

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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FACT SHEET

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Comprehensive ESRD Care Model Fact Sheet

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Overview

In 2013, the Centers for Medicare & Medicaid Services (CMS) announced the CMS Innovation Center will test a new Comprehensive End-Stage Renal Disease (ESRD) Care model. Through this new initiative, CMS will partner with groups of health care providers and suppliers – ESRD Seamless Care Organizations (ESCOs) – to test and evaluate a new model of payment and care delivery specific to Medicare beneficiaries with ESRD. The goals of the model are to improve beneficiary health outcomes and reduce per capita Medicare expenditures.

After receiving stakeholder feedback on the model, on April 15, 2014, the CMS Innovation Center released a revised Request for Applications (RFA) for the Comprehensive ESRD Care model. To view the revised RFA, please visit <http://innovation.cms.gov/Files/x/CEC-rfa.pdf>.

Improving Care for Beneficiaries with ESRD

Beneficiaries with ESRD have significant care needs. In 2010, beneficiaries with ESRD constituted 1.3 percent of the Medicare population and accounted for an estimated 7.5 percent of total Medicare spending, totaling over \$20 billion. These high costs are often the result of underlying disease complications and multiple co-morbidities, which often lead to high rates of hospital admission and readmissions, as well as a mortality rate that is much higher than the general Medicare population.

These complex health needs often require beneficiaries to visit multiple providers and follow multiple care plans, which can be challenging for beneficiaries if care is not coordinated. Through enhanced care coordination, these beneficiaries will have a more person-centered care experience, which will ultimately improve health outcomes and beneficiary satisfaction.

The CMS Innovation Center

The CMS Innovation Center was created by the Affordable Care Act to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care. The CMS Innovation Center evaluates models of payment and service delivery for their effectiveness in improving the care offered to beneficiaries of Medicare, Medicaid, and the Children's Health Insurance Program; improving the health of those beneficiaries; and lowering expenditures to those programs.

The Comprehensive ESRD Care Model – Improving Care for a Unique Population

CMS established the Comprehensive ESRD Care Model to test a new system of payment and care delivery that will lead to better health outcomes for Medicare beneficiaries living with ESRD, while lowering costs to Medicare Parts A and B. Under the model, CMS will work with groups of health care providers, dialysis facilities, and other suppliers involved in the care of ESRD beneficiaries to improve the coordination and quality of care that these individuals receive.

Participating Organizations – Improved Care Through Collaboration

Participating organizations will consist of groups of health care providers led by care professionals experienced in providing care to beneficiaries with ESRD. The organizations must include representation from dialysis facilities, nephrologists, and other Medicare providers and suppliers.

ESCOs will be differentiated by those that include participation of at least one dialysis facility owned by a large-dialysis organization (LDOs) defined as an organization with more than 200 dialysis facilities versus those that include the participation of non-LDO facilities.

In the revised RFA, CMS has removed the requirement that participating nephrologists and/or nephrology practices must be independent entities. Please refer to the RFA for more information.

To be eligible, ESCOs must have a minimum of 350 beneficiaries “matched” to their organization. The matching process will use historical data on beneficiaries who are receiving care from participating providers.

In the revised RFA, ESCOs with participating non-LDOs have the option, for the purposes of satisfying the minimum matched beneficiary requirement and for financial benchmarking and distribution of shared savings, to aggregate with other non-LDOs. Please refer to the revised RFA for more information.

Payment Arrangement – Rewarding High Quality Care

Participating organizations will be clinically and financially responsible for all care offered to a group of matched beneficiaries, not only dialysis care or care specifically related to a

beneficiary's ESRD. Using a robust set of quality measures that assess both the health and experience of beneficiaries with ESRD receiving care from providers and suppliers participating in the model, CMS will assess the performance of the organizations in improving beneficiary outcomes. ESCOs that succeed in offering high quality care that lowers the total Parts A and B cost of care for those beneficiaries will have the opportunity to share in Medicare savings with CMS.

The model offers two payment tracks, depending on the size of the dialysis facility participating in the model. ESCOs that include at least one dialysis facility owned by an LDO must participate in a risk-based payment arrangement over the life of the model. Other participating non-LDOs have the option for participating in a one-sided payment arrangement over the life of the model.

In the revised RFA, CMS has updated the large dialysis organization (LDO) payment track by applying the guaranteed discount only to non-dialysis fee-for-service Medicare Parts A and B per capita benchmark and eliminating rebasing. For the non-LDO payment track, CMS is now offering only one payment track with no down-side risk and eliminating rebasing. Please refer to the revised RFA for further information.

Beneficiary Protections

The principal goal of the model is to provide beneficiaries with ESRD an improved care experience. To ensure beneficiaries receive this high quality care, CMS has developed a model that puts beneficiaries at the center of their care:

- **Putting the Person First** – The model creates new incentives for providers to work together to improve the care beneficiaries receive.
- **Beneficiary Choice** – Beneficiaries matched to an ESCO will maintain all the rights and benefits of beneficiaries in Medicare fee-for-service, including the freedom to see any health care provider that accepts Medicare.
- **Active Monitoring** – CMS will closely and routinely analyze data assessing the utilization of services of these beneficiaries. This monitoring will occur through the use of audits and other actions as necessary. Beneficiaries will be surveyed each year to assess their experience with the new initiative.

Beneficiaries can contact CMS to ask questions and relay any concerns. ESCOs will send a notice to beneficiaries that will inform them that they can call 1-800MEDICARE at any time to ask questions about the program, and alert CMS of any issues they may have with the participating organization.

Governance Structure – Giving Beneficiaries a Seat at the Table

CMS believes it is important that beneficiaries and their advocates be meaningful partners in improving care delivery. Each ESCO must have at least one dialysis facility and at least one independent nephrologist or nephrology group practice as a participant owner in the ESCO.

The governing body of the ESCO must include at least one patient representative or independent consumer advocate. Through this representation, CMS will ensure that the beneficiary and consumer representatives participate in all strategic decisions made by the organizations and that the beneficiary perspective is integrated into operations.

Quality Measures

Under the Comprehensive ESRD Care model, participating organizations will be held financially accountable for delivering high quality care and improving the health outcomes of their matched beneficiaries. Participating ESCOs will be required to report on a variety of care delivery and health outcome measures across the continuum of care, not only for ESRD services.

ESCOs that do not achieve a high standard of quality will be ineligible to share in savings generated from the model, and may also be terminated from participation. CMS will also require that the ESCOs' participating dialysis facilities receive a minimum Total Performance Score (TPS) assigned by the ESRD Quality Incentive Program (QIP) for that ESCO to be eligible for any shared savings.

For more information on the quality measures selection process, please refer to the Innovation Center website: <http://innovation.cms.gov/initiatives/comprehensive-ESRD-care/>

Application Process

Organizations interested in participating in the testing of the model are required to submit both a letter of intent and an application to CMS. Letters of intent are nonbinding, but are a required prerequisite to submitting an application to CMS.

In the revised RFA, CMS has two different application periods for ESCOs.

ESCOs that include at least one dialysis facility owned by an LDO must submit both a letter of intent and an application to CMS by June 23, 2014

ESCOs with participating non-LDOs must submit both a letter of intent and an application to CMS by September 15, 2014.

Information about how to apply is available on the Innovation Center website at <http://innovation.cms.gov/initiatives/comprehensive-ESRD-care/>

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