

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Daniel Farmer
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2:00 p.m. ET

Operator: Good afternoon. My name is Beth and I will be your conference operator. At this time, I would like to welcome everyone to our Comprehensive ESRD Care Initiative. All lines have been placed on mute to prevent any background noise.

After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star one on your telephone keypad. Please limit your questions to one question and one follow-up question. If you would like to withdraw your question, press the pound key. Thank you.

Matthew Brown, you may begin your conference.

Matthew Brown: Thank you, Beth. Good afternoon and good morning to those joining us on the West Coast. I'm Matthew Brown. I'm with the CMS Office of Public Engagement and I will be your moderator for today's call.

I want to thank you – excuse me – I want to thank everyone for joining us for today's special open-door forum on the comprehensive ESRD Care Initiative. Today's' open-door forum is the second open-door forum we have held on this initiative. A recording and transcript of the first open-door forum are available on the Innovation Center Web site at innovation.cms.gov.

I am now going to turn things over to Melissa Cohen, the CMS staff lead on the Comprehensive ESRD Care Initiative. Melissa?

Melissa Cohen: Hello. Thank you, Matthew. And thank you to everyone for putting this time aside today. My name is Melissa Cohen and I am the staff lead on the Comprehensive ESRD Care Initiative here at CMS.

I am joined today by a few of my colleagues; (Gary Schorr), also on the program team; Dr. Mai Pham, director of the division of ACO populations for the Center for Medicare & Medicaid Innovation; and Tom Nolan from CMS' Office of the Actuary.

On today's open-door forum, we are going to open the lines for questions you all might have about the program and do our best to answer them. Before we begin, I wanted to start with a few program updates.

Resources. We want to remind all of you of a few resources available to you about this initiative. The Web site is our main depository of information, including information about how to apply and frequently asked questions that we continue to update. If you haven't already, please visit that site which can be found at innovation.cms.gov.

If you are not able to get your question answered today, we also have an e-mail inbox and we are responding to your questions as quickly as possible. Our e-mail inbox that's specifically dedicated to this initiative is esrd-cmmi@cms.hhs.gov.

Before we begin, I wanted to answer a few frequently asked questions that we have received to the inbox. Starting with questions on the payment arrangement. We have received a number of questions about why dying patients should be excluded from the benchmark expenditure calculation.

We wanted to correct any misconception about this policy. The baseline is comprised of expenditures for beneficiaries who would have been matched to the ESCO during the historical base years. The cost of patients prior to death will therefore be included in both the baseline and benchmark calculations as well as in the expenditure calculation for the ESCO and for the reference population.

We have also received questions about how CMS plans to rebase in year four and five of program. First, let me point out that year four and five of the program are optional. The new baseline will include any amount that ESCOs have earned in shared savings. This means that in calculating the new baseline, shared savings payments to an ESCO for performance year “X” would be considered additional baseline expenditures for year “X” as it were employed as a base year under the rebasing.

We have also received some questions about the reasoning for different payment tracks. In initial stakeholder conversations, we received feedback that some dialysis organizations were confident that they could assume high levels of financial risk. We understand that different providers based on size, capital, level of infrastructure and experience with risk-based contracting are more equipped than others to begin the model with downside risk.

The payment arrangements were developed based on this stakeholder input. We have performed some modeling of the different payment arrangements to ensure that there is a business case for participation. And our projections, in addition to the feedback we have received, on the opportunity for cost savings, have informed our payment policy.

Regarding the prescribed structure of the ESCO, we have been asked about the other Medicare provider/supplier, participant-owner requirement. As this is an accountable care model that is meant to serve the whole patient and all of his or her comprehensive clinical needs and not solely the ESRD-related services, we want to encourage ownership by non-renal related Medicare providers and suppliers.

These ESRD patients have a complex set of chronic conditions. Two thirds of the Medicare expenditures for ESRD patients are for non-dialysis related services. The purpose of this model is to encourage better coordination between all the providers that will take accountability for the care of this beneficiary population.

All of the governance requirements as well as the structure of the legal entity have been designed with both program integrity and clinical aims in mind. The goal of this model is to create a patient-centered care environment that is equipped to serve the needs of this complex patient population while taking financial accountability for the cost.

Now, without further ado, we're going to go ahead and begin the question period. Beth, can you get things started?

Matthew Brown: Sure. Beth, if you would remind the callers how to enter the queue to ask their questions?

Operator: At this time, I would like to remind everyone, in order to ask a question, star one on your telephone keypad. Remember, it's limited to your first questions and one follow-up question. And if you wish to ask additional questions, press star one again in order to enter the queue. We'll pause for a moment to compile the Q&A roster.

Your first question comes from the line of Diane Wish, Center for Dialysis. Your line is open.

Diane Wish: (Inaudible) we're less than 500 patients. We think that more patients would be able to benefit from better coordinated care because more providers could participate. Would you consider either removing the minimum number of requirement or lowering the minimum number of requirement?

Tom Nolan: This is Tom Nolan from the Office of the Actuary. So the modeling that we did in conjunction with the design of the program was intended to have a minimum patient size for an ESCO that would control sufficiently for variation and expenditures for group – for a group expenditure's target versus actual.

So the level of variation that was considered acceptable sort of compared to the level of the various (nets) sort of set as the minimum for other Shared Savings Programs within Medicare. And that's where that 500 came from and why it's meaningful to us.

So in terms of going lower than that that would be a policy decision that, obviously, the Office of the Actuary could work with, you know, the team to quantify what that effect would have on the ability to generate benchmarks. But, at this point, that is our recommendation in order to sort of be consistent with the level of confidence that we've put into other Shared Savings Programs in – across the Medicare program.

Diane Wish: Can I have a follow-up question?

Melissa Cohen: Is there a follow up?

Diane Wish: Yes. I know that part of the plan was to put together a number of providers involved in the demo other than just large dialysis organizations. And we've kind of looked at it and there's only, like, about 15 providers that we think in the country are going to be able to meet that 500 patient requirement and we also have some data that shows that if it's probably as low as 350, it probably seems to be acceptable for the amount of risk. Just wondering if that is something that could be taken into consideration.

Melissa Cohen: Our expectation is that dialysis organizations will need to find partners – peer partners in order to get to the 500 beneficiary minimum. And we do appreciate the care that you've taken in your modeling. But from the perspective of the agency and the Office of the Actuary, there's a certain statistical level of confidence that we require which is what is driving that 500 number.

So we strongly encourage you to take the time between now and when the applications are due to think creatively and carefully about the collaborations that you might form. They were anticipated and they are encouraged.

Operator: Your next question comes from the line of Cherilyn Cepriano, Kidney Care Council. Your line is open.

Cherilyn Cepriano: Good afternoon. Thanks for the opportunity to ask (inaudible) I have a series of questions.

We understand that CMMI is running a series of integrated care programs including several large programs in Medicare and Medicaid that are already underway. And we appreciate that creating ESCOs is – it was correctly a recognition that the ESRD patient population is unique and it's in the specialized care that could we well-coordinated through our specialty provider.

However, we believe that presenting ESRD beneficiaries were being drawn into an ESCO simply because they were placed in another Shared Savings Program initially even before ESCOs have to come into being, it represents a barrier of the success to the ESCO project. So I'm curious to know whether CMMI would reconsider the project feature that beneficiaries are assigned to an (ACR) similar project on a first-come-first-serve basis and instead allow for (ESMV) patients with their unique healthcare needs to be prioritized into the ESCO if one is able to operate in their locality.

Mai Pham: So we appreciate the concern and we point to several dimensions of this policy. First of all, as you have noted but it's worth emphasizing, it is a first-come-first-serve nature the way that we resolve potentially overlapping participation among different shared savings initiatives.

So it is not that a beneficiary with ESRD is off limits to ESCO by virtue of ever having been assigned to another shared savings initiative but rather that at the time that this model runs its matching algorithm, the beneficiary is assigned to another shared savings initiative. Only under those circumstances will the beneficiary be off limits.

And we would ask you to consider that, while we completely understand and appreciate your concerns, there are very similar and analogous concerns on the part of providers who are participating in those other initiatives. For that and other reasons, the scale of this model is intentionally modest, but we believe that there are sufficient number of communities out there where there is plenty of opportunity for the different shared savings initiatives to co-exist and for participants to arrive at meaningful numbers among their population.

We – you know, some of this will be proof in the pudding. We simply won't know until we run the matching numbers and, being the Innovation Center, we do have more flexibility than permanent Medicare programs to adjust policies if they become necessary. But we, at the moment, believe that it is worth following through on this policy because it's consistent with how we are managing potential overlaps among all of the other Medicare shared savings initiatives the agency is sponsoring.

Cherilyn Cepriano: And, certainly, just in follow up, I appreciate that and we are very interested in being good partners with, you know, other providers. And I feel – I'd like to pick up on your point about flexibility and say, you know, we believe that there are a number of waivers that the secretary has the authority to grant that are very important to ensuring the success of the ESCO program.

We have heard that information may be forthcoming, but it's very difficult for providers to identify their proposal without understanding what will be in or out of bounds in the program. So, for example, in your reference document, you indicate that there may be an opportunity to provide on-site co-location of just the providers or other rounding services by non-dialysis providers at dialysis facilities.

But we also understand that a waiver might – could potentially be required in order to effectuate that type of care. So I'm wondering when CMMI will (articulate) the specific waivers and common to the ground rules that will apply to all applicants and providers and ESCOs and will that be in advance of the CMMI deadline to establish in the application process so that we can understand the rules of the road, the flexibility that you are willing to provide and able to provide in advance of undertaking this process.

Melissa Cohen: We appreciate that input. It's very helpful to hear feedback from the community. We are working with our components within CMS and we are prepared, if we are able to offer any waivers, for those to be available prior to signing any agreement with CMS. But at this time we are not able to offer any further input on whether waivers will be available.

- (Mai Pham): We do appreciate that you need to know the information sooner rather later. We – therefore, if the application deadline arrives before full details of any offered waivers are available, we will take into account and we would not hold you accountable for reading our minds in terms of what you propose in your care management plan.
- Operator: Your next question comes from the line of Doug Johnson, Dialysis Clinic, Inc. Your line is open.
- Doug Johnson: (Inaudible) need to be a (inaudible) owner (inaudible).
- Melissa Cohen: Your line was breaking up but I believe you asked whether nephrologists had to participate as participant owners or whether they could be participants that sign contracts with the ESCO. The model requires that nephrologists participate in this model as participant owners.
- Operator: Again, if you would like to ask a question, star one on your telephone keypad. Your next question comes from the line of Robert Sepucha from FMC. Your line is open.
- Robert Sepucha: Thanks again for the open-door forum and taking the call. Just a quick follow up on the ACO carve out that was raised a few minutes ago. I'm curious – you made the comment that you believe there's a sufficient number of communities where 500 beneficiaries can be met even with this carve out for beneficiaries who have already been assigned to ACOs.
- I guess the questions is how will prospective applicants know that? How are applicants supposed to know whether they'll be able to meet the 500 beneficiary threshold if there happens to be a, you know, reasonable high penetration of ACOs in a given market? Are – is this another example similar to the waiver – or the waiver instance in which applicants are just going to have to submit an application hopeful that they can meet it?
- (Mai Pham): So, you know, the short answer is yes. We can do our projections and you can do your projections. Neither one of us will have perfect knowledge of what the reality will be until we actually run the preliminary matching algorithm after we receive your applications.

The same is true in every other shared savings initiative. Every round of the Medicare Shared Savings Program application cycle, there are providers who apply in good faith and wait to hear whether they meet the minimum beneficiary threshold. It is simply the nature of the new reality that we all live in where there are many ambitions and many competing priorities and market players who, you know, have their strategies that they want to pursue.

And we want to work with you to get you the information as quickly as possible. But you can understand that we can't make that determination for you without receiving your TIN NPI list and actually running the algorithm. Our projections are based on what we currently know of the distribution of ESRD beneficiaries and the current distribution of ACOs.

Robert Sepucha: Understood. A quick follow up and I think it's a little bit different because you actually have the data on which Medicare beneficiaries have been assigned to ACOs and no one else does. Is that information you'd be willing to share with prospective applicants so they can have a sense of whether or not their application will meet the – will be able to meet the threshold?

(Mai Pham): We use published fee-for-service data, but we will take that request into consideration and see if we can, you know, offer a more targeted set of summary results geographically that will help you think that through. Thank you for the suggestion.

Robert Sepucha: Yes.

Operator: Your next question comes from the line of (Laura Weinman), (M) Group Consulting. Your line is open.

(Laura Weinman):Hi. Thank you for taking the call. I need a little bit of help understanding a bit more about what you mean by nephrology – nephrologist (as an) employee say of the dialysis center. Do you mean a W2 employee, a 1099 employee, a contract employee who is the medical director? I kind of need to figure that out. Hello?

Melissa Cohen: Hello. Thank you for that question. That is the type of complex question that we would really appreciate it if you e-mailed us to the comprehensive...

(Laura Weinman): Will do. Not a problem. I just ...

Melissa Cohen: Sounds great. Thank you.

(Laura Weinman): ...need to figure this all out.

(Mai Pham): And it's something that we can add to future written frequently asked questions to publish.

(Laura Weinman): Very good. Thank you.

Operator: Your next question comes from the line of Arvind Goyal, Illinois Medical Aid. Your line is open.

Arvind Goyal: Thank you. Arvind Goyal is my name and my question has to do with what exactly are the nephrology-type services covered? Is it limited to dialysis? Is it something else? Are primary care conditions that caused the ESRD included in terms of shared savings or responsibility for care?

(Mai Pham): Can you clarify whether you mean by what's included what is included in the expenditure calculation?

Arvind Goyal: When the applicant organization agrees to take the risk, what are they taking the risk for?

(Mai Pham): They are taking risk for total Part A and B expenditures for that beneficiary including the PPS bundle.

Arvind Goyal: OK. And that includes care of diabetes, hypertension or whatever underlying conditions?

(Mai Pham): Correct. Total Part A and B expenditures.

Arvind Goyal: Thank you, very kind.

Operator: Your next question comes from the line of (Nathan Lowmeyer, Village) Health. Your line is open.

(Eric Franco): Thank you. This is actually (Eric Franco) calling (up here). Thank you for the introduction and the FAQs earlier around the inclusion of debt cost in the model. A follow-up question to that.

How will the baseline be calculated for centers that are relatively new where they would not necessarily have history of – a history of patients over the three years. If someone can perhaps provide some guidance on what kinds of patients the cost are going to be included in the ESCO baseline, that would be appreciated.

(Mai Pham): Can you clarify whether you mean that the particular TINs associated with the ESCO are new or that the providers had previously not provided dialysis services at all.

(Eric Franco): It's more for the latter. So are – assuming that the ESCO will be – or is the multiple dialysis providers and it's a relatively large ESCO than the historical benchmark. Would the historical benchmark just simply be based on the existing ESCOs in – historically, for the calculation?

(Mai Pham): Right. So if the providers within the ESCO have historical TINs under which they bill for Part A and B services, we would ask you in the application to include those historical TINs and NPIs for our use in matching and in expenditure calculation for the baseline.

If the provider truly is new and has not provided Medicare services to beneficiaries for three years, we may consider using two years of data. We believe that one year of data really would not produce a reliable baseline. But we would encourage you to, if there is an actual circumstance, to send that question into the inbox as well.

(Eric Franco): OK. If I may – can I ask a follow-up question as well?

(Mai Pham): Sure.

(Eric Franco): Related to that is the trending. Will there be additional information provided on how the trending rates will be provided more than what is provided in the document, so, for example, how the cost and – will be calculated and what methodology will be used?

Tom Nolan: Sure. Thanks for that follow up. The trending, to expand on what was in the RFA, trending essentially looks at the entire national population of ESRD beneficiaries who would have been alignable in baseline and calculates their expenditures.

It continues to calculate expenditures for the universal alignable beneficiaries in performance years. And the difference in spending over time is what is between those time periods. It is what defines the trend and that is used to trend baseline years to (reform) the circle benchmark as well as update the benchmark to perform its target years.

(Eric Franco): And I should have clarified, so will that mirror the Medicare advantage rate setting process or will it be a new process that CMMI will apply for this model?

(Mai Pham): It more closely mirrors the methodology used in the Medicare Shared Savings Program. It is not a geographically-based method.

(Eric Franco): OK. Thank you.

Operator: Your next question comes from the line (Richard Borstruff), University Medicine. Your line is open.

(Richard Borstruff): Hi. I had a question about an earlier comment about nephrologists having to be owners. And I wondered if nephrologists were working for a physician group that owned – or employees of a physician group that owned a dialysis center in partnership with another company if that qualified them.

Melissa Cohen: Again, because that is a unique situation, we would appreciate if you would send that question to the inbox so that we could more closely examine and give you the specific answer.

(Richard Borstruff): OK. Thank you.

Operator: Your next question comes from the line of (Lisa Huffson), your line is open, Dialysis Clinic, Inc.

(Lisa Huffson): Hi. We were wondering how do you propose that we work with major help systems who also have an ACO and employing nephrologists.

(Mai Pham): I'm sorry. Were you asking whether you should partner with the in the ESCO?

(Lisa Huffson): Well, if they can.

(Mai Pham): They are certainly eligible to. There are a variety – a range of business arrangements that ESCOs could potentially have with their business partners. And, you know, we – and if you send – if there's a particular circumstance – market circumstance you have in mind, again, that sounds like a scenario that would be best sent into the inbox so that we can be sure we give you the correct answer.

Melissa Cohen: Regarding participant eligibility, we just need to iterate that if a tax identification number is used for the Medicare Shared Savings Program, then, it cannot concurrently be a participant in the ESCO.

(Mai Pham): Right. But that TIN may be able to participate in, for example, the Pioneer ACO model depending on both the policies of that other shared savings initiative and the way in which they are participating.

Operator: Again, if you would like to ask a question, star one on your telephone keypad. Your next question is a follow-up question from the line of Diane Wish, Center for Dialysis. Your line is open.

Diane Wish: It's very difficult to encourage potential partners, especially physician partners, to participate in the ESCO without being able to share with them the quality metrics. When will we see those?

(Mai Pham): You will certainly have a full set of described quality metrics before you have to sign any participate agreement. Our hope is to be able to release the descriptive set of measures well before the negotiation phase.

Diane Wish: So when is that prior to May 1?

(Mai Pham): It will not be prior to May 1.

Diane Wish: It will not be prior to when we have to submit the application, so we're – we need to talk to – talk nephrologists into taking upside and downside risk without having any idea what the quality metrics would be.

(Mai Pham): So we pointed out that this was a very analogous situation to what happened with applications for the Pioneer ACO model which had to be received and broadly negotiated before the final regulations for the Medicare Shared Savings Program made the quality metrics for both programs public.

It's also analogous actually – a rather (seated up) timeline relative to the comprehensive primary care initiative which is still finalizing if metrics after the program has gone live. We appreciate that providers within the ideal want to know as much as possible about those metrics, but there were tradeoffs in trying to get to the marketplace, a description of the model and the opportunity as quickly as possible while trying to do as much as the development work as needs to be done.

Melissa Cohen: And, again, we won't be asking participants to sign any contract with CMS prior to seeing what those quality metrics will be.

Operator: Your next question, a follow-up question from the line of (Laura Weinman, M), Group Consulting. Your line is open.

(Laura Weinman): Hi. Thank you. In many states, the states are all pioneering with the federal government to create special managed care programs for dual eligible – people who are eligible for Medicare and Medicaid. This includes many of our dialysis patients. Would these patients automatically be excluded from the ESCO.

(Mai Pham): They would automatically be ineligible to be in an ESCO only if they are enrolled in a Medicare advantage plan and, hence, not a fee-for-service beneficiary. So some states engaged in the dual demonstration have managed fee-for-service components as opposed to managed care component. And we would encourage you to take information from your state about its design for the dual demonstration.

(Laura Weinman): Thank you.

Operator: Your next question comes from the line of (Amy Reddell), The Alliance – your line is open.

(Amy Reddell): Yes. The Alliance for Home Dialysis is very encouraged that one of the expected results of the ESCO is increased use of home dialysis modalities as appropriate. We believe that patient experience and quality of life are important indicators of quality of care and that often home dialysis patients have historically demonstrated improved satisfaction with their care.

The RFA indicates that one of the key measures for evaluating ESCOs on patients and caregiver experience is through the current ICAP survey. However, as you know, this survey is designed for use only within center or home dialysis patients. How do – how do you plan to evaluate the experience of home dialysis patients participating in ESCOs?

(Mai Pham): It is a very high priority for us to have a comprehensive set of measures around patient experience as possible. And so as we develop the full set of performance metrics, we will take those priorities into account. But we encourage you to send suggestions and recommendations regarding what those metrics should focus on to the Pioneer inbox and we will take our stakeholder input into account.

Operator: Your next question comes from the lie of Claudia Dahlerus, Arbor Research. Your line is open.

Claudia Dahlerus: Thank you. Good afternoon, everyone. The RFA on page 27 refers to CMS conducting a separate evaluations. So will CMS be acquiring the services for

an independent evaluation of the ESCOs that would be released under a separate RFA through CMMI?

Melissa Cohen: That's correct.

Claudia Dahlerus: At what time the CMS anticipates releasing the RFA?

Mai Pham: We can't speak to that, but it will be through the usual (set this up) mechanism.

Claudia Dahlerus: All right. Thank you so much.

Operator: Your next question comes from the line of Robert Blaser, Renal Physician Association. Your line is open.

Robert Blaser: Hello. Thank you. Is any consideration being given to extending the May 1 deadline for applications?

Mai Pham: We would encourage you to send in those please also to the Comprehensive ESRD Care inbox.

Operator: Your next question, a follow-up question from the line of (Nathan Lowmeyer, Village) Health. Your line is open.

(Nathan Lowmeyer): Thank you. Just a follow-up question to serve as a reference to copying the other Medicare Shared Savings Programs. I wanted to understand the context for why this renal ACO is also hard to provide guaranteed savings on top of the shared savings. I want to get additional context for that.

Mai Pham: Sure. Thank you for the question. If – one looks at the payment arrangement offered in the Medicare Shared Savings Program, the comprehensive ESRD care initiative and the Pioneer ACO model. The ESRD payment arrangement fall somewhere in between.

So in the Pioneer ACO model, for example, Pioneer ACOs were able to collect payment options where they had to provide CMS with a guarantee discount and then assume full risk beyond that discount. In the ESCO model, we are asking ESCOs to provide that guarantee discount and then we will

shared in savings or losses beyond that discount, so somewhat less – more risk than some of the pioneer arrangements but higher risk than most of the MSSP arrangement.

(Nathan Lowmeyer): Thank you. So, as a follow-up question, is it possible then to also request for a (mono lev) with (many of) the pioneer option where we do have that choices in (LBO) to apply for other models as well?

Mai Pham: That would be a substantial policy change, but we never say never. And we encourage you to send those suggestions into the inbox.

(Nathan Lowmeyer): Thank you.

Operator: Your next question comes from the line of (Diane Morris), Rogosin Institute. Your line is open.

Stephen Pollak: Hi. This is, in fact, Stephen Pollak at the Rogosin Institute. In other – some other programs through the Innovation Center, the Innovation Center has, in cases where providers need to make up-front investments to create a new delivery model, has contemplated the possibility of helping to finance some of that investment provided there's a payback. Is that possible under the current program that we're contemplating here? Thank you.

Melissa Cohen: Thank you for that question. We are not contemplating any sort of advanced payment for the comprehensive ESRD care model.

Stephen Pollak: Yes.

Operator: Your next question comes from the line of Cherilyn Cepriano, Kidney Care Council, follow-up question. Cherilyn Cepriano, your line is open.

Cherilyn Cepriano: Can you hear me now?

Melissa Cohen: Great.

Cherilyn Cepriano: My question is on outlier patients. If you look at the clinical data and the payment data from our ESRD patient population, you can see that there are certain patients that are clinical and the cost outliers based on their –

usually their co-morbid condition or other health conditions – sickle cell anemia is a good example.

Will you recommend that the top 1 percent of the patient in terms of (positive) (inaudible) (outliers), I'm wondering if, you know, am I as open to reviewing the data which you all should have and looking to potentially exclude that top 1 percent of outliers.

Mai Pham: The foremost individual (inaudible) that this model is offering is a truncation of the expenditure beyond that 99th percentile. So the beneficiary would – the beneficiary's expenses under that 99th percentile would still be included in expenditure calculations but not the excess amount.

Operator: Your next question, a follow-up question from the line of (Lisa Huffson), Dialysis Clinic Inc. Your line is open.

(Lisa Huffson): Thanks. As far as the rural areas, we find it very difficult to find 500 patients in a rural market. Would you consider decreasing the minimum number of patients in that market?

Melissa Cohen: We encourage you to send that question to the inbox. I'd also like to remind you that the definition of a market area for rural areas is no larger than an entire state. Also, it is possible for rural areas that are not included in the Medicare CBSA to also be included within the two Medicare CBSAs. The definition of the market area is no larger than two Medicare CBSAs and the surrounding rural counties.

(Lisa Huffson): OK. And then, secondly, can we give bonus payments to non-owner nephrologists for meeting quality metrics?

Melissa Cohen: Nephrologists and nephrology group practices are required to be participant owners in this model. However, any participants in this model are eligible to receive shared savings payment. Does that answer your question?

(Lisa Huffson): I think so. So can we align our owners by NPI instead of TIN?

- Melissa Cohen: We encourage owners to include an entire – an entire TIN, but it is not a requirement for the program.
- (Mai Pham): To clarify, it's – it is one among many selection criteria that we would consider that participation is at the whole TIN level, but again, it's not an absolute requirement.
- Operator: Again, if you would like to ask a question, star one on your telephone keypad. If your question has been answered, the pound sign to remove your question. Star one on your keypad if you wish to ask a question.
- Your next question comes from the line of (Lindsay Merta), Hogan Lovells.
Your line is open.
- (Lindsay Merta): Thanks very much for having this call. I was just wondering, would ESCOs be able to override local coverage decisions and some circumstance, for example, if they felt that permitting more frequent home dialysis would help them lower cost? So would they be able to override such local coverage decisions and still receive reimbursement for those services?
- (Mai Pham): At this time, we're not contemplating waiver of any existing Medicare payment regulation. However, if there is a specific suggestion that you have, it would be something that once we have selected participants, we can begin policy discussions over.
- (Lindsay Merta): Thank you.
- Melissa Cohen: And I'd also like to add that while – if a provider is not able to be reimbursed for additional dialysis, if they feel that it will reduce the overall expenditure of the beneficiary, then that could come through in a shared savings payment.
- Operator: There are no further questions at this time. I'll turn the call back to our presenters.
- Matthew Brown: Thank you, Beth. Melissa, do you want to over any closing remarks?

Melissa Cohen: Yes. We just wanted to encourage potential applicants that if your organization requires more in-depth conversation in order to understand the program design, if you have organization-specific circumstance – specific situations that you would like our feedback on, we would be open to having one-on-one conversations, resources and time allowing.

And the best way to do that is, again, to communicate via the inbox to see if we can arrange time for you to have that interaction with the team. Any information that we convey to you will be information that we will also convey publicly via FAQs, but if you require additional information or explanations about the program, we welcome you to communicate with us via the inbox and we'll try to set something up.

Matthew Brown: Thank you. And a reminder that a recording and transcript of this open – excuse me – of the first open-door forum is available on the Innovation Center Web site at innovation.cms.gov. And, Melissa, will this one also be posted on that Web site?

Melissa Cohen: Yes. It will.

Matthew Brown: OK. So both will be posted on the innovation.cms.gov Web site. And that concludes today's call. You may now disconnect.

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