savings rate, that margin of error calculation I talked about earlier is set, actuarially based off of the number of beneficiaries in the aggregation pool. However, for two-sided ESCOs it is currently set at a flat 1%. As per PY2 we are now going to allow you to choose a number between one and two percent. It will give you the option to choose a little higher levels of risk or of savings, and to decrease your potential for losses while at the same time decreasing your potential for savings, then at the same time cap the expenditures to help protect against some high-cost outlier patients.

The next one, just a quick overview on alignment. Our general principle here is that the beneficiaries are aligned to the ESCOs who visit those ESCO dialysis facilities. Beneficiaries then stay aligned for the rest of their performance here, unless they die, get a kidney transplant or move out of the service region which would cause them to be excluded at the end of the year. There is a new rule for PY2, is that beneficiaries will now be removed at the end of the performance year if they did not visit an ESCO dialysis facility during the performance year. It previously has been for the life of the model, but we wanted to, I think, really make sure that the ESCOs were responsible for the patients who they were actively seeing. A single dialysis visit from a beneficiary still would align the beneficiary to your ESCO.

Now I want to give a brief overview of where the model is and get into the solicitation. We launched October 1st 2015 with Round 1 of the model. We currently

have 13 ESCOs with a mix of LDOs and non-LDOs in different markets around the country and approximately 16,000 beneficiaries. The model will run until December 31, 2020. There is three base performance years of the model which are 2015/16, 2017, and 2018, and then two option years for the model at CMS discretion which are 2019 and 2020. The model would not be extended for new applicants who come in, if you came in you would have the two performance years of 2017 and 2018 and two option years after that at CMS discretion of 2019 and 2020.

This is a list of our current ESCOs participating in the model. We have the Rogosin Kidney Care Alliance as our one non-LDO currently participating in New York. We have DaVita ESCOs in Miami, Philadelphia, and Phoenix, Fresenius ESCOs in Columbia, South Carolina, Philadelphia, Chicago, Charlotte, San Diego, and Dallas, and DCI ESCOs in Newark, Nashville, and Spartanburg, South Carolina.

Now I want to get into and talk about the solicitation process a little bit. Just a brief overview about why we're doing this. I think our real goal is to just improve the quality of the model test. The greater number of participants that there are in the model will improve the test that we're doing, to really detect any cost-savings or improvement in quality. We view the CEC Model as a test for this model of care, and really seeing what are the effects on quality and cost, to see if this is something that CMS should expand. Our next goal is to really bring more non-LDOs into the model just to improve our ability to test out the non-LDO track. Finally, just to recognize that there is demand out there in the marketplace, which we can see just given the number of participants on this call and some of the increased incentives to participate in models like CEC.

Here are some of the key dates. We announced the solicitation May 19th. Request for applications is due July 15th. As Mai said we know that this is a cramp time frame and we apologize for this, and it was due to some factors outside of our control. I think what our big message is, is that we want to tell you to please apply. We recognize that the cramp time frame could potentially hurt the quality of your application, but we will keep that in mind as we evaluate the applications.

What's most important right now is to, A. Get your application in. Begin to think about forming your ESCO, but the most important thing to having your application is the providers. You won't be able to add providers until PY2 of the model. It's most important right now, if possible, to talk to your providers and try to align them. The most important providers of course, outside of the dialysis facilities would be the nephrologists. As part of nephrologists' co-equal status in two-sided models, in both financial models, nephrologists are co-owners of the ESCO, and in two-sided models would be required to receive shared savings separately and pay back losses separately. Just as a way to serve we add extra incentive and to really keep nephrologists as a key part of the model.

The applications are due July 15th and we'll let you know if you're accepted as a finalists in September, at that point we'll send you a whole bunch of materials including a final participation agreement for you to sign and get back to us by

December. Then new ESCOs would begin January 1, 2017 for the second performance year of the model.

The application process. The key thing here and some of you have already done this, is to e-mail the potential ESCO name along with the e-mail and name of the main ESCO contact to our e-mail address ESRD-CMMI@cms.hhs.gov. Once you e-mail us with that we can set you up an account on the portal. The RFA, the request for application's document is also posted on the CEC website and that will show the application and it will also give a lot of background on everything that we're looking for and include a lot of details there. I think I'm good, next slide.

Just going over some of the key differences between this and the different solicitation. The model is now up and running, that's different than applying to just a more hypothetical program. We have a final participation agreement and waivers. We have the benefits of operational experience, both on the CMS side and on ESCO side. We know that ESCOs can work and we know we have a better idea about what we're doing on the CMS side.

MACRA, the Medicare Access and CHIP Reauthorization Act, that I'm sure you've all heard a lot about. It really helps to encourage physician participation in models like CEC by giving bonuses for participating in alternative payment models like CEC. That's not finalized but that's a big incentive for the physicians. Finally, we just wanted to note that our real goal is that when we get the applicants to come in, is that we're going to treat everybody the same. The only exception would be that the new participants would have the first year of quality reporting as pay-for-reporting. That'll be a little easier as you're getting used to the quality reporting process, but otherwise you'd be treated the same, with the same access to CMS, the same policies, the same participation agreement, and really the same opportunity to participate in this big learning event that we're very excited for.

For additional resources the biggest one by far is our website. There's some of the key things on there. There's the press release that's just summing up the solicitation. There's a fact sheet that sums it up and should be shared. This is also all public so we encourage you to point anybody you want to this. There's the full request for applications document that includes the application. The application has not really changed since the 2014 one, if you got started on that, the application has not changed very much. We'll have the future webinar to go over that, as well as the PY1 financial methodology and the quality methodology, showing, giving details about our quality measures and the financial methodology. Then there's also a link there to the waivers for our current model participants.

Thank you all for coming. This is step one of our webinars. We have three more webinars and three more sets of office hours. Our next webinars, we have one on June 8, about what the ESCO experience is like. We're going to have one June 16th, talking about the application and going over that with you about how to fill it out and really what CMS is looking for. One on June 29th, going into detail about the financial and quality methodologies. We're also going to have three sets of open office hours

where that will include just be an open time for you to ask CMS any questions about the application, about forming an ESCO, and allow everybody to listen in. Next slide.

I think with that our big message is, we're very interested in having you all apply and we're very interested in doing what we can to help you through this process. The best way to reach CMS by far is to e-mail us for anything, ESRD-CMMI@cms.hhs.gov. We're happy to talk to you. We're happy to reach out to any providers who you want us to talk to. We're happy to really help you work through this process in whatever way possible and really encourage you to look at the website. The RFA document is the most important. There is the full financial and quality methodologies and a checklist to help you with your business planning.

I think the final thing that I have here, before opening it up for questions is really, if you're going to set-up an application or if you're thinking about setting up an ESCO, e-mail us to set that up sooner rather than later, with your first name, last name, e-mail, and the names of any ESCOs that you're thinking about. It's a bit of a process to get that set-up and to get you into the portal, so you can start working on the application earlier just based off of what's in the RFA document that's posted on the website, but it takes us a little bit of time to get you set-up into the portal. Please e-mail us as soon as you're ready to say yes or even thinking about saying yes to applying, just so we can get you set-up and into the portal.

With that, I also have Magda Barini-Garcia with us and Emma Oppenheim from the team, and we're opening it up for questions.

Jennifer: Thank you, Tom, for opening the floor to questions. Before you enter your questions that you have into the Q and A pod I'm going to go over brief logistics. For the question and answer portion of today's event the CEC members choosing to answer the question will have two minutes to respond to each question before the next question is asked by me, the moderator. All questions entered in to the Q and A pod will be anonymous unless you choose to send them to all. Any questions not addressed today during the Q and A portion may be e-mailed following today's event to ESRD-CMMI@cms.hhs.gov. I apologize in advance if you're question is not able to be asked during today's event.

All right, let's get started. Tom and CEC Team, I have our first question for today. What is the initial first touch date? Is it 1-1-2016?

Tom: The initial first touch date, it's going to differ for each beneficiary and our goal here is it's one that care relationship with your ESCO begins. That means it's the first time that they visit an ESCO dialysis facility when they're eligible. That means that it's whenever they have that first visit and that starts the accountability for financial purposes and for quality purposes.

Jennifer: All right, thank you. Our next question, can you summarize in brief how Round 2 is different for non-LDOs?

Tom: Sure. The biggest reason that Round 2 is going to be different for the non-LDOs is the addition of the two-sided track. You're going to have the option different than the first time, of being able to choose whether you want to take on downside risk, but in exchange for having a much higher level of upside. There's also the larger alignment changes, as well as the fact that you will no longer ... You can now have ESCO facilities in up to three Medicare CBSAs, which affects everybody in the model, but the big non-LDO specific one is that you could now have the option for two-sided risks.

Jennifer: Thank you, Tom. Will there be any further waivers issued if needed or do we have to stay within the waivers already issued?

Tom: There will not be any additional waivers issued and what is posted is what is currently being given and active for the current CEC participants.

Jennifer: Any small dialysis organizations, SDOs using one-sided model be able to choose the two-sided model next year?

Tom: That is an issue that we are doing some internal thinking about. I know that we've gotten that question before and I think that's something we're going to try to get you all an answer about as soon as possible. Hopefully on the next webinar, but that's something that we're thinking about.

Jennifer: How do we submit hybrid measures through CROWNWeb or any other way?

Tom: Emma, if you want to talk a little bit about the quality reporting process.

Emma: Sure, happy to answer that question. We submit hybrid measures through an application that was developed in part for our model and it's called QMAT, the Quality Measurement Assessment Tool. That's a separate process that operates on a platform that's owned and run by CMMI and we help you out, and we help all of your staff gain access to that and learn more about that system.

Jennifer: All right, next question, do non-LDO dialysis facilities need to be in existence for at least three years in order to apply? Next question, do non-LDO-

Tom: Sorry about that. Just to go back to that one, I think our general approach on this one is that all facilities and all providers have to be actively enrolled in Medicare. They have to have, for providers, in the application they're going to ask for your TIN and the NPI for each provider, for a dialysis facility, they're going to ask for the CCN. As long as you can make sure that you have an active CCN then that's what we really care about.

Jennifer: Great. Another question, can a non-LDO ESCO choose one-sided risk for 2017 and switch to two-sided in 2018 and thereafter?

Tom: Thank you again for that question, and the fact that we're getting this multiple times shows this is something we're going to work to get you all an answer on as soon as possible.

Jennifer: My apologies. Can you elaborate on historical cost calculation?

Tom: Sure. What we do is that we say these new ESCOs will be starting in 2017 and we picked all of the ... For your list in 2017, it will be all of the people who visited your dialysis facility from January 1st 2016 onwards. We look back one year to see when beneficiaries first visited your dialysis facility and those are the beneficiaries aligned who you're fully responsible for. We do the same things in the base years, in 2012, 2013, and 2014, and what that means is that we say, "If your ESCO had existed during those years, who would have been aligned based off of those dialysis facilities? Who were the patients who met all of the relevant eligibility criteria? Who had the relevant dialysis visit to one of your dialysis facilities?"

We look at those patients, look at their costs, then add up all of their Medicare A and B costs to form what we call the baseline. Then we trend that forward by the national trend factors and risk adjust to account for the differences between that population and your performance, your population to come up with what your actual benchmark is going to be.

Jennifer: Great. Next question, if we are in a region that already have ESCOs will we not be approved?

Tom: Being in a region that already has ESCOs is not a disqualifier. We're happy to entertain every application and I think we're definitely interested no matter what. I will say though, that this is a test model so we want to just get the greatest diversity of participants possible, but even if your region already has ESCOs and as you can see I'm looking at a map. We're concentrated in the Northeast Corridor, I think we're still interested in applications from there. We just want to make sure ... We would, as long as your application shows that you can successfully be an ESCO, I think we would still be interested in taking you.

Jennifer: Next question, how is billing and claim submission impacted for services provided by the dialysis provider and nephrology practices on an ESCO?

Tom: The short answer here is that it won't be. What we do is that we ... The ESCO model exist on top of the current fee for service system. You still submit all of your claims, get paid by Medicare in the same way throughout the year. The main difference though, is that at the end of the year or after the performance year and after there's some run out time, you will either then receive the shared savings to the ESCO, then to be distributed down to the various participants or the ESCO will have to pay back the losses to CMS. At the end of the year you would either have to pay money back or receive shared savings. We don't effect normal claims payment during the year.

Jennifer: All right. Team, the next set of questions may be handled in upcoming webinars but we basically run out of all the questions for things that will not be handled in upcoming webinars. Moving forward, question about the application, can the application be started, stopped, and returned to or must the application input be completed at one time?

Tom: The application can be started, stopped, and return to. Once you get set-up in the portal you're going to be able to just add things at various points, which is why we really encourage you to e-mail us as soon as you're ready with any potential ESCOs so that you can get started in the portal and begin filling out the applications in there.

Jennifer: Do you expect any changes in the quality measures throughout the life of the CEC demonstration?

Tom: There always could be changes. We've seen these models change over time. What we have here are and what are posted on the website are the quality measures that were in use for performance year one. If there are any changes we'll let everybody know about it.

Jennifer: All right, next question. Are current ESCO participants seeing savings?

Tom: It's too early for us to know. The model's only been active for approximately eight months right now. We just don't have final data and we're not going to have final data until after the year, until we know what the final benchmarks are, until we know what the final cost savings are. I will make a pitch though that our next webinar is going to involve participants from some of our current ESCOs talking about their experience. That will be a good opportunity to bring any questions you may have about current ESCOs, but we just don't know any financial results yet.

Jennifer: When will savings be paid after the fiscal year?

Tom: Sure, after the fiscal year we do everything on a three-month claims run-out to allow time for claims to come in. At that point then CMS does all the financial calculations, gets all the risks scores, and then we have to wait for all of the quality data. It's some point in the summer of fall, depending on when all of the quality data comes in.

Jennifer: Does participation in other ATMs preclude or inhibit ESCO application, particularly with reference to non-LDOs?

Tom: The key point here, and this is a big deal, is participation in the Medicare Shared Savings Program, because they have a rule of TIN exclusivity, meaning that any provider who is part of any TIN that is included in the Medicare Shared Savings Program, even if it's a giant multi-specialty practice, they cannot be in any other ACO model. What that means is you should check to make sure that any providers, especially a nephrologist, who you want to work as part of the CEC Model and want to be part of your ESCO, are not included currently in the Medicare Shared Savings Program. But in general, no, we look to obtain MPI combinations.

Jennifer: Great. One question here, is there a limit to the number of applications you will approve?

Tom: I think we're going to see how many come in. We are just looking for the model test, it will really depend, I think on how many come in and then I think we'll be able to

make a judgment at that point. We definitely want to increase and we want increases on both the LDO and the non-LDO side. It will just depend on how many come in. We wouldn't go crazy that we'll add like 50 ESCOs but we'll see how many come in.

Jennifer: What happens if the facility did not exist in 2012, 2013, or 2014, how do you calculate historical cost?

Tom: That's a good question. In general what we do is we use the dialysis facilities that you have on your list for the ESCO for that year to come up with what the average cost was. If that facility wasn't around for that year then we could use the average cost from your other dialysis facilities to come up with what your baseline cost would be.

Jennifer: Can we aggregate with the current ESCO participants?

Tom: Yes, if they are a non-LDO. The Rogosin Institute who is our only, currently non-LDO participant, they would be eligible to aggregate with any new non-LDOs that came in for PY2.

Jennifer: Is 350 minimum patient count absolute to avoid aggregation pool?

Tom: Yes. If you're under the 350 number you are required to aggregate, but if you're above 350 then you have the option, because even at 350 it's still relatively difficult to hit that minimum margin of error, that minimum savings rate. There are benefits to aggregating even if you are above that number.

Jennifer: All right. Can you elaborate on the rationale behind aggregation pools based on the risk option?

Tom: Sure. Our general goal is that we want to avoid mixing one-sided and two-sided risk where possible, given that one set of participants would have to pay back any losses that occur and one side would not. We really wanted to keep those separate and to keep this while still keeping the opportunities for shared risks.

Jennifer: One more question here, actually two more questions. Next one, how will you recognize frequent home hemodialysis costs over 3 times a week which some MACs don't recognize as accepted costs?

Tom: The way that we do this is that we just look at the claims that come in and the claims that are paid out. If there are claims that maybe disallowed for whatever reasons or claims that ... or even some like that specific situation, we just look at what the amount that CMS paid out. That's how we judge what the final cost were for beneficiaries.

She also had another question that I wanted to jump back up to, about when will we learn our benchmarks before January 1, 2017 to know our target? This is something key and we're going to be doing a later presentation about the financial methodology that will go over this in a lot more detail. Part of the issue is that in order to have, essentially the accurate risk adjustment numbers to ensure that we can really risk

adjust between the baseline years and the current year, as well as the accurate trending information, to know how much the national cost growth was between 2012, 2013, and 2014 and the performance year, 2017. We're not able to get those factors until after the year.

We also won't know who all the beneficiaries are that were in your ESCO at the time and the total number. What this means is that we're not able to give you a benchmark before the start of the year. The final benchmark will not be known until after the year and we're working to see about what we can give you to help you estimate what some of those historical expenditures were, but we're not going to be able to get you the exact one until after the year.

Jennifer: All right. How many Medicare beneficiaries in the current ESCO and is it 16,000 or a much smaller number?

Tom: 16,000 was the number that we started with in about October, at least now it's over 18,000-19,000 beneficiaries who have been aligned. Now this does include that some of these beneficiaries have died given the high mortality rate in the ESRD population. That's always a worry. Not all these patients are actively seeing their dialysis facilities but there are approximately 19,000 currently aligned.

Jennifer: All right, we have four minutes left for question and answer. If I have missed your question on accident while going through the list or if you have any additional questions, please enter them into the Q and A chat now.

Tom: There was one other question that I wanted to bring up. The question was, "Are patients being prioritized into an ESCO and removed from an ACO in future performance years?" This is about how we deal with the overlap between the CEC Model and other ACO programs. The short answer to this question is yes, the CEC Model, just recognizing our relatively small size and that we're very focused on the ESRD population get alignment priority over other ACO models of the start of each year. That means before the start of each year a beneficiary would be aligned to CEC rather than to pioneer the Medicare Shared Savings Program or a next generation ACO model.

During the year, given that's a pioneer next generation ACO models and SSP track 3 used ... Given that they get a set of beneficiaries at the start of the year, those models would keep those beneficiaries for the remainder of the year even if they visited an ESCO facility. For beneficiaries in SSP track 1, which is the majority of ACOs in the country, if they're in SSP track 1 and then they have a relevant dialysis facility visit to a CEC ESCO they would then immediately go to be a part of that ESCO.

Jennifer: All right. I have no other questions in the cue right now. Before I close the Q and A period, I just wanted to thank everyone who submitted questions for their participation today. Tom, is there anything you would like to add before I close the Q and A period?

Tom: I think we just want to add that please just e-mail us for anything, ESRD-CMMI@cms.hhs.gov, that's the best way to reach us. It goes straight to the team. We just use that address in the central mailbox to organize everything, but that's by far the best way to reach us with any questions. We're willing to talk. We're willing to do what it takes, I think, to help you really have a successful application process. Also, just as a reminder to e-mail to set-up the application to that same address, and that it's really worth doing that sooner rather than later to get started on the process.

Jennifer: Thank you, Tom. Please attend our upcoming webinar on June 8, from 12:00 PM to 1:30 PM Eastern time, call the ESRD Seamless Care Organization Experience. Links to register for this upcoming webinar will be e-mailed to the e-mail address you used to register for this event.

Before I close today's event, I would like to thank everyone who attended today, asked questions, and I especially would like to thank our two speakers and as well as the CEC Model Team. Please visit the CEC website to access model-specific details, including recordings and slides from previous learning events, a copy of the RFA and the new RFA fact sheet, which is also attached to the download material pod to the bottom left of your screen.

All right, please take a few moment to complete the feedback survey on today's event. We really use this information to improve our future learning events. It is extremely, extremely beneficial to us in helping us to improve and provide you quality events in the future. With that, I'd like to thank everybody and I hope everyone had a great time today and I'm officially closing the webinar. Thank you.