



# The Comprehensive ESRD Care Initiative



# Model Background

- Establishes a new Medicare model of payment to test for
  - improving care for beneficiaries with ESRD
  - reducing costs to the Medicare program
- Developed under the authority of the Center for Medicare and Medicaid Innovation (CMMI)
  - Section 3021 of the Affordable Care Act

# Model Description

- Hypothesis: comprehensive medical management of, and better care coordination for, ESRD beneficiaries will result in improved outcomes and expenditure savings
  - Comprehensive and Coordinated Care Delivery
  - Enhanced Patient-Centered Care and Improved Communication
  - Improved Access to Services

# What is an ESCO?

- Group of healthcare providers and suppliers who will work together to provide beneficiaries with a more patient-centered, coordinated care experience.
- The ESCO and its participants agree to become accountable for the quality, cost and overall care of matched beneficiaries and to comply with the terms and conditions of the ESCO Model Participation Agreement.
  - Participants include participant owners and participant non-owners

# What is an ESCO?

- Must have a taxpayer identification number (TIN)
- Separate and unique legal entity
- Recognized and authorized to conduct business
- Must be capable of:
  - Receiving and distributing shared savings payments;
  - Repaying shared losses, if applicable; and,
  - Establishing reporting mechanisms and ensuring ESCO participant compliance with program requirements, including but not limited to quality performance standards

# What is an ESCO?

- Legal entity recognized and authorized under applicable State, Federal, or Tribal law and identified by a TIN;
- formed by ESCO participant-owners, who must include the following:
  - at least one dialysis facility;
  - at least one nephrologist/nephrology group practice not employed by the dialysis facility; and
  - at least one other eligible Medicare-enrolled provider or supplier including physicians and non-physician practitioners, but excluding DMEPOS suppliers, ambulance suppliers, and drug/device manufacturers.

# What is an ESCO participant-owner?

- A Medicare-enrolled entity that:
  - is comprised of one or more ESCO providers/suppliers, each of whom bills under the same Medicare-enrolled TIN assigned to the entity
  - has an ownership stake in the ESCO,
  - is a signatory to the ESCO Model Participation Agreement, and
  - assumes a minimum portion of the liability for shared losses (“downside risk”) as specified by CMS and agrees CMS may recover such shared losses
- All dialysis facilities and nephrologists/nephrologist group practices participating in the ESCO must be participant-owners.

# What is an ESCO provider/supplier?

- An individual or entity that
  - is a Medicare-enrolled provider or supplier other than a DMEPOS supplier, ambulance suppliers and drug or device manufacturers
  - is identified by an NPI or CCN; and,
  - bills for items and services it furnishes to Medicare fee-for-service beneficiaries under a Medicare billing number assigned to a TIN of an ESCO participant
- All ESCO providers/suppliers
  - must be included on the ESCO's TIN/NPI list submitted to CMS on an annual basis and
  - Are required to comply with applicable terms and conditions of the CEC Model Participation Agreement.

# Applicant Eligibility

- Together, the following providers are eligible to form an ESCO that may apply to participate in the Model:
  - Medicare Certified dialysis facilities, including
    - facilities owned by large dialysis organizations (LDOs),
    - facilities owned by small dialysis organizations (SDOs),
    - hospital-based facilities, and
    - independently-owned dialysis facilities;
  - Nephrologists and/or nephrology practices; and
  - Certain other Medicare enrolled providers and suppliers

# Applicant Eligibility (Cont'd)

- Must have a minimum of 500 ESRD beneficiaries matched to ESCO
- Organizations will not be able to submit a single application for multiple facilities located across different markets
  - Markets are defined as no more than two contiguous Medicare CBSAs with permissible inclusion of contiguous rural counties that are not included in a Medicare CBSA.
    - Exception: For rural applicants not included in any Medicare CBSA, the market area of the ESCO will be defined based on a geographic unit no larger than a state.

# ESCO Beneficiary Matching

To be matched to an ESCO, a beneficiary:

- Must be enrolled in Medicare parts A and B
- Must NOT be enrolled in a Medicare Advantage plan, cost plan, or other non-Medicare Advantage Medicare managed care plan
- Must be receiving dialysis services
- Must reside in the United States and within the market area of the ESCO and receive at least 50% of his/her annual dialysis services (measured by expenditures) in the ESCO's geographic area
- Must be age 18 or above Must NOT have already been assigned or aligned to a Medicare ACO or another Medicare program/demonstration/model involving shared savings at the date of initial matching for the ESCO Model

# ESCO Beneficiary Matching (Cont'd)

To be matched to an ESCO, a beneficiary:

- Must NOT have a functioning transplant
- Must NOT have Medicare as a secondary payer

Pediatric beneficiaries (age 17 and under) are excluded from matching due to different needs of this small population (<1% of total ESRD beneficiaries).

# ESCO Matching Process

- “First touch” approach
  - Beneficiary’s first visit to a dialysis facility in an ESCO during a particular period will prospectively match that beneficiary to the ESCO
- Historical matching
  - Based on “first touch” using historical claims data for a prescribed look-back period
- Quarterly matching

# Payment Arrangement

For each performance year, the historical expenditure baseline will be risk-adjusted, trended, price-adjusted, and bundle-adjusted to form an updated benchmark reflecting the performance year to compare with the ESCO's actual performance year (PY) average per capita expenditure amount — **potentially generating shared savings, or shared losses, if applicable.**

# Payment Arrangement

- Directly tied to whether or not the applicant ESCO includes a Large Dialysis Organization (LDO) facility
- Applicants that include an LDO will be in the LDO two-sided payment track.
- Applicants that include only non-LDO facilities can choose from a 2-sided risk model (phasing in risk in the third year) or a 2-sided risk model (from start)
- All savings and losses subject to a minimum savings/losses requirement

# Payment Arrangement

Design Feature	LDO ESCO 2-Sided Risk Throughout	Non-LDO ESCO 2-Sided Risk from Start	Non-LDO ESCO 2-Sided Risk Phase-In
Risk Structure	2-sided	2-sided	1-sided (2-sided in Y3)
Minimum savings rate (MSR)	+/-1% threshold for first-dollar shared savings or losses (option for higher threshold if desired)	+/-1% threshold for first-dollar shared savings or losses (option for higher threshold if desired)	4% MSR for first-dollar shared savings at 500 beneficiaries, decreasing to 2% as number of beneficiaries increase to 2,000 (1% under 2-sided risk in year 3+)

# Payment Arrangement

Design Feature	LDO ESCO 2-Sided Risk Throughout	Non-LDO ESCO 2-Sided Risk from Start	Non-LDO ESCO 2-Sided Risk Phase-In
Guaranteed Discount	Year 1: 1% Year 2: 2% Year 3+: 3%	Year 1: none Year 2: none Year 3+: 1%	None
Shared Savings / Shared Loss Percentages	After locking in guaranteed discounts, sharing up to 70% of first-dollar savings/losses in year 1, 75% in years 2+	Year 1: Up to 60% first-dollar share/loss Year 2: Up to 70% share/loss Year 3+: Same as LDO Y1 (lock in 1% discount and share up to 70% on either side)	50% in years 1-2 60% in year 3+

# Payment Arrangement

Design Feature	LDO ESCO 2-Sided Risk Throughout	Non-LDO ESCO 2-Sided Risk from Start	Non-LDO ESCO 2-Sided Risk Phase-In
Caps on Shared Savings/Shared Losses	10% years 1&2 15% years 3+	10% for all years	5% in years 1&2 10% under 2-sided risk in years 3+
Rebasing	Rebase for Years 4 and 5 on data from PY1-PY3, including net shared savings dollars as baseline expenditures	Rebase for Years 4 and 5 on data from PY1-PY3, including net shared savings dollars as baseline expenditures	Rebase for Years 4 and 5 on data from PY1-PY3, including net shared savings dollars as baseline expenditures

# Quality Performance

- ESCOs will be required to meet a minimum threshold score in order to be eligible for shared savings.
- Quality measure domains:
  - Preventive health
  - Chronic disease management
  - Care Coordination/Patient Safety
  - Patient/Caregiver Experience
  - Patient Quality of Life

# Agreement

- Must agree to participate in the program for at least a 3-year period
- After 2016, ESCOs may enter into a 2 year agreement with an annual start date of January 1 and calendar performance years.

# Governance & Leadership

- ESCO must maintain an identifiable governing body
- Must have:
  - Authority to execute the functions of the ESCO
  - Authority for final decision-making for the ESCO
  - A conflict of interest policy
  - A transparent governing process to ensure CMS has the ability to monitor and audit as appropriate.

# Governance & Leadership

- ESCO participants (owners and non-owners) must have at least 75% control of the ESCO's governing body.
- No one participant in the ESCO can represent more than 50% of the membership on the governing body.
- Members must place their fiduciary duty to the ESCO before the interests of any ESCO participant.
- The governing body must include an independent ESRD Medicare beneficiary representative and a trained and/or experienced non-affiliated, independent consumer advocate on the governing body.

# Data Sharing

- CMS plans to share several types of Medicare data with ESCOs to support care improvement efforts
- Beneficiaries will have 30 days to opt out of having their identifiable data shared with the ESCO before CMS begins sharing data.
  - Beneficiaries may opt out of data sharing at any time thereafter.

# Data Sharing

- CMS plans to share the following data files and reports with ESCOs on a regular basis:
  - At the start of the first performance year – Detailed, standard (not customized), historical (one year) claims data on matched beneficiaries who have not opted out of data sharing. During each performance year, CMS will also provide historical claims data as additional beneficiaries are matched to the ESCO.
  - On a monthly basis – Standard beneficiary-level claims feeds, which will include beneficiary identifiers, and services delivered by providers inside and outside of the ESCO.

# Data Sharing (cont'd)

- CMS plans to share the following data files and reports with ESCOs on a regular basis:
  - On a monthly basis – Total Medicare Part A and B expenditures and claims lag reports.
  - On an annual basis – Financial reconciliation reports, including the ESCO's performance on quality and patient experience metrics.

# Application Process

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- Two Steps:
  - Letters of Intent
  - Applications

# Letter of Intent

- Must be submitted by March 15, 2013
- CMS will only consider applications from organizations that have submitted a letter of intent by the deadline. However, the letter of intent is non-binding.
- Should include at least 50% of ESCO participants.
- Template available in Appendix A of the RFA
- Online-only submission process.

# Application

- Must be submitted electronically no later than May 1, 2013.
- Template available in Appendix B
- Must include 100% of proposed ESCO participants owners

# Questions?

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For more information:

[innovation.cms.gov/initiatives/comprehensive-ESRD-care](https://innovation.cms.gov/initiatives/comprehensive-ESRD-care)

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