Centers for Medicare & Medicaid Services

Moderator: Courtney Pippen
August 1, 2013
4:00 p.m. ET

Operator: Good afternoon. My name is (Steve) and I will be your conference operator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Comprehensive ESRD Care Initiative Special Open Door Forum.

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 then the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Dr. Mesiwala, co-lead of the Comprehensive ESRD Care Initiative, you may begin your conference.

Alefiyah Mesiwala: Thank you, (Steve). Welcome everybody. I'm joined here today with my co-lead Melissa Cohen and it's our pleasure to be able to hold this open door forum on this Thursday afternoon to be able to give you an update on the revised RFA that we recently released to the public. This is an update of the RFA that was initially announced with the Comprehensive ESRD Care Initiative when the model was announced in February.

Our goal today is to cover the substantive changes that are reflected in the revised RFA. The four main areas that you will find substantive changes in the revised RFA are around the legal entity requirement, changes in the risk arrangement, clarification of our rebasing methodology, and finally, we'd like

to give you an update of where we are in terms of development of the quality strategies for the Comprehensive ESRD Care Initiative.

So to begin, I would like to summarize what the changes are to the risk arrangement. And these changes are reflected in the revised RFA on page 33. We made changes to the LDO two-sided risk track. We are no longer requiring that ESCOs start the program with a 1 percent guaranteed discount on the expenditure benchmark in the first performance year. In the revised RFA, the LDO two-sided risk track has a 0 percent guaranteed discount of the expenditure benchmark in PY1, a 1 percent discount in PY2, a 2 percent discount in PY3, and a 3 percent discount in PY4 and PY5.

In addition, ESCOs participating in all risk tracks will have the option of truncating a matched beneficiary total annual Medicare Part A and Part B fee for service per capita expenditures for each benchmark and performance year to minimize variation from catastrophically large claim.

The truncation point for expenditures associated with a matched beneficiary in a given benchmark or performance year will be set at the 99th percentile of annual Medicare Parts A and D expenditures for non-ESRD beneficiaries plus the difference between the average annual Medicare Part A and Part B expenditures for ESRD beneficiaries and the average annual Part A and B expenditures for non-ESRD beneficiary. I know that's a mouthful.

So, the resulting truncation point is expected to be between the 90th and 95th percentiles annual Medicare Part A and Part B expenditures for ESRD beneficiary. And to ensure appropriate comparability, benchmarks will be trended using the same truncation method for the national average annual Medicare Part A and B expenditures for beneficiaries with ESRD.

So at this point, I'm going to have Melissa give us an update on how – on the clarification of the rebasing methodology.

Melissa Cohen: Thank you. And I'd also like to mention that these updates that we're providing will also – in the revised RFA will be available in short order on our website on a revised updated Frequently Asked Questions document.

So the first thing that I would like to go over is the legal entity requirement. We have revised the legal entity requirement, which prior to the publication of the revised RFA were that each ESCO needed a dialysis facility, a nephrologist or nephrology group practice, and one other type of Medicare provider and supplier. We have eliminated that other requirement. Therefore now, to be eligible to participate in the Comprehensive ESRD Care Initiative, an ESCO must have as a participant owner at least one dialysis facility and a nephrologist or nephrology group practice.

We would also like to emphasize that as stated on page 35 of the revised RFA, an applicant must demonstrate that if organizational structure promotes the goals of the model by including a diverse set of providers that will demonstrate a commitment to high quality coordinated care for ESRD beneficiaries. So while we have eliminated the requirement for another Medicare provider or supplier to be a participant owner in the legal entity, we will still be looking for applications that demonstrate this diverse set of providers.

Another thing to note is that because of this change in legal entity requirement, CMS is not requiring resubmission of the letter of intent. If your ESCO participant owners have now changed, there's no need to resubmit a letter of intent, but we would be expecting that all participant owners are included in your application. We will not be able to add additional participant owners after submission of the application.

The other thing that we would like to mention is a clarification of the rebasing methodology. In performance year 4, we are – we will rebase for each ESCO the expenditure baseline using the previous three years – performance years as base years. This is covered in page 33 of the RFA.

So for purposes of clarification, the way that we are rebasing is the PY4 expenditure baseline will be the average of the total annual expenditures of the first, second, and third base years. And those annual expenditures will be the sum of the actual Medicare Part A and B expenditures for matched beneficiaries plus the shared savings payment, if any, that would have been made to CMS – that would have been made by CMS to the ESCO for the

relevant performance year if the expenditure benchmark, the relevant performance year was calculated without a reduction for the applicable guaranteed discount.

So this means that the net shared savings will be paid out to an ESCO if applicable using the expenditure benchmark that has incorporated the guaranteed discount. However, strictly for the purposes of rebasing, when we include net shared savings in the baseline expenditure calculation, we are calculating shared savings as if the expenditure benchmark does not include a guaranteed discount.

And now, I am going to turn it back over to Dr. Mesiwala to talk a little bit about the quality strategy and then we'll be taking questions.

Alefiyah Mesiwala: So since the release of the original RFA, we have heard from our stakeholders from all of you numerous times. We try to be as responsive as possible with the changes that we have just covered in the updated RFA. We've also heard a lot of concern and a desire to better understand the quality strategies for the Comprehensive ESRD Care Initiative. And at this point, I'd like to just give you a little bit of an overview in terms of the development of the quality strategy.

Our intention is that before the signing of any participation agreement, we will make available to our potential participants set of quality measures that we will be holding the ESCO accountable to during the performance period. In order to be able to – in order to develop the set of measures, we have contracted a set of experts to help us measure development and to also develop a methodology in terms of how we will calculate the quality score.

In order to assist us and in order to ensure that we really are maximizing the best available information available to us, we are holding technical evaluation panels in the month of September. We have invited experts from across the country to participate on the technical evaluation panel and we are – we feel comfortable that when we do release the measures and provide more information about our quality strategy that our community of stakeholders will be pleased.

In terms of the quality strategy, please again refer to the RFA for a more extensive description in terms of quality measure domain, potential example measures and data sources that we will utilize in creating this quality strategy.

At this point, I would like to turn it over (Steve) to open up the line so that Melissa and I can take questions from the community.

Operator: Certainly. As a reminder ladies and gentlemen, if you would like to ask a question, please press star then 1 on your telephone keypad. If you would like to withdraw your question, press the pound key. Please limit your questions to one question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may press star 1 again to rejoin the queue.

Your first question comes from (Steven) with DaVita Healthcare. Your line is open.

(Steven): Hi, I appreciate you guys providing some additional call around some of the material changes that have been made to the RFA. My question focuses on the changes to the ESCO ownership structure and in particular, there has been some confusion as to how the revised requirements impact participation as – in an ownership capacity in the ESCO with facilities that are JV clinics with physicians who might also be participating in the ESCO.

We're interested in understanding any limitations on how the revised requirements might affect participation by JV Clinics and physicians who might hold ownership interest in those clinics in the ESCO.

Melissa Cohen: Thank you for that question. I would encourage you to submit it in full to the Comprehensive ESRD Care mailbox and that e-mail address is available on the website.

To give a broader answer, the requirements that you need at least one dialysis facility and at least one independent nephrologist (inaudible). So while you may have as many participant owner, nephrologist and dialysis facilities as you would like, the requirements that at least one of those nephrologist or

nephrology group practices be independent of the dialysis facility is still a requirement. And in the revised RFA, we have clarified the definition of independent as someone who does not have a W2 from the dialysis facility.

Alefiyah Mesiwala: And just to clarify the e-mail address that you should be using to ask questions is cecapplications@hcmsllc.com. We'll take the next question please.

Operator: There are no questions at this time. Once again, if you would like to ask a question, please press star 1 on your telephone keypad.

Your next question comes from (Steven) with DaVita. Your line is open.

(Steven): Hi this is a different (Steven). Wanted to clarify when you expect the starting date, if someone is granted an application and you participate in the program, when do you expect the program to start and what kind of lead time prior to whatever the start date is would someone have to prepare to get ready?

Alefiyah Mesiwala: So we are currently planning on announcing participants in January with the intent of having a go live date right in that timeframe.

(Steven): Just as – just for clarification I guess. For those folks who are planning a comprehensive program, any lead time that we might have would be greatly appreciated just to ramp up the facilities. That's not something that happens overnight.

Melissa Cohen: We understand. And once applications are submitted and finalists are selected, we will begin having discussion and at that point, more clarity about lead time will be given.

(Steven): Thank you.

Alefiyah Mesiwala: Next question please.

Operator: Your next question comes from Robert with Renal Physicians, your line is open. Your line is open.

Robert Blaser: Hi, this is Rob Blaser from the Renal Physicians, and I'm wondering about waivers. There's a lot of folks who think that it would be hard to be successful in terms of achieving the quality benchmarks and being able to be viable and do savings, achieve savings if there's not some sort of waivers allowed and understanding that's complicated because you've got to deal with the other federal agency partners.

If waivers are allowed, are they're going to be on a case by case basis. Do you think that they're going to be any waivers that would be allowed to anyone who is granted an application, and is there any caller you can give us on the issue of waivers?

Melissa Cohen: Hi, this is Melissa Cohen. On the issue of waivers, we are currently working with our law enforcement partners. We have had conversations with stakeholders in the community about what sort of waiver would be helpful in the types of interventions that you think it would be necessary to engage and to succeed in this program. And we have communicated this to our law enforcement partners.

Any waivers, if given, if granted at all would be universal and not given on a case by case basis. It would be a universal waiver that was incorporated into the participation agreement. And again, I must caveat that by saying that these would be narrow waivers that would not be in any way similar to the Medicare Shared Savings Program, if granted.

Alefiyah Mesiwala: Next question please.

Operator: Your next question comes from (Joe) with DaVita. Your line is open.

(Joe): Hi. My question, I'm trying to better understand what the hierarchy regarding the attribution of patients to different shared savings programs looks like. In other words, kind of what is the order of operations in attributing patients to different shared savings programs?

Melissa Cohen: So the way that it works is that different shared saving programs will run their alignment or matching algorithm at different times during the year. And there

are different attribution rules based on whatever shared savings program, you know, that a beneficiary becomes aligned to.

The way that we're doing this at the innovation center and at CMS is that beneficiaries will be aligned on a first come, first served basis. So there will be no preference for ESRD beneficiaries to be matched to an ESCO. However, unlike other shared savings program, if a beneficiary is matched to an ESCO unless they lose eligibility and the reasons for losing eligibility are available in the request for application. Unless they lose eligibility, they will be matched to that ESCO for the life of the model and this is unlike other shared savings programs where attribution is run on an annual basis.

But I just want to reiterate that if a beneficiary has already matched to another shared saving program, they will not be removed from that program to be matched to an ESCO if they are receiving dialysis services at a dialysis facility that is participating on its program. We will not be doing that.

Thank you, next question.

Operator: Your next question comes from (Eric) with Village Health. Your line is open.

(Eric): Hello, thank you good afternoon. Thank you for walking us through this. My question revolves around how the trending calculations will be performed, the methodology around trending for the targets for years 1, 2, and 3.

First, will CMS or CMMI provide more detail around how the trend calculations will be done, for example, if the dialysis rate for the dialysis bundles cut if it will show the means on how that was calculated and factored into the trend targets?

Alefiyah Mesiwala: So yes and yes. Our intention is that before any participation agreements are signed, we will have – we will make available a detailed methodology paper in terms of how we will be trending more generally doing our financial calculation.

Next question.

Operator: Your next question comes from (Nadu) with Advanced Dialysis. Your line is open.

(Nadu): I'm a new listener to this meeting and I do not have any other meetings from the before, so how to get information and detail from the past? And we are basically do have about a hundred patients in our program, are we able to participate in this program with CMS at present time?

Alefiyah Mesiwala: Yes, so a couple of things. All information in regards to the Comprehensive ESRD Care Initiative can be found on our website. If you visit innovations.cms.gov, there is a link to the Comprehensive ESRD Care Initiative. And then in terms of whether or not you as a practice can participate, again, I'd refer you to the request for application to read the rules in order to qualify for application to the model and we have a minimum beneficiary requirement of 350 beneficiaries.

Next question.

Operator: Your next question comes from (Ross) with (Cousino) County. Your line is open.

(Ross): Hi, I was just hoping you could review – I missed the first, the legal entity requirement discussion you mentioned at the beginning. I was hoping you could just quickly review that.

Melissa Cohen: Sure, and again, this is available in the revised request for applications and very shortly we will be posting some additional frequently asked questions on the website. But we have eliminated the requirement that one other type of Medicare provider and supplier other than dialysis facility and an independent nephrologist or nephrology group practice to be part of the legal entity to be eligible to apply.

Now, the requirement is strictly at least one dialysis facility and at least one nephrology – nephrologist or nephrology group practice that is independent of the dialysis facility and in the revise RFA, we have defined the definition of independent as not receiving a W2 from this dialog. And it is spelled out

more specifically in the revised request for application. So again, I would suggest that you look at that on our website.

Thank you. Next question.

Operator: Your next question comes from Stephen with DaVita. Your line is open.

Stephen McMurray: Hi this is Stephen McMurray. I just wanted to ask, on the meeting that you're having with experts in September, is that going to be an open meeting or is that a closed meeting?

Melissa Cohen: So the technical expert panel that my colleague referred to is a TEP that is actually being held by a contractor of ours. The Innovation Center is not going to be convening this TEP. It is going to be convened by a contractor that we have contracted with to help us develop our quality strategy. So because of federal rules and regulations, we will not be the one that are planning that and it is up to them to decide who would be invited.

Thank you. Next question.

Operator: Your next question comes from Robert with Renal Physician. Your line is open.

Robert Blaser: Yes. It's Rob Blaser again. I'm going to follow up on Dr. McMurray's question. So, is there going to be a process where nominations can be submitted for the TEP or is that something that the contractor is just going to pick them. I mean, is it going to be kind of a closed process or will it be open with some sunshine where people can nominate folks to be on the TEP?

Melissa Cohen: It will be a closed process. We believe that they're looking for measure stewards and people from a variety of areas. I think Dr. Mesiwala would be best to comment on that because she is actually the lead on quality work stream.

Alefiyah Mesiwala: So on the TEP, we will have a presentation from all the leading measure stewards and we will also have representation some the renal community.

We're still in the development of those TEPs but we – again, this process is being run with – by our contractor and it is going to be a closed process.

Robert Blaser: I guess it would recommend that it should be – you just said it's going to be a closed process so maybe this is just a silly comment to make but be as open as you could be only because some of the TEP processes in the renal space that have occurred in the last couple of years haven't gone well from the perspective of the stakeholder community. So you might be saving yourself from aggravation in the long run by letting folks know what's going on at the minimum.

Melissa Cohen: We appreciate that. And one thing I would like to mention is that as many of you on this call are aware, this model has been long in the development process and many of you have had the opportunity to provide us with information and guidance on what you think the quality strategy for this model would look like. And please rest assure that we have taken that information from the stakeholder community and we are reviewing it as we consider our quality strategy.

Next question.

Operator: Your next question comes from (Nadu) with Advanced Dialysis. Your line is open.

(Nadu): In relationship to the experts being invited from the private contractor, I think as had been said (Steve) from DaVita. They should have a participation from people basically from DaVita-like organizations and also from independent physicians who are doing so their input can be put in there and in any way they do it because if it is not that involved then the system would be missing both the perspective from their point of view and may create more problems in the future.

Alefiyah Mesiwala: So thank you for that feedback. Again, we're going to continue to listen to the feedback that, you know, the community is giving us and we'll make sure to consider it. Thank you.

Melissa Cohen: And please feel free to send us anything in to our mailbox and we'll make sure to take a look at it.

Operator: There are no further questions at this time. I now turn the call back over to the presenters.

Alefiyah Mesiwala: So at this point, we'd like to thank all of you for joining this open door forum. Again, we are going to be posting in the near future frequently asked questions that will cover some of the topics that we covered today plus more.

In addition, I just want to reiterate, if you haven't gotten the memo that the dates for this model have changed, we are looking to close the letter of intent period on August 30th and applications will also be due on August 30th. We're very much looking forward to receiving applications and to move towards the goal of making the Comprehensive ESRD Care Initiative more of a reality.

So with that, we'd like to sign off. And again, please feel free to submit questions to our inbox. Again, the address for that inbox is cecapplications@hcmsllc.com. Thank you.

Operator: Thank you for participating in today's Comprehensive ESRD Care Initiative Special Open Door Forum Conference Call.

This call will be available for replay beginning at 9:00 a.m. Eastern Time, Monday August 5th, 2013 through midnight on August 7th, 2013.

The conference ID number for the replay is 14927067. The number to dial for the replay is 855-859-2056.

This concluses today's conference call. You may now disconnect.

END