Updates to Innovation Kidney Models Webinar
March 02, 2022

>> Welcome to today's webinar on the updates on innovation Center kidney models.

I am Kate Blackwell and I am the director of special populations and projects at the innovation center.

We are a group that operates the innovation Center kidney models.

We go through the three models and update about all the exciting things happening in our models.

Before we begin, I have a couple of housekeeping items.

First, this webinar is being recorded.

The recording will be posted on the website next week.

During the webinar, we will be using the Q and A feature in Zoom to take questions.

If you have questions during the presentation, feel free to ask them via the Q feature.

We will not be taking questions via the chat feature.

Please target your questions toward Zoom.

If you have more information about the models, you are welcome to visit the model website.

There any questions you have that we are not able to answer today, please direct those questions to the model help desk.

The addresses for the website and the help desk are available in Zoom check.

-- Zoom chat.

Turning to today's agenda, we will be giving updates on the three innovation Center kidney models.

First, we will cover the comprehensive ESRD care or CEC model.

Laura will provide an overview of the model, and Tom will talk about the CEC model of valuation.

Second, we will talk about the kidney care choices.

Laura will join us again and provide an overview of the model as well as give updates about our first cohort of participants.

Then, our alignment we'd -- lead will talk about the applications for 2023.

Third, we will talk about the ESRD treatment choices or DET C model.

Kristin will give an overview of the model as well as upcoming processes for participants.

Then we will talk to Tom, who will talk about the collaboration for transplantation.

Time permitting, we will answer questions at the end of the presentation.

Again, feel free to ask questions via the Q and a function in Zoom throughout the presentation.

With that, I will hand it over to Laura.

>> Thank you.

Thank you all for attending.

First, we are going to discuss the innovation centers first ever kidney model which was the comprehensive ESRD care model.

It is called the CEC model for short.

There we go.

The CEC model began in 2015 to see if an ESCO type structure, which we call a seamless care organization or ESCO for short can succeed in coordinating care specifically for beneficiaries with end-stage renal disease.

This is in order to lower cost and improve care, much like a savings program for the next generation model.

In this model, dialysis and nephrology providers and suppliers teamed up to form ESCO and take care of beneficiaries if they receive dialysis.

The financial dialysis with a care group trends historic expenditures forward to determine if the Esco succeeded or met the benchmark in order to achieve savings or reliable shared losses.

Then, how well it performs on certain quality measures would dictate how much shared shavings -- savings they would receive, or how much they would owe.

This is a timeline of the CEC model.

In October of 2015, there were five performance years.

It ended in March of 2021.

That was a three month extension past the original due date due to COVID.

The CEC had 37 Esco's at its peak it this map shows where they were located, and who owns them.

Most Esco's were concentrated east of the Mississippi, as you can see here.

There were a few in the Southwest and a couple in the Northwest.

Next, I will pass it to Tom to go over some CEC evaluation findings.

>> Thank you.

So, I highly recommend folk go to our website.

For the CEC model.

We have a detailed valuation report.

It is a good summary of what we saw through the model and how we evaluated it.

It is a helpful way to show how CMS thinks about it and sees the results there.

Overall, we were pleased with the results from the CEC.

Here are some of the key findings from the fifth report which sums up the performance over the entire model.

The biggest factor, of what we are hoping to see, we saw a decrease of 3% and hospitalizations, which really helped to drive approximately $85 per beneficiary per month decrease in gross Medicare spending.

That was a pretty positive one.

We are trying to build on that with the new model.

More dialysis specific factors, which was a key focus of the model is a 6% decrease in long-term catheter utilization and a .4% increase in dialysis sessions.

All of those findings are statistically significant.

Again, I recommend folk go to the website for a lot more details and information.

We just want to say that this -- these results were what inspired us to build on the model.

We appreciate the work of a lot of people on this call to do that within CEC we hope we can build on that.

>> Thank you.

Now, we will move to the next evolution of the innovation Center kidney model it that starts with the kidney care choices model.

The kidney care choices model, as Tom said, took some of the successes of the CDC model and built upon them.

We now offer two structures for participation.

There is an ACO type structure which we call a KCE, and there is Casey F.

-- Casey F.

-- KCF.

It must include one provider.

Other things such as vascular surgeons, our realities, they are optional to help coordinate care for beneficiaries with not only ESRD like in the CEC model, but also for kidney diseases stage four and five as well as beneficiaries who receive a transplant.

Case EEs can choose various choices for year one, with no downside risk.

All the way up to 100% risk in the global option.

The Casey F option -- the KCF option cares for late stage ESRD and transplant beneficiaries, but rather than shared savings and losses, they would receive positive or negative payment adjustments depending on how they performed on certain quality measures.

Here is the timeline for the K C C model.

It started in October of 2020 with an implementation.

They could start to form care relationships and develop care plans and innovations.

The first performance here where entities will start to measure their financial and qualitative performance has officially begun.

January 1 of this year.

The model is supposed to run until December 31 of 20 to 26 -- 2020 2020 six, which is five performance years like the CEC model was in many innovation Center models are.

Here is a look at our participants for the first performance year of the model.

We have 30 K C F practices.

We have 6000 CKD beneficiaries and 4600 ESRD beneficiaries.

There are almost 300 nephrology professionals in this section.

All right.

This is the K C E side of the house.

We are strong with 55, varying in different risk levels, with most choosing the professional risk option.

That is 50% shared savings or losses.

There are about 2400 professionals in this option.

Alongside almost 200 transplant providers.

And, 2000 dialysis facilities.

These providers and suppliers are providing care to roughly 63,000 beneficiaries.

Ann's -- and 54,000 beneficiaries.

Next.

Here is the national map showing a location of the K C C practices.

VK see E -- the case see E -- the K C E are marked with stars.

Here's a closer look at the West Midwest, Northeast region's, showing coverage from coast-to-coast.

If there is a number in parentheses, there is more than one in that city, like New York and Philadelphia.

You can see the city names a little better in this view.

All right.

Here's a closer look at our outlying states and southern regions.

I'll give you a few minutes to look that over.

I'm going to pass this over to discuss the future of dissipation in the Casey see model.

-- K C C model.

Soliciting entities for cohort two will begin on January 1, 2023.

That was released on Monday, for every 28th at noon.

-- February 28 at noon.

Applications are due on Friday, March 25, at 5 p.m..

Applicants will receive access to for I early April to upload the participant let's.

Except applicants will be notified in May if they have been chosen.

I also want to note that it is important that if you are submitting an application, you do so with the form.

The link is available on the website and a PDF version.

If you have any questions, please contact our helpdesk.

I will turn this over to Kristin to discuss the ESRD treatment choices.

>> Winky.

As many of you know, the ET C model is a mandatory model that includes ESRD facilities and managing clinicians in a proximally 30% of the country, mandated into the model.

It is done through role making and it went into effect in January of 2021.

It has to payment adjustments.

The first is a home dialysis adjustment, so that is a positive adjustment proclaims from January of 2021 through December 2023.

We also have a performance payment adjustment so that is a positive or negative adjustment on all dialysis claims rated based on transplant rates.

We assess performance in different measurement years and determine if it is positive or negative during the corresponding PPA.

The chart shows an example of how HEPA and the PPA payments occur during the different measurement years.

We also have, as part of the model design, kidney disease education benefit flexibilities.

We will go over our collaboration.

This map shows which selected HRRs were selected in the EPC model.

-- VTC -- E T C model.

You can see the selected ones in the color.

Here is the timeline.

As you can see, we first propose the role under the specialty care models role.

That was in July of 2019.

It was finalized in September of 2020.

It is in effect since January of 2021.

It began in 2021, and as many of you know, we had another round of role making through the calendar year 2022 ESRD PPS rule.

We propose some changes in 2021 from public comments, and we finalized the rule in October of this past 2021, and any changes that are in effect due to rulemaking will be in January 2022.

The payment adjustment will begin in July of 2022 and also positive payment adjustments of the H D C a begin in July 2022 and at in 2023.

We want to highlight this -- what changes occurred during the last rulemaking, as opposed to our original rule.

One of the important things we changed in this model is that we have a health equity.

We have a tool -- two-tiered approach to transplants through benchmarking and scoring methodology.

The first is our health equity incentive.

If a participant demonstrates a significant improvement in their home dialysis rate or transplant rate among their beneficiaries who are either dual eligible for Medicare and Medicaid or low income subsidy, you could earn additional improvement points.

Secondly, we will stratify benchmarks by the proportion area beneficiaries who are due eligible for Medicare and Medicaid or who are low income subsidy to ensure that the participants receive a high volume up or dispense, disproportionately negatively affected under the benchmark methodology.

We also change the preemptive living donor transplant beneficiary attribution.

Preemptive living donor beneficiaries will be attributed to the managing clinician who submitted the most claims for services, or the beneficiary during the three to 65 days prior to the transplant date in order to have attribution closely attributed to the correct managing clinician.

Next, for the home dialysis rate calculation, we added nocturnal in center dialysis, and this was to incentivize additional renal modalities under the ET C model.

We also clarified waivers for the furnishing of kidney CDs -- disease.

With flexibilities through telehealth where kidney disease patient education services are.

Telehealth can be used after the public health emergency ends.

For participants and their beneficiaries.

This might be the most important slide for those you think are a year one participant.

We have a survey link.

It is not on the website, but we hope to have it next week when we send out webinar slides and recordings.

We will have it on the website as well as sent via the list.

So, as described in our regulations, we will notice I -- notify each participant in a manner determined by CMS of your participant attributed beneficiaries.

The modality performance score and the performance payment adjustment or PPA.

No longer than one year before the start.

That means we will let you know of the score and other related reports by June.

Through the most recent ESRD perspective payment system, annual rulemaking, we idolize the regulations that state that we will have it in a manner for a web based platform and provide further information.

As I said, we will have a new web based platform that requires an email address.

In order to have collected those email addresses, if you believe you are a one participant, and you started on January 1, there will be a survey link on our website.

If you do not provide an accurate email address, we may user email address to send out invitations to the web-based platform, which is for innovation.

We plan to send out innovations in early May of 2022.

Again, your reports will be available on June 1.

In addition to receiving your PPA report, in order to receive your beneficiary attribution report, there will be a datastream for you to sign.

More information is forthcoming, and we will have that link for you, shortly.

At this point, I will hand it back over to Tom.

>> One of the other interesting aspects of the model is the learning collaborative.

The collaborative is really meant to get to the question of how do we really increase the supply.

The ET C model for clinicians increases living donor transplants as well as transplant weightless.

This is around organ supply.

The learning collaborative is targeted to OP owes and transplant centers and VTC model participants.

The real goal is to see if we can increase the utilization of kidneys that they get, particularly with higher organs as well as increasing a yield of kidneys by rival OPOs.

If you are interested in seeing that, go to our event.

There will be linked in our slides, and if you have any questions, hit us up on those slides.

Thank you.

>> That brings us to the end of the formal presentation.

We have plenty of time for questions.

See a number of questions have come in the Q&A answering.

We will start taking those questions live.

I have seen a number of questions come in about beneficiary minimums for part in the KCC model.

That seems to be a common theme.

Laura, could you speak about beneficiary minimums.

>> I can take that.

The minimums will remain the same as they were for performance year 2022.

That is for KC is and the KCC option.

It is for beneficiaries and 350 ESRD beneficiaries.

For the KCF option, it is 350 beneficiaries and 200 ESRD's.

You.

>> I've seen a number of questions about the timeline for request for applications.

For participants to enter the model for 2023.

Could you review the application timeline for us?

>> I would be happy to.

So, as I noted earlier, the application was just released this past Monday.

February 28.

Application submissions are due on Friday, March 25 by from -- 5:00 p.m..

Applicant entities be extended in order to submit the initials participant list in April.

Entities will be notified of their acceptance into the model sometime in early May.

You will need to evaluate your participant list.

We give you an opportunity to correct any errors in those list and there will be a second window in June.

Once those lists are approved, then the entity has a full entry to the model.

>> Thank you.

I am also seeing a number of questions about the payment mechanism.

Can you go over the payment mechanisms, Tom?

>> There are a few different payment changes in the model.

For individual nephron adjusts and the participant level, as well as at the larger entity.

The first is for caring for patients, as well as a few other codes.

They will zero out the claims in the quarter out payment.

That will go out and paid to an entity for those claims.

It will encourage greater investment.

Another key payment is recognizing the payment difference between nephron adjusts -- nephrologists for ESRD patients and the home dialysis rate which is equivalent to the three visit rate.

Similarly to that to up.

It is functionally equalizing the payment amount.

In a previous version of the model, we had done a flat visit rate for the monthly capitation rate, regardless of the number of visits.

That is no longer a part of the future.

This is the only major model feature there.

This is more on the individual level.

A larger entity level.

There are two key payments.

One is the kidney transplant bonus, the idea of up to $50,000 in payment for the entity to get folks to a transplant process.

It is paid based on successful transplant without going back to dialysis.

One year, two years, and three years afterwards.

It is meant to encourage greater investment in the transplant infrastructure, and sort of supporting folks through that process.

The other major one for CKCC's payments and losses.

Measuring the expenditures for beneficiaries, regardless if they were just dialysis or not, or just kidney or not, or based off of the providers in your specific entity.

We count up all of the expenditures and payout savings or losses, depending on the track you are on.

For the practices, we have a different quality measure with a performance-based adjustment.

>> Thank you.

I have seen a couple questions come through about our quality measures in our plans for the KCC model moving for.

Can you talk about the quality measures we are developing?

>> I am on mute.

Sure.

There are two quality measures we are developing.

The cost of care measure and the ESRD cost of care measure, but other than that, we don't expect to change any of the quality metrics in the future.

The other metric includes patient activation and the depression measure.

Also, and optional start measure.

Thank you.

>> Those are our existing measures.

We've also been engaged in some measure of development.

So, we are currently familiar with two new measures which are successful in testing, and showing that they are reliable and valid.

They may consider inclusion in the quality strategy in the future.

The first is a mortality measure that would include both the CKD and the ESRD population.

The second is a measure of delaying progression from CKD to ESRD.

At this point, both are under development, so nothing bursar about -- nothing for sure about that development being successful.

>> We've talked a bit about KCC, Solis give our team a break and turned to her ET C team.

We have some questions about the health equity policies that we incorporate into the model in our last round of rulemaking.

Could you go over the health equity policies again?

>> Sure.

For health equity incentives, it begins with measurement in year three, so it went into effect on July -- sorry, January 1, 2022.

Two approaches.

One, basically, additional points that qualify torture modality performance score.

That would be, in order to -- if you serve a population that is over 50% beneficiaries that are dual eligible or low income subsidy you could earn additional points which could affect your overall PPA or performance payment adjustment.

Then, in doing that with the additional points, the 50% mark is to basically try to not disadvantage providers, especially in certain areas that take care of certain beneficiaries, so that is why we have a 50% threshold in order to receive those additional points.

The other thing I did want to point out what we are talking about this is that we have seen a few questions about participation, so one thing I want to note is that we have an HR our map -- HRR map Excel file.

Those are listed on the website.

Additionally, as a reminder, some people may have gotten a letter saying that they are a participant.

At the end of the measurement year, measurement year one, it ended on December 31.

2021.

That just ended.

So, it is based off of your claims as well.

If you believe you received a letter, and you build the claim -- billed the claim that would make you a participant, we would want you to fill out the link and it is based off of ESRD and the practice number and location for an PI -- NPIs.

This is at the CCM or NPI level.

I will also state that I've seen a couple of things, such as questions asking about if we will make any payment adjustments to the model as a result of the continuing public health emergency.

I will say that anything we do through ET C has to go through rulemaking.

If anything was to be adjusted, we would have to go through another round of rulemaking.

Those would have to be applied.

We would have to go through public comments.

We did however, 3TC -- through ET C, and through the education services, so, once the emergency ends, we do have people who can continue to be used for telehealth waivers.

>> Thank you.

I've also seen a number of questions related to the first performance payment adjustment or PPA.

And if we will be punishing best publishing that information on the website.

We are not playing to publish individual participants for the PPA.

Not on the website or anywhere else.

As I've you have asked, we are not publishing, similar to the ESRD.

That is not part of the model.

We made publish aggregate data, that shares information about rates of trans-plantation, but we may also public best publish aggregate data about quality performance.

It includes two quality measures.

There is a standardized mortality measure and a hospitalization measure, and we made publish that on our website.

To get your individual performance scores, you have to go through the portal to obtain that information through your entity.

>> Turning back to KCC, we had a number of questions about 2023, and whether that will be the last application for the model or if there will be subsequent solicitations.

Laura, would you like to answer that?

>> Has been decided that this will be the last application cycle for this model.

So, if you are even remotely interested, I would suggest putting in an application because this will be your last opportunity to join the model.

>> Following on that, Laura, can use beak little bit to the -- you speak a little bit to applying to a new entity as opposed to being added to an existing entity in the future?

>> Yes.

A new entity that would be applied now would be farmed amongst providers and suppliers who are generally not currently in the model.

If you don't want to start your organization, there are options.

If you have one that already exists near you, you can talk to that K C E about participating.

>> We had a number of questions regarding whether or not participants and beneficiaries can overlap with other models and programs.

In particular, in relation to the Medicare shared savings program.

Can you speak about overlaps?

>> Yes.

There are a lot of different models and programs and Medicare.

There is a strong preference for not double paying for beneficiaries, so generally, there is overlap.

Policies amongst different models with the standard models.

Most of the time, there is no -- it is checked at the level.

If you have a 10 or a multispecialty, and you want to be in this model or that model, it is generally OK.

Participants can't participate in more than one model, but if you are going to participate here but someone else wants to participate with reach, for example, it is OK.

However, the Medicare savings program checks overlap at the 10 level.

An entire 10 in Medicare is in their model and no one from that 10 can participate in another model if it is not allowed.

Generally, if it is also a shared savings initiative.

I hope that helps.

>> Thank you.

I know overlaps are a hot topic, especially as you all are planning participation for 2023.

Turning to CEC for a moment, we have a couple of questions about the closeout of the final performance year.

When we will be making sure -- shared savings determinations.

Tom, could you speak to that?

>> We run into some slight operational issues with the system changeover.

We have not been able to finalize the quality scores, and therefore, finalize the payments.

We are planning this in the forthcoming months, and finalizing the CEC by the summer.

We are interested in closing out with folks on the call who are interested in closing out.

We're also working on sending out preliminary reports that will show results with all of the inputs except for quality.

So, I think we have it understanding of our folks are coming from.

They plan to get reports out and finalizing close out the model in the next few months.

Thank you.

>> Great.

Thanks Tom.

Turning back to K C C.

We have a question about beneficiary minimums and why the beneficiary minimum for beneficiaries is higher than beneficiary minimums for ESRD's.

And, to answer that question, we have a little bit of background about minimum beneficiary counts e-models.

The KCC model has to assure actuarial soundness to get a sufficiently large beneficiaries to be able to assess the performance of each entity in a reliable way.

If we don't have a sufficient number of beneficiaries, we cannot say with statistical certainty that an individual entity or a group of entities is actually improving quality order think off.

-- or reducing costs.

It is a result of different properties that I say beneficiary populations with quality of cost.

ESRD beneficiaries are high acuity beneficiaries with multiple comorbidities, often, they have complex candidates, and therefore, they are very similar in that they are all going to dialysis three times a week, depending on the beneficiary, and the cost for dialysis or the primary driver of the beneficiary costs.

So, that pool is relatively homogenous in terms of cost profiles in terms of quality profiles.

The population however is much more diverse in terms of cost profiles and quality profiles.

The CKD beneficiaries could have variety of different clinical profiles that make them cost very -- make their cost very different or make them very different from a beneficiary with stage five.

In order to account for that broader distribution, of cost and quality.

We need to have a larger number of them, relative to beneficiaries that have produced, and assess for disciplines.

>> We have a couple of questions about the construction for the sea KCC option of the KCC model.

Can you give a little bit of background on the benchmark construction?

>> Sure.

Our general philosophy around benchmarks is a few different ideas.

One is that it is a fully prospective benchmark.

Really trying to send out benchmarks for participants in the model.

We are -- that is the relevant mark for the year.

Prospective so that folks know what it is before the start of the a.

It is also based on a mix of factors.

There are a lot of complicated ones there.

The real goal is to use all of that to get what we think is a fair and reasonable target the major influences for historical spending are beneficiaries who were aligned in 2017, 18, 19.

We trend those forward, risk-adjusted, and that forms the majority of the benchmarks.

We also added rates from Medicare advantage rates.

For the relevant locality.

To sort of provide of -- a balancing factor in regional rates.

It is all adding up into one total number, with multiple total numbers in the population.

Multiplied by population of beneficiary months within each of us.

We come up with the benchmark number there.

We count up the expenditures for your align beneficiaries in the quarters in which they were aligned, and compare that to the overall savings calculation.

>> Thinking.

-- Thank you.

We've had a handful of questions about -- that basically boiled down to what is in queued -- included in the product kidney disease quarterly payment under the KCC model.

If you refer to the requester application on our website, there are a list of claim types and services that are included in the QC P.

To clarify, this is intended to act as a capitated payment to replace payment for those services.

Anything listed as included, you will -- were you to participate in the model, you would continue to build those services for aligned beneficiaries, but instead of receiving payments through the traditional fee-for-service system, we would make a capitated payment to you based on beneficiaries aligned to you for that quarter.

It is not that you are prohibited from furnishing of services to beneficiaries, but the services are included in the capitated payment.

Rather, instead of being paid fee-for-service, you will be paid a capitated amount for the services.

And then, if you are a participant in the K C F option of the C KCC model, the payment for the services would be adjusted up or down based on your performance on the quality and utilization measures.

If you improve quality and produce cost for beneficiaries, they pay more for the services included in that capitated payment.

There is no equivalent adjustment in the C KCC option to the other.

It remains the same for the duration of the model.

>> We have a couple questions about the composition of kidney tracking, particularly what constitutes a transplant binder?

Could you talk a little bit about transplant writers?

>> Great question.

We have purposely left the definition pretty open to allow different structures to exist so you can have a transplant center, you can have a transplant surgeon.

You could have a transplant nephrologist as well.

However, a transplant nephrologist, as if they are listed by the provider, can they cannot also be unaligned enough religious.

You have to pick a role as one or the other.

But there are a lot of different transplant providers, and as long as you have one of them, you should be good to go.

>> I've seen a handful of questions come through about if there are ways for you all to provide feedback to us about the KCC model NDE TC model.

To make potential adjustments for the future.

We are happy to hear from participants and from the stakeholder community about how our models are working, what is and is not working, what adjustments we can make to the models to make them better serve are model participants and more importantly the beneficiaries.

The best way to revive feedback to us at the time being is through our model help desk, so if you have anything you as a participant are observing and you think you be run better, or you think he is a stakeholder in the community identify as a possible area for us to think about it and incorporate it into one of these models or a future model or a separate model, please feel free to reach out to us by our helpdesk.

We have a little what more -- bit more flexibility with our core practice-based model, and we have a low bit more flexibility there.

We have little bit less flexibility with the ATC model since it is mandatory and conducted through rulemaking.

The benefit of that is for the model, we have notice in will making.

If and when we consider changes to the model, so we have a notice of rulemaking to provide feedback for us as well.

So, as a closing thought, please reach out to us by our helpdesk's to let us know if you have ideas or concerns or things you think we could be doing better to improve these models and the care that we all provide for beneficiaries through them.

With that, I think we will close for today.

Thank you all so much for joining us on this webinar.

We look forward to continuing to work with those of you who we have worked with, and those of you who might also be applying to the KC C model for the next cohort.

We look forward to your applications and working with you if you do participate in the model.

Thank you so much.

Please reach out to us if you have any questions by our helpdesk.

If there's anything we did not get to today, or we are happy to answer them at the helpdesk.

Thank you very much, and have a great rest of the day.