Transcript of the CMMI CEC Model Learning Event
Finance and Quality Methodologies
June 29, 2016

Leslie: Good afternoon, everyone. I'd like to welcome you to today's learning event entitled Finance and Quality Methodologies. My name is Leslie Vasquez, and I'll be moderating this afternoon's event. Today's webinar provides an overview of financial methods, discusses the CEC quality strategy and requirements, and provides a brief overview of CEC beneficiary alignment. We'll hold moderated Q&A sessions on our topics. Today's event focuses on dialysis facilities including large dialysis organizations, or LDOs, and non-large dialysis organizations, or non-LDOs.

In addition to that, the event is open to nephrologists and other clinical and nonclinical ESRD care providers, and stakeholders interested in learning about the second solicitation for the CEC model. Just a note before we get started, I'd like to inform everyone on the call that all comments made during the event are offered only for general informational and educational purposes. As always, the agency's positions on matters may be subject to change. CMS's comments are not offered as and do not constitute legal advice or legal opinions, 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.

ACOs are responsible for ensuring that their actions fully comply will applicable laws, rules, and regulations. 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 event. We intend to gather your individual input only. CMS is not seeking group advice. Now, I'd like to just point out a few tips, so that we can have a successful learning event. First, since we are recording this event, we'd like to make sure that all attendees keep their lines on mute and stay in listen only mode.

The recording from today's event will be emailed to registered attendees following the event. It can also be accessed on the Center for Medicare and Medicaid Innovation Comprehensive ESRD Care model webpage within two weeks. Next, there will be three Q&A periods during the event, one on alignment, one on finance, and one on quality. We're asking attendees to submit any questions you may have into the Q&A pod on the right-hand side of the screen during the event or during the Q&A period.

During the Q&A period, all questions will be answered in the order in which they are received. I will attempt to address all questions answered in the pod to the model team. However if this is not possible, attendees are encouraged to email any questions not addressed to the following email address. It's ESRD-CMMI@cms.hhs.gov. We'll display that on screen at the end of the event. If you have any technical questions or issues,

please submit a question to Charles Gluck, who's our producer. He will be happy to assist you.

Finally, a PDF copy of the slides for today's presentation along with the copy of our fact sheet and user manual can be accessed by clicking on the links under the materials pod located on the right-hand side of the screen. We've also got a feedback pod there. We do have a survey. We appreciate any feedback that you have on today's event. The survey pod is available throughout the entire event, and it takes less than two minutes for you to complete.

Let's go ahead and get started. I'd like to conduct a brief poll just to get a sense of the audience joining for today's event. Charles, will you please open the poll?

Charles: The polls are open. If you can, please enter your responses to question one and question two. If you have a response to question one that is "other", please see that in the middle of your screen. I'll leave the polls open for a couple of seconds to get everyone's responses (silent pause).

Okay, I'm going to close the polls. Thank you everyone for participating.

Leslie: Thanks everyone. Taking a look at the polls and some of the responses that we're getting back, it looks like the majority of our attendees today come from dialysis companies and are attending in a room by themselves rather than with a group. Thanks so much for participating in today's polls. Let's wait a moment for the slide to launch.

Now I'd like to turn the presentation over to our first presenter, Emma Oppenheim, who's representing the CEC team.

Emma: Thank you. Hi everyone. This is Emma Oppenheim from CMS. I'm currently the non-LDO project director for the model. I also have a number of other roles. Today I'm here to talk to you about the Alignment Methodology. Then we will also have a talk about Finance Methodology and then about the Quality Methodology.

We wanted to start off this conversation about alignment, because alignment in some ways is the foundation for other domains in the model, including the finance domain and the quality domain.

What is beneficiary alignment? I think this might be the first time that some of you are hearing about this. Beneficiary alignment includes identifying beneficiaries eligible for the CEC model, aligning eligible beneficiaries to ESCOs, identifying reference group beneficiaries, and transmitting beneficiary alignment information to ESCOs. I'll pause here to emphasize. Alignment is figuring out who at your dialysis facilities is actually participating in the ESCO program. It's not everyone at all of your dialysis facilities. We'll talk more about that.

There are a number of eligibility criteria for participating in the model. These are the eligibility criteria for beneficiaries. Basically, a beneficiary is aligned to an ESCO based

upon a 72x claim at a dialysis facility. Really one of the major components of this model is the "first touch" perspective alignment. First touch means that once they have a 72x claim at one of your participating dialysis facilities, these beneficiaries are aligned to the model for the life of the model. This has been slightly amended for PY2 (“Plan Year 2”) and onward, in that if you have a first touch you are aligned for the life of the model, but then in the next year, in each subsequent year, you need to have at least one touch and be within the market. That's something we'll talk a little bit more about as well in order to continue to be included in all the financial calculations better.

Then what are the rest of the eligibility criteria? This is often very important. A beneficiary cannot be in an ESCO unless they are enrolled in Medicare Fee-For-Service including both Part A and part B. Medicare must be the primary payer. This is very important, so in particular, this affects people under sixty-five who receive Medicare, because they have ESRD. As you know there is a ninety day waiting period, and there are some other eligibility criteria that can lead to a delay and having Medicare as the primary payer. This is a large reason that we see many people that receive care at their facilities not being part of the ESCO population.

No beneficiary can have Medicare advantage and be part of the ESCO. A beneficiary cannot have had a transplant in the previous twelve months. A beneficiary must be over eighteen. They must have a US address. They can't be enrolled in another CMS shared savings program. That requirement is something that we handle on the backend. It's also very important for us to know that CEC has alignment priority over most other ACO model. Beneficiaries in managed care duel models are excluded from CEC, because we are one of the smaller models, and because we have a very specific population. We have priority over other larger models, including Pioneer and the SSP program.

I want to make a few more key points on alignment. We really emphasize having ESCOs be accountable for beneficiaries who visit their dialysis clinics, but something else that's very, very important, that we really think you should think about as you put together your participant list, is that just because someone is aligned to the dialysis facility does not mean that they are aligned or receiving care really at a nephrology practice that is part of your ESCO. This is one of the biggest mismatches we see on the backend: only a small percentage of the people who are receiving care at your dialysis facilities and are part of your ESCO have a Nephrologist that are part of the ESCO model who are participants. We really strongly recommend that this is one of the major things that you look into when you send us information about your participant list. We recommend trying to really widen your nephrology network, so that a lot of the nephrologists who provide care to your dialysis patients are participating in the model and have the same incentives that you have.

Then alignment of significant beneficiaries in your clinic will not be aligned to your ESCO. In particular, this is talking about Medicare as a secondary payer. It's important to note that, especially regarding those beneficiaries under age sixty-five, there is typically a waiting period. It's not an immediate qualification for being part of the ESCO. It usually is a few months.

Then the alignment grows during the year. This is also something that you would see as you participate in the ESCO program, so you start off with a certain number of beneficiaries, and each month additional beneficiaries would be added to your beneficiary list as they receive care at your dialysis facility and have 72x claims. They become aligned usually at the end of the year. That number goes back to about what it started as with dialysis and transplants.

Another rule that's also very important to note is that a beneficiary must receive 50% or more of their care in the ESCO's market area where they're having their first touch. That also removes beneficiaries, but you would only find out about that at the end of the year when three months claims run out.

As you can tell there's quite a bit of fluctuation in the alignment list during the year. Again, we don't remove beneficiaries during the year. We will remove them at the end of the year, and so know that only the final list is used for financial reconciliation. Some of this noise that you see on your beneficiary list is removed at the end of the year.

I'm going to pause here for some questions.

Leslie: Thanks, Emma. Everyone, I see that we've got a couple of questions in the chat window, but I'd like to encourage you that if you have any questions on the Alignment Methodology, please go ahead and submit them now. I'll go ahead and read our first couple of questions.

Emma, the first question is, "If a patient had very few, single digit, number of treatments and transferred out, are they still our responsibility?"

Emma: That's a very good question. One that we get quite a bit. I think it depends on what you mean by "transferred out". If this bene comes in from Florida, and you're a facility in Ohio, and they are there for a week. That's one week of care. They're going to show up, remember that they're going to start showing up on your beneficiary list, but it's very extremely likely that they would fail at market rule at the end of the year and be removed for all of your financial calculations.

However, if for some reason they receive care at your facility and then don't come back your facility, or move across town and start going to a different facility, because they continue to be in the market area, they are going to be considered part of your population for that year. Now we tried to make an adjustment to get around part of this. It's very important that there is no claim on these lists by the ESCO, so that's why we have the first touch rule.

For PY2 and onward, if a beneficiary has not had a single dialysis visit at an ESCO dialysis facility within the year after that first year, then those beneficiaries would not be included in financial calculations even if they are included in the market area.

Leslie: Thank you. Our next question, "Just to clarify, beneficiaries become participants based on their dialysis clinic tins, T-I-N I believe, not their Nephrologist tins?"

Emma: Yeah, beneficiaries are aligned through dialysis facilities. Basically, what that means is that they have to have a first touch, which is they have to receive care at an ESCO dialysis facility. That aligns them to the ESCO. Beneficiaries are not aligned through Nephrologists.

Leslie: Thanks, Emma. We've got one more question in the chat window. "How do you treat transmit patients who live in the market?"

Emma: That's a very similar question to the first one that I answered. I think I'll basically repeat the same answer. I think its worth repeating, because again, I think this is one of the sources of confusion. We're trying to be really clear about this. If they live in the market and for some reason received care at your facility - let's say once or twice, or something happened and they came to your facility for a week - those people will be included in your financial calculations for that year. From the month of the first touch onward. Remember: we look at months.

However, there are many things you can do in those circumstances. We say try to make all of the benefits of being in an ESCO such that those beneficiaries want to come back, and want to receive care, and be part of your ESCO, because the care that they're receiving there is so great. I think that in PY2 and onward, if that beneficiary never comes back in the next year to any of your ESCO dialysis facilities, they would be removed and would not be included in financial calculations.

Leslie: Thanks so much. It looks like we've got one more question in the chat window. Then we're going to have to move to our next portion of the presentation. The question is, "What happens if there is a major disruption of service, such as Hurricane Sandy or Katrina?"

Emma: That's a very good question. I think it's known as a catastrophic emergency. That would be something that absolutely you should bring to the CMS team and we would discuss. I think if you're talking about what happens if there's a major earthquake or a hurricane that would cause lots of people to come into your dialysis facility, again it would be something to bring to CMS, but it is possible, depending on the outcome, that those people would again be included for that year.

Let's say all of them went back to their new facility in the next year, that they would be removed for that next year, but again, I think Hurricane Sandy was a very specific and large scale massive example. I think that would be something where we would be willing to discuss that with you, and try to identify alternatives to identify these people, and pull them out of the financial model.

Leslie: Thank you. Now we will turn things over to Thomasina for the finance portion of the presentation.

Thomasina: Thank you so much. Hi everyone. My name is Thomasina. I'm the finance lead for the CEC model. Goals of the Financial Methodology are to: one, calculate aligned

beneficiaries actual expenditures during a given performance year. Calculate a benchmark using expenditures of beneficiaries aligned to the ESCO in historical periods and trending forward to performance year. As well as to calculate shared savings or loses, which we'll go through as an overview on today's call.

There are three risk tracks for the model. They include: one, the first track is for large dialysis organizations that is two-hundred or more dialysis facilities following the USRDS definition. This is a two-sided risk model where financial guarantee is required. You may select available minimum savings rate or minimum loss rate of between one percent to two percent, which is inconclusive, at the start of each performance year.

The second risk track is the non-large dialysis organization. That is fewer than two-hundred dialysis facilities. However, this is a two-sided track where financial guarantee is required. However, performance is aggregated with other two-sided non-LDOs. If beneficiary alignment numbers are too low or if the ESCO elects to have its beneficiaries grouped in an aggregation pool. I'll go in some more detail here in a later slide.

The last risk track is also for non-LDOs. However, this is a one-sided risk track, so that means there's no downside risk, so financial guarantee is not required. Like the other non-LDO risk track, performance is aggregated with other one-sided non-LDOs again if alignment numbers are too small or if the ESCO elects to do so. One thing to note here is that the minimum savings rate is based off the number of beneficiaries in the ESCO or aggregation pool.

ESCOs are accountable for their aligned beneficiaries, Medicare parts A and B care, regardless of what care is delivered. This does not include Part D costs or costs from other payers including Medicaid. Shared savings if aligned beneficiaries' expenditures are below the benchmark outside the minimum savings rate. If you are in a two-sided risk model, shared losses if beneficiaries' expenditures are above benchmark outside the minimum loss rate. Again, I'll go into this in further detail.

This is an overview of the Financial Methodology. We're not going to go through any part in significant detail, but the goal is for you all to leave with the general sense of the CEC Financial Methodology. The first feature we would like to emphasize is the historical expenditure baseline. The historical expenditure baseline is calculated using three years of financial expenditure data that is 2012, 2013, and 2014, which I'll now refer to as base years. 2012 being base year one. 2013 being baseline year two. 2014 being base year three. I would like to emphasize that we trend and risk adjust base year one, so that is 2012, and base year two, that is 2013, figures so that they are expressed in base year's three dollars. The figure in this slide gets that done.

The first adjustment is trending. Trending is where we multiply base year one and base year two per beneficiary per year figures by the growth rate and national ESRD populations per capita expenditure. The second factor that goes into this calculation, which is the second adjustment, is what we call risk adjustment. We multiply base year one and base year two per beneficiary per year. All of this is figured by the growth rate and the aligned population's HCC or demographic risk scores. All of these calculations

are conducted or performed separately for five eligibility categories that is aged duel, aged non-duel, disabled duel, disabled non-duel, then ESRD only.

The second feature that we would like to discuss is the Performance Year Expenditure Benchmarks. This is an overview. The graphic that you're seeing is an overview of this process. I would like to say here that it is very similar to what we see for the base year, except this is done by performance year. We start with the Historical Expenditure Baseline, which we discussed in the previous section. We then trend and risk adjust the baseline, so that is expressed in terms of the performance year. Here, again, we see trending a risk adjust is conducted on the Historical Expenditure Baseline to make them in terms of performance year dollars.

Again, this is so much of a process that we used for the base year figures to make them comparable to base year three. At this point, for each ESCO we will have five expenditure figures for each performance year. One for each eligibility category, which is what I was saying on the previous slide about calculations being done by eligibility category. If you are a LDO a discount is applied. For non-LDOs the difference here is that you will be able to elect aggregation. If your alignment numbers are too small, you will be put in an aggregation pool.

Next, we have comparing the performance year expenditures to the performance year benchmark. The term in shared savings and losses involve comparing the performance year expenditures to the performance year benchmarks we just described. If that results, as you see in this calculation or formula above, is greater than zero, the ESCO is then eligible for shared savings. If the result is less than zero, the ESCO is eligible for shared losses.

However, in order to actually have shared savings or losses, you must satisfy the minimum savings rate for MSR or the minimum loss rate for MLR. The savings or loss multiplier accounts for quality performance and adjusts accordingly. The savings or loss cap is applied based on where you fall.

This table provides a clear overview of the different elements of the Financial Methodology. Please note that these elements may differ based on which financial track you are in for the model. The elements include the minimum savings rate or the minimum loss rate. Again, this differs by which track that you're in. A discount is applied in performance year to and on if you're an LDO. Shared savings or shared loss percentages also differ based on the track that you're in. A cap is applied. Those figures also differ based on which track you are in. There is no rebasing for this model. For the base year one, base year two, and base year three that will be the three years of expenditure data that is used to calculate your historical expenditure baseline for every performance year that you are in.

Applicants should also know that aggregation is an option for them to non-large dialysis organizations or non-LDOs only. Aggregation is a process of combining financial performance to likely increase the reliability of financial results and possibly reduce the minimum savings rate. For non-LDOs who may not meet the three-hundred-fifty

beneficiary threshold, this is required. For non-LDOs that voluntarily opt to aggregate, aggregation is optional. The aggregated benchmark and aggregated performance year expenditure figures are based on performance per beneficiary per year. Expenditures for all ESCOs that have their beneficiaries grouped in a particular aggregation pool.

CMS will determine the makeup of aggregation pools based on the number of the non-LDOs in each risk track. ESCOs may share preferences with CMS, but the makeup of the pools will be at CMS discretion. ESCOs receive various forms of financial reports throughout their performance year. They include the baseline report, monthly expenditure and claims live report, claims and claim line feed reports, or CCLS, quarterly expenditure reports, then the reconciliation report that is given through month after the performance year ends.

There are a few caveats we would like to emphasize for these expenditure reports. Midyear reports that is any point that is given prior to reconciliation analyzed partial years of expenditures. Midyear reports use trending based on the partial year of alignment eligible that is reference population expenditures. Alignment reconciliation and inclusions occur at the end of the year. Only the final expenditure report at the end of the year, so the settlement or reconciliation report, they're the same thing, will provide a comprehensive view of all relevant adjustments including expenditure capping.

Key takeaways from the overview of the Financial Methodology is one, the CMS strives for accuracy over prospectively estimating within the CEC model. Interim finance reports are meant to provide a general idea of ESCO performance. Final expenditure figures and adjustments will occur at the end of the performance year. The final benchmark will not be known until the end of the performance year.

The second takeaway is that alignment and finance are inherently linked. You won't know final cost or benchmark until after alignment reconciliation is performed. Any change in the makeup of beneficiaries in baseline years or performance years will change savings or loss estimates and figures.

Lastly, CMS values partnership and transparency. We understand the risk that you are taking. The CEC finance team seeks to provide clear communication and the tools necessary for understanding financial figures of the utility or the reports that we send. With that, I'll stop and take any questions.

Leslie: Thanks everyone. We've got a couple of questions already in the chat for Thomasina on finance. I would like to invite anyone to go ahead and post any additional financial related questions in the Q&A pod now.

Our first question is, "When will we receive our baseline calculations?"

Thomasina: Thank you. In terms of when baseline calculations will be received, ESCOs will get a baseline report at the beginning of the performance year or during the performance

year. Those calculations are final with that report, but then again they're given at the performance year. For the performance year, you will get a new baseline report.

Leslie: Thank you. Our next question, "Can a non-LDO join an LDO for the purpose of voluntary aggregation?"

Thomasina: No. A non-LDO cannot join an LDO for the purpose of voluntary aggregation. Aggregation is restricted to non-LDOs.

Leslie: Thank you. We have a follow up question. I think this is related to the first question that you answered. The question is, "Can we get a preliminary baseline calculation?" I want to make sure that's answered.

Thomasina: We will provide a report that will give a sense of ESCO financial performance prior to the performance year, but we won't necessarily give a preliminary based on calculation. It will give you a sense of what your performance could be, but it's not a baseline calculation.

Leslie: We have another question around baseline reporting. "The baseline reporting change the benchmarks for each performance year?" That's being asked as a question.

Thomasina: I'm not sure if I'm understanding the question correctly, but the baseline report will change for each performance year for various factors. If your alignment number changes or figures change based on dialysis facility's ads, or anything like that, your baseline will be changing.

Leslie: I think that addressed her question. Are there any additional questions? She's confirming that this addressed the questions. We have an additional question in the chat window. "What is the baseline calculation based on? Is it the average cost in the state or locality?"

Thomasina: Sorry if I didn't make that clear in this presentation. The baseline calculation is based off of the ESCO's financial expenditures for base year 1, 2, and 3. That is 2012, 2013, 2014 financial expenditure data. Not for the state or the locality.

Leslie: Are there any additional questions regarding the Financial Methodology?

We're going to go ahead and move on to the next portion of our presentation. Now we will turn thing back over to Emma and to Kate Blackwell to talk about Quality Methodology.

Kate: Great. Thank you. This is Kate. I'm going to start by outlying to CEC's quality strategies. I'm going to give a high level overview of the classes of quality measures included in the model. Finally, I'll assess quality scoring. Then I will hand things over to Sid. He's going to discuss the kidney disease quality of life, so we'll go in a little bit more detail.

CEC's quality strategy seeks to encourage participants to provide patient-centered care that conforms to clinical care standards and to encourage ESCOs to coordinate care for their patients across care settings outside of the dialysis clinic. To do this, we measure the quality of care that ESCO beneficiaries receive across the five dimensions of care specified that's assigned in the National Quality Strategy, which are listed on the slide.

Then we compare ESCO quality performance to both national benchmarks and to their own performance in past years in order to determine the ESCO quality score, which we will use to adjust shared savings with shared losses. In ESCO's first year of participating it is only subject to take a reporting for all quality measures. Whereas in subsequent years, ESCOs are subject to pay for performance on quality measures.

CMS selected the quality measures included in the quality measures set through a rigorous selection process. After assembling the universe of possible measures, CMS convened its technical expert panel, sought public comment, conducted research into the feasibility of these potential measures, and got input from a variety of stakeholders. This process resolved with the selection of the twenty-five measures currently in the measure set. However, we are also mindful that CMS priorities might change in the future or that measures may not work out as intended, so we do have periodic opportunities to amend the quality measure set as need be.

There are three types of measures in the quality measures set. By type here, I'm referring to where the data for the measure comes from. I will quickly go over the types of measures. I'd be happy to address specific questions in depth about the measures during the Q&A.

The first type of measure is the hybrid measures listed here, which use data from both Medicare plans and from the patient's medical records. ESCOs report data on these measures to CMS to provide an example of their beneficiaries through an online platform once a year during the quality reporting period. As you can see here, these hybrid measures span across all of the quality domains. The measures include diabetic eye exams and foot exams, advance care planning, medication reconciliation after a discharge, influenza and pneumococcal vaccinations, depression screening, tobacco screening, and health assessments.

The second type of measures comes from survey data. This includes the ICH cap survey with which you may already be familiar and the kidney disease quality of life survey, which we will discuss in more detail later. These measures focus on patient experience and outcomes, and includes composite measurement in the ICH caps for Nephrologist communication and caring, quality of dialysis and care in operations, providing information to patients, and ratings of kidney doctors, dialysis center staff, and the dialysis center overall.

The third type of measures are the result at the dialysis facility level. These include measures already compiled by ESRD-equipped and owned labs and the National Healthcare Safety Network. These measures focus on the more clinical aspects of dialysis care. The measures included here include bloodstream infections, hemodialysis

and peritoneal dialysis adequacy, hypercalcemia, vascular access for both fistulas and catheters, standardized mortality ratio, standardized hospital admission ratio, and standardized readmission ratio.

Once we collected all of this data, we construct quality performance for the CS level. In an ESCO's first year, the ESCO will receive full credit for two clients for each measure that they reported completely and accurately. After the first year this will be based on performance. As you can see in the slide, there are two scoring scales. One based on ESCO performance in relation to national performance. One based on ESCO performance in relation to its own improvement from previous years. For each measure the ESCO receives the higher of these two scores.

For example, if for a given measure your facility scored in the fiftieth percentile nationally, but shows greater than ten percent improvement in relation to your own performance on that measure last year, you would receive one point five points for that measure. Also, ESCOs must contain the minimum equipped TPS threshold to qualify for shared savings in the model.

The ESCO total quality score is used to adjust shared savings and shared losses. Each measure score will be derived by determining the quality improvement points and multiplying the higher of those two scores by the measure rate. The sum of the weighted individual measure scores will be used to calculate the ESCO TQS. If the ESCO does not meet the minimum performance level for a given measure, they are given a zero for that measure. After the TQS is finalized, it will be used to adjust your shared savings and shared losses. I'm going to turn it over to Siddhartha.

Sid: As Kate mentioned, the kidney disease quality of life survey is among the quality requirements for the CEC model. I need to emphasize, however, that we are currently considering the use of the survey for the quality requirements. It is not definite yet. CMS is currently considering the options for analyzing and scoring the KDQOL survey for the performance year 2018. If your ESCO is participating in 2017, that performance will not be included in the scoring for 2017 or be based on 2017.

We've engaged with a research organization under contract who is conducting a survey and conducting analytical and methodological activities to decide whether and how to use the KDQOL for the model. Among the activities, survey to a full census of beneficiaries aligned to the ESCOs has occurred in 2016. We are planning a survey to a poll census early in 2017. You can expect beneficiaries in the dialysis facilities to be surveyed on to the model.

For the survey we are using a thirty-six item questionnaire that has been developed by the RAND corporation. I'm sure the dialysis organizations are familiar with this survey. It includes questions on physical and mental well-being, burden of kidney disease, treatment associated symptoms and problems, and the effect of kidney disease on daily life. Added in the survey instrument that has been fielded for the CEC are seven questions about dialysis modality and the personal situation.

The final approach is being developed. It will be determined after reviewing the data for 2016 and 2017. One item that is important to add is that the survey that is being fielded to the beneficiaries as part of the model, this does not obviate the requirement that is in the dialysis or the conditions of coverage that requires dialysis facilities to conduct the psychosocial assessment of patients within their facilities. Thank you very much.

Leslie: Thank you so much, Sid. Now let's have our final Q&A session of the afternoon focused on quality. We have one question in the chat so far. I would encourage the rest of the audience if you have any questions on the Quality Methodology or the surveys that Sid just discussed please type them in the Q&A window now.

I'll go ahead and field our first question. The question is, "If there are ten facilities in the ESCO, how will the QIP, Q-I-P is the abbreviation, will it be a weighted average if one facility of the ten has a penalty, will this result in no shared savings?"

Kate: There will be a weighted average. The exact calculation is yet to be determined. We are reviewing potential options for weighting right now. If one of the facilities of the ten has a penalty, will this result in no shared savings? That is also that we would bring to the ESCO and discuss, because as you know QIP scores reflect prior years, so we do not have results yet for current performance year. That is something that we would be bringing to you. It's likely that that would result in a cap on the ESCO. A cap is a corrective action plan, so we would established some sort of plan for keeping you in the model, but maintaining high quality at all of our dialysis facilities.

Leslie: Thank you. Our next question is, "Did that last slide say that CMS administered the survey in 2016? I missed it if they will be doing it in future performance years?"

Sid: Yes. CMS administered the survey to beneficiaries that are currently aligned to the ESCOs in 2016. There have actually been two distinct administrations. One is going on right now. We are expecting that this survey will be administered to align beneficiaries including those for ESCOs joining in 2017. We expect that there will be administrations in future years. Particularly in 2017.

Leslie: Thank you. Our next question is, "How will the ESCO QIP total performance score be calculated if the ESCO will be comprised of multiple facilities involved?"

Kate: That's a very good question. Also similar to the weighting question. This is the question that we are actually working on right now. As you know, we haven't received any results yet for any of their performance years. Basically, we will be determining a weight. Then that will be applied to the ESCO.

Leslie: Thank you. Are there any additional questions on quality? Please go ahead and type them in the chat window if so, or we can also open it up to other questions as the audience may have them.

We've got another question, "How does a Nephrologist ensure that the ESCO will report quality measure to CMS?"

Emma: I'm wondering now if this was not covered in our presentation. To participate in an ESCO you must report quality measures to CMS. That's a big must for the model. What we do is we provide an entirely new platform for the ESCO to report quality measures to us. It's a platform that's on the CMS portal if you have experience with the CMS portal. It's somewhat similar to GPRO if you have experience with GPRO. Basically, there is this set of measures that Kate walked us through. You report directly on the hybrid measures. We receive the QIP results in the same way that you would submit QIP results to us.

Basically, your ESCO needs to come up with some sort of process for getting information on these quality measures to CMS through this quality measurement assessment tool, which is the tool that lays down the CMS portal that we use for reporting to CEC.

As Kate talked about, the process is that you will receive a sample. Then your leadership and your quality staff will have to come up with a way to get all the information and all the numerator information, for the beneficiaries for the hybrid measure. I hope that answers the question.

Leslie: We've got another question in the chat window. "Since an ESCO owns Medicare beneficiaries in a multi-facility ESCO, does it not make sense to aggregate the results for the purpose of quality?"

Emma: I am not sure I completely understand that question. Basically, I think what I'll say is that the sample that you receive is derived from all of the dialysis facilities. It's a random sample. In that way your quality results will reflect the quality of all of the dialysis facilities.

Leslie: We have got a couple of questions that are coming up in the chat window. The next question is, "Is the VM waiver a definite option available to Nephrologists to participate in ESCOs?"

Emma: That is a really great question. I'm really glad you brought that up. By participating in the CEC model, you receive credit for PQRS. You also receive a waiver from the Valued Modifier Program. All of the ten NPI combinations in the ESCO at the end of each year, like on December 31st, will receive credit for TQRS. As a reminder that means that you have to successfully report on all of you hybrid measures and all of your other measures to CMS. You would also receive a VM waver when your ESCO successfully reports. Those are both huge benefits. Moving forward there will be expected benefits that are not specified. We won't speak to it at this time.

Leslie: Thank you. Our next questions is, "Is the historical expenditure data baseline based on and utilized for each individual ESCO's historical expenses? IS the baseline an aggregate of all ESCO's data?"

Thomasina: Thank you for that question. This is Thomasina speaking. No, I guess I should have also made that clear in the presentation. The historical expenditure data baseline is based on the individual ESCO, as are all financial expenditures. No, we don't aggregate.

Are you asking ... I guess I should also clarify your question. Are you asking for if a non-LDO elects to aggregate or it's in the aggregation pool? Is that what your question is pertaining to? Are you asking about the baseline in general?

Leslie: I think while we're on clarification from that audience member, I'd like to briefly go back to the prior question where someone asked about whether an ESCO owns Medicare beneficiaries in a multi-facility ESCO. "Does it not make sense to aggregate the results for purpose of quality?" We've got a follow up on that to clarify. That point is that they meant the similar processes will be applied and implemented to all facilities in a multi-facility ESCO.

Emma: Sorry. If this question was about the QIP results, I think that's an interesting point. I think it's very important for us that we recognize someone failing QIP essentially. That's really important to us. It's necessary to recognize that performance. We do expect to apply a weight to all of the different dialysis facilities lightly based on how many beneficiaries there are at each dialysis facility.

Leslie: Going back to the question on historical expenditure of baseline data, we've got a clarifying point on this. The question is, "Is the baseline for all thirteen ESCOs and additional round two ESCOS? Do you look at what the historical expenses have been for your own ESCO for the baseline?"

Thomasina: Thank you for the clarification, Karen. That is what I understood from your question. I wanted to make sure. No, it is for your ESCO. The data from the base year, so 2012, 2013, and 2014 are for your particular ESCO. We do not use base data from all of the current ESCOs and the new ESCOS. To add additional concept there, the baseline is compared to your benchmark, so you understand in the way that it's meant to be applied symmetrically. Whenever we're doing the performance year, it happens for the base year. The base years are the baseline calculation. Since we are assessing just your own financial performance, we put you up against your own benchmark for those three years.

Leslie: Thanks, Thomasina. We've got two more questions in the chat window. We can go ahead and address those. The first one is, "If a Nephrologist is already participating in a Medicare shared savings program, which is an ACO, how do they get moved into the ESCO? What happens to reimbursements, garnishes or penalties, as a result of their transition?"

Emma: That's also a very good question. I think that question passed in to a lot of internal workings here at CMS and CMMI. There are different rules depending on the shared saving program that may already have one of your beneficiaries. If it was the SSP program then for two of the three tracks CEC has priority, which means that if a

beneficiary receives care at a dialysis facility that's part of your ESCO, those beneficiaries would become aligned to CEC and would be no longer aligned to SSP.

For the new ... I'm realizing I might be answering a slightly different question. I'm talking about beneficiary alignment. If a Nephrologist is already participating, there are some allowed overlaps. I would say I would absolutely recommend that when you're putting together your participant list, have a conversation with all of the participants in your ESCO and say, "Are you currently in any of these other shared savings programs?" That does not necessarily preclude them from participating in the CEC model, but you definitely be aware of that and have the (participants) be open with you about that. Then know that it is possible that we will not allow some of those participants to be in the CEC program.

For the SSP program, in particular, they have exclusivity, so if one of your Nephrologists has a ten NPI combination that is participating in an SSP, they cannot participate in CEC. However, that does not mean that they can't participate in CEC if they go through any other ten NPI combinations. If they go through a ten that does not participate in an SSP, they can participate in CEC through that ten.

Leslie: Thank you. We're going to have to close with this next question. The question that we've got is, "If an ESCO aggregates, I thought the quality data was not aggregated, just the financial data. Is this correct?"

Emma: Yes, that's correct.

Leslie: Thank everyone. To remind if we were not able to address your question today, or if you think of additional questions, you can email them to the model team. Charles will go ahead and post that email direct in the Q&A window, so that you can see where to submit those questions.

I'd like to remind you of a few learning events coming up. On July seventh, we have another webinar for specifically for clinicians. Its title is Clinical Providers in the CEC Model.

We also have several office hours coming up with open Q&A team with the model team. We encourage you to register for those early as space is very limited. The events are July sixth, twelfth, and the fourteenth. They are filling up, so please go ahead and register early for those.

Now we would like to thank everyone for attending the event today and thank our speakers for sharing their expertise. You can visit the CEC model team website to access more specific details on the model including recordings and slides from previous learning events, a copy of the RFA, and the new CEC RFA fact sheet.

We would greatly appreciate if everyone would take a moment or two to provide us with feedback pertaining to today's learning event. All feedback provided is confidential. It really helps us to improve future learning events. To provide your feedback, I want to

call your attention to the survey pod that's on your screen. You can click on that survey pod. Click on the word survey. Select browse too. It will send you to that survey pod, so that you can fill it out. It really takes a minute to complete. We greatly appreciate any feedback that you have.

Thanks everyone. I'd like to go ahead and formally close today's event. I hope that you have a wonderful evening.