CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Matthew Brown
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1:00 p.m. ET

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

All line have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star, then the number one, on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Mr. Matthew Brown, you may begin your conference.

Matthew Brown: Thank you, (Martina).

Hello. My name is Matthew Brown. I am with the CMS Office of Public Engagement. Thank you for joining us for today's Open Door Forum on the Comprehensive ESRD Care Initiative. Thank you also for your patience as we got started a few minutes late. We had a number of people still dialing. We wanted to give them a chance to be a part of the beginning of this call.

On today's call, staff from CMS will be providing an overview of this new initiative and answer any questions. I am joined today by a few CMS staff members, Melissa Cohen, the staff lead on the Comprehensive ESRD Care Initiative, Dan Farmer from the Stakeholder Engagement Group in the CMS Innovation Center. We may be joined by other CMS staff on the call as well.

A recording and transcript of today's Open Door Forum will be posted to innovation.cms.gov. Once there, select Webinars and Forums from the menu options and choose today's Open Door Forum.

Finally, more information is available about the Comprehensive ESRD Care Initiative on the New Initiatives Web page within the Innovation Center Web site. On the Innovation Center Web site home page, select Innovation Models and find the link to the Comprehensive ESRD Care Initiative. And there will be an encore of this call. So, you will be able to listen to those instructions again.

We also will have slides available. I will let Melissa Cohen talk about that. Melissa will be the main presenter.

And, with that, I will turn the call over to Melissa Cohen. Thank you.

Daniel Farmer: Hi. Before we begin, this is Dan Farmer with the CMS Innovation Center. And I want to go back and make sure that people have access to one of the resources for today's Open Door Forum.

As Matthew mentioned, we have a dedicated Web page on the Innovation Center Web site for this Open Door Forum. And if you go to innovation.cms.gov, that will take you to our home page. From there, you can click on Webinars and Forums in the menu option. That will bring you to a new page where you can select the page dedicated to today's Open Door Forum.

Now, we do want to note that we had anticipated having slides available. And, unfortunately, we are having some technical difficulties with that. So, we do not currently have slides available for the participants. However, we are still going to go through the presentation and we hope to have those slides available shortly.

Also, for everybody's reference, we will have a transcript and recording of this Open Door Forum on this page when they become available, at which point you will be able to follow along with slides and the recording.

So, without further ado, we will turn things over to Melissa Cohen, who is the staff lead on this new initiative.

Melissa Cohen: Hi, everyone. Welcome and thank you, all, for joining us for the Open Door Forum on the Comprehensive ESRD Care Initiative, which was announced by CMS yesterday, February 4, 2013.

As just previously stated, my name is Melissa Cohen, and I am the project lead for this initiative. This Open Door Forum will give you an overview of the initiative as well as provide some specificity around the applicant eligibility requirements and the application process for this model.

We will be taking questions at a break during the presentation and then again at the end of the Open Door Forum. But, please remember that much more information is contained the Request for Applications located on the CMS Innovation Center Web site.

After you have had a chance to review the RFA, please do not hesitate to ask any additional questions by e-mailing us at esrd-cmmi@cms.hhs.gov. This information is also included on the Innovation Center Web site and at the end of the slide deck if you are ever able to view it.

The Innovation Center was created to test innovative payment and service delivery models to reduce program expenditures pursuant to Section 3021 of the Affordable Care Act. The Comprehensive ESRD Care Initiative establishes a new Medicare model of payment to improve care for the ESRD population while lowering cost to Medicare. This initiative is slated to last for five years with three base performance years and two option years.

The ESRD population is one that CMS believe could benefits from a shared savings model that leads to improved coordination of care between Medicare providers and suppliers. CMS chose to focus the model specifically on the ESRD population for a number of reasons.

The ESRD has significant instances of comorbidities, diabetes, heart problems et cetera. And these comorbidities involve trips to a variety of other

healthcare providers including hospital admissions and readmissions. These trips and care plans can be difficult to manage in a fee-for-service environment.

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 in 2010. Those costs are not due simple to dialysis services. Our research suggests that roughly two-thirds of the cost I just detailed occur outside of the prospective payment bundle that CMS instituted to cover care for dialysis.

The hypothesis behind this model that we are testing is that comprehensive medical management of and better care coordination for ESRD beneficiaries will result in improved outcome and expenditure saving. In this model CMS is trying to realign incentives of Medicare fee-for-service to encourage groups of Medicare providers and suppliers to care for end-stage renal disease patients to come together to form and ESRD Seamless Care Organization or what we are calling an ESCO.

An ESCO does have many similarities to accountable care organizations or ACOs. In both, groups of providers will be forming voluntary arrangement in which they are held accountable for quality and cost of an attributed population. In this model, we refer to them as matched beneficiaries.

As with ACOs, beneficiary cost will be measured as total Part A and B expenditures. And as with similar initiatives like ACOs, matched beneficiaries will remain in original fee-for-service Medicare. That means they maintain full freedom of choice for providers and all original Medicare benefits.

Similar to a shared savings program ACO, the ESCO must form a new legal entity to participate in this program. The ESCO must be recognized and authorized under applicable state, federal or tribal law and identified by a tax identification number.

The ESCO must be capable of receiving and distributing shared savings payment, repaying shared losses, if applicable, and establishing reporting

mechanisms in ensuring participant compliance with program requirements including, but not limited to, quality performance standards. This new legal entity must be formed by participants in the ESCO who maintain an ownership stake, otherwise known as participant-owners in this model.

The ESCO may also contract with participants who do not have an ownership stake in the ESCO. However, every ESCO must have at least one of the following participant-owners – a dialysis facility, nephrologist or nephrology group practice and one other type of Medicare-enrolled provider or supplier including physicians or non-physician practitioners but including DMEPOS suppliers, ambulance suppliers and drug or device manufacturers.

It is also important to note that all dialysis facilities and nephrologists or nephrology group practices participating in the ESCO must participate as participant-owners. All other eligible Medicare providers and suppliers may either participate as participant-owners or participant non-owners, meaning they contract with the ESCO as participants without an ownership stake in the legal entity.

Each ESCO participant is defined by a Medicare-enrolled tax identification number. It is important to note that participants in the shared savings program also defined by a Medicare-enrolled TIN are not eligible to participate in an ESCO.

ESCO participant-owners are those ESCO participants that came together to form the legal entity and have an ownership stake in the ESCO. All ESCO participant-owners must be signatories to the Model Participation Agreement. They also must assume a minimum portion of the liability for shared losses defined by half of their percentage of the ESCO's billed fee-for-service claim. More information on that is available in the RFA.

As stated before, dialysis facilities and nephrologists must participate in the model as participant-owners. Within each ESCO participant are ESCO providers and suppliers. Each ESCO provider or supplier is defined by a TIN-NPI or a TIN-CCN combination.

For instance, a cardiology group practice could participate as either an ESCO participant-owner or an ESCO participant non-owner. Within that process, all the cardiologists would be defined for the purposes of this model as ESCO providers or suppliers. CMS is not asking potential applicants to list any of their potential ESCO providers or suppliers on their letter of intent, only ESCO participants. The ESCO provider and supplier information is, however, required in the application.

Prior to the start of the first performance year and on an annual basis thereafter for the life of the model, ESCOs won't need to provide CMS with a list of all participating ESCO providers and suppliers. Providers and suppliers are eligible to participate in multiple shared savings programs as well as multiple ESCOs. However, primary care providers that are part of a Pioneer ACO are not eligible to also participate in an ESCO and dialysis facilities that are participating in an ESCO are not eligible to participate in multiple ESCOs.

I'm going to continue with applicant eligibility requirement. Large dialysis organizations, small dialysis organizations, hospital-based facilities and independently-owned dialysis facilities are all eligible to participate in an ESCO. However, due to market concerns, CMS is restricting the types of dialyses that dialysis facilities that may come together to form an ESCO.

CMS will not entertain applications with dialysis facilities owned by two different LDOs. LDOs may also not partner in an application with a non-LDO-owned facility unless it would not be possible for the non-LDO-owned facility to meet the minimum beneficiary thresholds required for model participation. This is 500 beneficiaries. The – this information is also included in the Request for Application in the applicant eligibility section.

As I just stated, each ESCO much have 500 – at least 500 Medicare fee-for-service ESRD beneficiaries matched to the dialysis facilities in their ESCO to be eligible to participate in this model. However, ESCOs must operate within a predefined market area.

For instance, one large dialysis organization cannot submit a single application including dialysis facilities located all across the country. They

must partner with different providers and suppliers in each market that they wish to operate and submit multiple applications.

For the purpose of this program, a market is defined as not larger than two contiguous Medicare Core Based Statistical Areas, otherwise known as CBSAs, with permissible inclusion of contiguous rural counties not included in any Medicare CBSA. For ESCOs that wish to operate in only rural counties not included in any CBSA, the market may not be larger than a state.

Now, I will discuss beneficiary matching. First, I will discuss which Medicare beneficiaries are eligible to be matched to an ESCO. And then, I will discuss the how.

To be eligible to be matched, a Medicare beneficiary must be, one, enrolled in Medicare Part A and B; two, must not be enrolled in a Medicare – in Medicare Advantage; three, must be receiving maintenance dialysis services; four, must reside in the U.S. and receive at least 50 percent of his or her dialysis services in the ESCO's geographic area; five, must be 18 or older; six, must not already be assigned to another Medicare Shared Savings Program; seven, must not have a functioning transplant and, eight, must not have Medicare as a secondary payer.

To match eligible beneficiaries to an ESCO, we are using a "first touch" approach. For the first performance year, CMS will use a historical look-back period starting January 1, 2013. An eligible beneficiary's first visit to a dialysis facility in an ESCO during this time will result in the beneficiary being prospectively matched to the ESCO for performance year one.

Beneficiaries matched to an ESCO will be matched to that ESCO for the duration of the model unless they do not receive any care for a dialysis facility in the ESCO for the entire performance year. They will, then, not be matched for the subsequent performance year.

Beneficiaries will be added to the ESCO's matched population on a quarterly basis based on the "first touch" approach using the previous quarter as a look-back period. Beneficiaries will be matched for the life of the model unless

they become ineligible for the reasons that I just described. For example, receiving a functioning transplant or moving outside the geographic area.

Before I get into the – before I start discussing the payment arrangement for this model, I'll now stop to take some questions.

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

Your first question comes from the line of (Martin Lineshiff) from dialysis patient.

Your line is open.

(Martin Lineshiff): Hi. I have a question that is not directly applicable to what you were just speaking. But, I hope you will get to the subject. I have a transplant. I've been on dialysis for quite a while prior to that. I – my – the reason I was on – put on dialysis, to begin with, and the reason I lost my kidney was due to short bowel syndrome. I have a (colostomy) for 50 years.

One of the problems I have is I spend a great of money on my vitamins and minerals which are not covered by insurance. Out of the 35 medications I take to date, 10 of them are these vitamins and they cost me thousands of dollars. Is anything going to be pursued by CMS to rectify this situation as far as coverage? And, as I said, I apologize that this is not directly applicable to the subject that you're covering right now.

Daniel Farmer: So, that's a really important question. And we really appreciate you sharing that. I'm not a hundred percent sure that our model is going to get into the level of detail that you are talking about. However, we would really invite you to take a moment when we're done with the Open Door Forum to send an e-mail to esrd-cmmi@cms.hhs.gov to see if we can point you in the direction

of someone who might be able to give you a little more help than we will today. And I apologize we can't tell you more on the matter at this moment.

(Martin Lineshiff): OK. Thank you.

Daniel Farmer: So, while we are breaking between questions, I did want to let everybody on the call know that the slides are now available on the Web site I described earlier. So, again, if everybody who is listening can take a moment to pull up those slides, we'll be happy to let you know where we left off.

Go ahead on the next question.

Operator: Your next question comes from the line of Patricia Clark from (Greenware).

Your line is open.

Patricia Clark: Hi. I'm sure the slides will answer my question. I was just going to ask if you would repeat the eight reasons or eight things for eligibility.

Daniel Farmer: Sure. Well, that information will be up on the slide. And that's also in the Request for Application document that Melissa mentioned at the outset. So, that information will definitely be available.

Patricia Clark: All right. Thank you.

Operator: Your next question comes from the line of Michael Shapiro from Denver Nephrology.

Your line is open.

Michael Shapiro: Yes. My question is specific to participation in multiple initiative entities or existing (common) care organizations. It wasn't clear to me if participants could simultaneously participate in Medicare Shared Savings Program ACOs and/or Pioneer ACOs if they also participated in the ESCO.

Melissa Cohen: Thank you for that question. And the policy that we have developed is that if your organization is enrolled in a shared savings program as a participant with

a Medicare-enrolled TIN, then you will not be able to participate in the ESCO program with that same Medicare-enrolled TIN.

Michael Shapiro: Is that true also for –

Melissa Cohen: Individual providers and suppliers will be able to participate in multiple shared savings programs. However, as I mentioned earlier, primary care providers participating in the Pioneer ACO model will not be able to participate in the ESCO model.

Does that answer your question?

Michael Shapiro: If – I will – I guess one other thing. So, if an ESCO participant – is an ESCO participant, I guess, excluded from being an ESCO participant if they are also a specialist participating in a Pioneer ACO?

Melissa Cohen: No, they are not.

Michael Shapiro: All right. Thank you.

Operator: Your next question comes from the line of Linda Oliver from Atrius Health.

Your line is open.

Linda Oliver: You answer just past of my question. And it's regarding the Pioneer ACO. So, I just want to be sure that I'm clear. If a patient has been assigned or attributed to a Pioneer ACO, obviously, based on the provider's TIN, (I just want to make sure) that that patient is not eligible to be reassigned to the ESCO.

Melissa Cohen: Beneficiaries that have been assigned to other shared savings programs will not be eligible to be matched to the ESOC until the next assignment or matching period. For clarification –

Linda Oliver: So, to follow up on that, what would drive it at the next matching period, (were there) claims history?

Melissa Cohen: It's the function of when in the sequence of various shared savings program the Comprehensive ESRD Care model runs it's matching next. So, for example, if for the upcoming period, the Pioneer model runs (alignment) first, then any beneficiaries matched to the Pioneer for that upcoming period would not be available for matching in this initiative.

However, if this initiative went first (in the office), it would be true. So, it's on a first-come-first-serve basis in terms of program.

(Wanda Oliver): Thank you.

Operator: Your next question comes from the line of (Haley Earl):from Memorial Health Center.

Your line is open. (Haley Earl), your line is open.

Your next question comes from the line of Lisa Clive from (Sansonard Berstein).

Your line is open.

Lisa Clive: Hi. I just had a question in terms of the enrollment and how they – it's really defined in terms of each application. So, if you have a large organization like one of the LDOs, you mentioned that they have to submit multiple applications if they want to enroll multiple sites. In the document, it seems – it sounded like you expect to award between 10 and 15 different contracts.

So, would that mean that one of the LDOs, if they submitted – you know, if they submitted 40 applications, you may only end up accepting them for five or so because you want to keep the total number of beneficiaries small? And, also, just one follow-up question is, you mentioned that these markets are defined as contiguous Medicare areas. Roughly how many Medicare beneficiaries are in each contiguous area?

Melissa Cohen: Thank you for that question. Regarding the – regarding the applications, yes, each application submitted by and a potential ESCO would be counted separately, meaning that if an LDO submitted multiple applications from

multiple markets, all of those applications would be considered separately. And we are only planning on awarding 10 to 15 ESCO contracts.

Regarding the Medicare CBSAs, they do vary. And we can – and if you could follow up with – that question to the ESRD-CMMI inbox, we'll be able to get back to you on that. But, that information should all be publicly available.

Lisa Clive: OK. Then, I guess just a follow-up question. If you are going to award sort of 10 to 15 contracts in this first year, roughly how many patients do you think that would be? And, will you expand the number of contracts in years two and three and potentially more of the program if everything is going according to plan and if there are savings that are made?

Melissa Cohen: Currently, we are not planning on extending the number of contracts after they are awarded for the following performance years. So, the 10 to 15 would be all that we would choose for this model. It does not mean necessarily that the agency may not choose to expand the model in terms of a larger program. But, this particular solicitation will not have a format second application period.

And regarding the number of ...

Lisa Clive: OK.

Melissa Cohen: ... beneficiaries, we have – we have a 500 minimum. But, we do not have a maximum.

Lisa Clive: OK. But, given that one application can only – can only include two contiguous Medicare areas, it's basically determined by how big those Medicare areas are. Correct?

Melissa Cohen: Correct.

Lisa Clive: OK. That's very helpful. Thank you.

Melissa Cohen: OK. So, last question, please, before we continue with the presentation.

Operator: Your next question comes from the line of Gary Taylor from (Citi).

Your line is open.

Gary Taylor: Hi. Thank you. I just had a quick question. I thought I heard you say that dialysis providers could not participate in multiple ESCOs. I was wondering if an LDO could participate in different ESCOs in multiple markets.

Melissa Cohen: Yes, they can. And we expect them to. The – because dialysis facilities are going to be used to match beneficiaries, specific dialysis facility cannot participate in more than one ESCO. And when we say dialysis facility, we mean the site, the location.

Gary Taylor: Got it. Thank you.

Melissa Cohen: OK. At this point, we are going to return to the presentation. I am now on slide 14 for those that have been able to access the slide. The title of the slide is "Payment Arrangement."

So, this is a shared savings and losses model. And CMS will calculate a cross-sectional expenditure baseline using historical Medicare Part A and B expenditures. The benchmark will be developed using a risk-adjusted, trended, price-adjusted, bundle-adjusted approach. More information on this and the specific methodology is available in the RFA. And I suggest, for specificity, that you look to that.

ESCO's savings or losses will be determined based on a comparison of the matched population's performance year, Medicare Part A and B expenditures and the benchmark. This will be calculated in conjunction with the quality score to determine the shared savings or shared losses payments.

And, again, this is a very brief overview. A lot of thought and detail went into developing the baseline and benchmark methodology. So, please refer to the RFA and then follow up with any questions to our mailbox.

Next slide.

CMS is offering three payment arrangements for this model. If the applicant includes a participant dialysis facility owned by a large dialysis organization,

it must choose the LDO two-sided risk track that will be shown in the next slide. Applicants that do not include a dialysis facility owned by an LDO may choose either the two-sided risk track from the start or the two-sided risk phase-in.

So, the next three slides in the desk – and these will be slides 16, 17 and 18 – have a chart that shows the feature of the three – features of the three payment arrangements. For the LDO and non-LDO two-sided risk arrangement from this chart, there is a 1-percent minimum savings or losses requirement to receive any shared savings or be liable for shared losses. The non-LDO risk phase-in option has a 4-percent minimum savings or losses requirement or MSR in year one and move down to 1 percent in year three.

Next slide.

For the LDO track, ESCOs will be required to take a discount, meaning that their benchmark will be adjusted accordingly by 1 percent in year one, 2 percent in year two and 3 percent in year three and beyond. CMS will share up to 70 percent of the first dollar savings or losses in year one and 75 percent in year two and beyond.

When I say up to a certain percentage of shared savings, that is depending on the (quality for) calculations. This will be discussed in an upcoming slide.

For the non-LDO two-sided risk tract, ESCOs will not be required to take a minimum discount in the first two performance years but will be required to take a 1-percent discount in year three and beyond. For year one, CMS will share up to 60 percent of shared savings and losses. For year two, shared savings or losses move up to 70 percent. Year three and beyond is the same as the first performance year in the LDO track, 70 percent of first-dollar shared savings or losses with a 1-percent discount to the benchmark.

The third payment arrangement, which is also for applicants that do not have dialysis facilities owned by LDOs, phases in risk at three. In years one and two, ESCOs may receive shared savings of up to 50 percent but are not on the (hub) for losses. In year three, the risk arrangement becomes two-sided and ESCOs may share savings or losses up to 60 percent.

Next slide.

For the LDO and non-LDO two-sided risk track at this chart, the cap on shared savings or losses as a percentage of total expenditures of the matched population is 10 percent for years one and two. For the LDO track, it increases to 15 percent in year three. For the non-LDO phase-in risk track – and this is where risk is phased in at year three – there is a 5-percent cap in years one and two where ESCOs are not taking on any downside risk. And, in year three, the cap is increased to 10 percent. In all payment tracks, the baseline calculation will be rebased for years four and five based on data from performance years one through three.

Next slide.

The quality measures upon which part of the shared savings calculation will be based is calculating – is calculated using quality measures from five critical domains – preventative health, chronic disease management, care coordination and patient safety, patient and caregiver experience and patient quality of life. The exact quality measures have not been finalized. But, applicants will know the final set of quality measures prior to signing a Participation Agreement with CMS.

Next slide.

The Participation Agreement will require ESCOs to sign up for the three-year performance period. As mentioned at the start of the presentation, there is a possible extension of two option years.

Next slide.

The RFA lays out specific criteria for the governance structure of the ESCO. Each ESCO must have an identifiable governing body with authority to execute the functions of the ESCO, a conflict of interest policy and a transparent governing process.

Next slide.

The governing body must include a representative mix of participants including owner and non-owner participants in the ESCO. All participants must make up at least 75 percent of the governing body. No one participant may maintain more than a 50-percent share in the ESCO.

Members of the governing body must place their fiduciary duty to the ESCO over the interest of any one participant. And each governing – and each governing body much include a beneficiary representative and/or experienced non-affiliated independent consumer advocate.

Next slide.

CMS will be sharing claims data with the ESCO on the beneficiaries that are matched to support ESCO care improvement effort. Similar to the Pioneer ACO initiative, beneficiaries must be notified by the ESCO that they have been matched to the organization and given 30 days to opt out of data sharing.

CMS will begin sharing beneficiary data after the three-day opt-out period. However, beneficiaries continue to be able to opt out of data sharing at any time by notifying the ESCO or through 1-800-MEDICARE.

Next slide.

The data the CMS will be sharing includes historical claims data on matched beneficiaries for the previous year along with monthly standard beneficiary-level claims feeds for services delivered by providers both inside and outside of the ESCO.

Next slide.

CMS will also share data files and reports with ESCOs, including a monthly claims report on total Part A and B spend for the match population and, on an annual basis, financial reconciliation reports including quality of performance reports.

Next slide.

So, that is a basic overview of the initiative. I implore you to go to the Innovation Center Web site to read the full Request for Application to get more details of the model. We are currently accepting letters of intent or LOIs to apply.

The letter of intent is non-binding. But, we will not accept your application if you have not submitted and LOI. The LOI is an online form and can be access through a Web link on the Innovation Center Web site. Letters of intent are due by March 15, 2013. Please try to include at least 50 percent of your proposed participants on the letter of intent form. We are currently only accepting LOIs via the online form. But, a template of the LOI is available as Appendix A of the RFA.

The application for this initiative is due on May 1, 2013. We are also only accepting applications through an online portal. That portal is not currently available. We will notify all potential applicants that have submitted letters of intent when the online application becomes available.

A template of the application on which the online form is based in included in Appendix B of the RFA. And, again, the RFA is located on the Innovation Center Web site.

It is not required that applicants form new legal entities prior to the submission of the application. However, CMS requires that 100 percent of proposed participant-owners of the ESCO be identified in the application. And, again, that's the application, not the letter of intent.

Thank you, again, for your interest in the Comprehensive ESRD Care Initiative. For more information, please visit the Innovation Center Web site. The Web site also includes a link to an e-mail subscription list where you can sign up for updates specifically about this initiative. And if the Web site is not able to answer your questions, please e-mail us at esrd-cmmi@cms.hhs.gov.

And now, I will open it up for questions.

Operator: Ladies and gentlemen, as a reminder, if you would like to ask a question, please press star, then one, on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Remember to limit your questions to one question and one follow up to allow other participants time for questions.

Your first question comes from the line of (Kate Lindsmolly) from Medpac.

Your line is open. (Kate Lindsmolly), your line is open.

Your next question comes from the line of (Dulskean Keano) from National Kennedy Foundation. Your line is open.

(Dulskean Keano): Thank you very much for this excellent summary. I had a question about your early statement that matched beneficiaries would be entitled to all fee-for-service benefits. Could you expound upon that?

Melissa Cohen: Yes. Matched beneficiaries in this program will still be in fee-for-service Medicare. They will be able to receive the same exact benefits. The purpose of the program is to align incentives between providers and, therefore, hopefully, provide more coordinated care to those beneficiaries. However, they have freedom of choice of provider and are not limited at all to the providers in the ESCO. They are able to go and see whichever provider they would like.

(Dulskean Keano): Thank you. That was exactly the information I needed.

Operator: Your next question comes from the line of Michael Kraus from Indiana University.

Your line is open.

Michael Kraus: Thank you. I appreciate it. A quick question. I think (I) know the answer. (But), we have an ACO already that has ESRD patients in it. So, this is a two-fold question. One, are we – can we then – or whether or not to move those to an ESCO? And, two, in future years, can an LDO move those patients from the ACO to the ESCO?

Melissa Cohen: So, beneficiaries that are already matched to a ACO for the current performance year will not be eligible to be matched to an ESCO currently. However, as previously stated by my colleague, Dr. (Mike), (there are) – beneficiaries during the next matching period will be able to become matched to an ESCO or another shared savings program based on the order at which those programs do alignment, meaning that if a – if the Comprehensive ESRD Care Initiative runs matching for beneficiaries prior to the ACO – the ACO program that you are currently in, then those beneficiaries will be eligible to be matched to an ESCO.

Michael Kraus: Thank you.

Operator: Your next question comes from the line of George Coutros from (Refcon Rafter).

Your line is open.

George Coutros: Hi. Is a nephrology practice is prohibited from participating in an ESCO because it is an ACO participant in an ACO? Can it's individual physicians participate even though he provide all of their services through the nephrology practice?

Melissa Cohen: This is dependent on the shared savings program that your nephrology practice is participating in. But, a TIN that is participating in a shared – in the Medicare Shared Savings Program will not be eligible to participate in the Comprehensive ESRD Care Initiative. And if those providers or suppliers are using that same TIN, again, they would not be eligible to participate in the Comprehensive ESRD Care Initiative.

George Coutros: OK. Thank you.

Operator: Your next question comes from the line of Lisa Clive from (Sansonard Bernstein).

Your line is open.

Lisa Clive: Hi. Sorry (to block up) your Q&A. Just a follow-up question. Is there going to be a comment period for this? And, if so, will you take sort of suggestions from various industry participants? And so, could be – could the boundaries and sort of rules of this documents potentially change a bit?

Melissa Cohen: There is not going to be a comment period for this. This is the final model.

Lisa Clive: OK. And then, I guess one follow-up question is, if under the first year or two, you actually see that the dialysis organizations are able to save a lot of money and this is clearly going very well, as you've mentioned, this actual program can't be expanded. But, is there another way that this could easily then get rolled out so that more Medicare beneficiaries who have ESRD would be able to enroll in this in the future?

Melissa Cohen: The secretary has the authority if the Innovation Center and the Office of the Actuary determines that a model sponsored by CMMI is successful is reducing (per capita) beneficiary expenditures while improving or maintaining quality. The secretary has the authority to expand that model. What we were saying before is that this particular solicitation will not include a second round of applications.

Does that make sense?

Lisa Clive: OK. Great. That's very – that's very clear. Thank you.

Operator: Your next question comes from the line of Eric Franco from DaVita.

Your line is open.

Eric Franco: Hi. I just have a question. Since you mentioned there was no comment period, will there be more specific guidelines or descriptions of how the benchmark rates will be calculated apart from what is already described in the document?

Mai Pham: There will be more detail in the RFA. And, during the selection process before selected applicants are required to sign the Participation Agreement, we will publish to those selected applicants a methodology paper.

Eric Franco: And just one follow-up question. So, that would be before the May 15 deadline or before the March 15 deadline?

Melissa Cohen: Before the signing deadline.

Eric Franco: OK. Thank you.

Operator: Your next question comes from the line of James Metera from Nephrology-Hypertension Associates.

Your line is open.

James Metera: Thank you. Excellent presentation. I have a question. We are currently involved in trying to put together an integrated nephrology group here in New Jersey aligning a number of practices currently with separate tax ID numbers under one. Will there be an issue if we try to apply for this as we are not yet unified and then, ultimately, if we went to one tax ID number as a group practice without walls, how would that fit in with the ESCO?

Melissa Cohen: That sounds like a very specific case. So, we would appreciate if you would e-mail us so that we could speak to it more thoroughly.

James Metera: OK. That sounds very reasonable. Thank you.

Operator: Your next question comes from the line of Chris Lovell from (Clinic Incorporated).

Your line is open.

Chris Lovell: Hi. This is Chris Lovell. Could you please explain the rationale for the minimum number of 500 patients?

Mai Pham: That is the minimum that the Office of the Actuary determined will provide an actuarially valid and reliable estimate of spending performance for this particular population.

Chris Lovell: OK. Would the exclusion criteria for (dual demos) and all the others include – included in that model, you think?

Melissa Cohen: Sorry, the minimum number is simply based on what actuarial estimate can you derive if an ESCO has at least 500 beneficiaries. So, it does – it's not really related to program rules regarding beneficiaries being in one program or another.

Chris Lovell: OK. Can I have another question or not?

Daniel Farmer: Sure.

Melissa Cohen: Sure.

Chris Lovell: If a hospital system is one of the three owners and they own a nephrology practice, is that an issue or – because they may have the same tax ID? Or, will that exclude them from participating?

Melissa Cohen: Again, that does sound like a specific question. And we would ask that you would e-mail our inbox with it. But, a hospital system is able to participate in the ESCO model as a participant-owner.

Chris Lovell: OK. But, a nephrology group is also required and they would have the same tax ID. That's why I want –

Melissa Cohen: We would ask that you e-mail the inbox so that we could look at that specific case.

Chris Lovell: OK. Thank you.

Operator: Your next question comes from the line of Toni Ambrosy from Northeastern Nephrology.

Your line is open.

Toni Ambrosy: Thank you. My question is a clarification of – is for nephrologists. Can they be in multiple ESCOs?

Melissa Cohen: Nephrologists can participate in multiple ESCOs – yes.

Toni Ambrosy: Regardless of the entities? Because, in our area – we are in a very large city. So, there are lots of dialysis units owned by several large dialysis organizations.

Melissa Cohen: Because dialysis facilities will be used for matching beneficiaries, dialysis facilities, specifically, can only participate in one ESCO. However, nephrologists are not going to be the basis of matching and can participate in multiple ESCOs.

Toni Ambrosy: As either – as they would have to participate as owners and they could be in multiple ESCOs, which may be within multiple large dialysis organizations, more than one organization potentially?

Melissa Cohen: Yes.

Toni Ambrosy: OK. Great. Thank you.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, star one on your telephone keypad.

Your next question comes from the line of Chris Davis from Carmel Health.

Your line is open.

Chris Davis: Hi. I wanted to point out that I am not able to link to the slides online. But, my question concerns the acute care hospitals. What impact does this have on them if they are not a dialysis center?

Melissa Cohen: Acute care hospital, as Medicare-enrolled providers or suppliers, are eligible to participate in this model. If they do not provide dialysis services, then beneficiaries will not be matched to the ESCO based on their patient population. But, they are able to partner with dialysis facilities to better coordinate care for that population. And, as usual in our fee-for-service model, the beneficiary remains free to use the facility of his or her choice.

Chris Davis: Thank you.

Operator: Your next question comes from the line of Patricia Clark from (Greenware).

Your line is open.

Patricia Clark: I have no question.

Operator: Your next question comes from the line of Mike Duchell from J.P. Morgan.

Your line is open.

Mike Duchell: Thanks. I wanted to touch on the – on the years four and five and the reset that you discussed in the application. Can you talk us through how that would work in term of, you know, the ESCOs achieving savings? How does the – how does the target get reset in years four and five?

Mai Pham: In years four and five, we begin using a new baseline period based on the first three performance years or performance periods. So, rather than the historical three-year, 2011, '12 and '13 or – sorry – '10, '11, '12, we would be using '13, '14 and '15.

Mike Duchell: So, in '10 and '11 and '12, you are using underlying fee-for-service (cost)? When you – when you move forward, are you going to continue looking at the baseline as fee-for-service?

Mai Pham: It is the fee-for-service – yes.

Mike Duchell: OK. So, this isn't going to be a reset to whatever the savings rate that's been achieved by the ESCO is? It's going to be a reset to whatever the expected overall fee-for-service cost are for ESRD across the country?

Mai Pham: Incorporate the ESCOs, however, in that population – in the baseline population. And the way that the bench – the baseline is calculated is that we look at the ESCO's average per capita expenditures for beneficiaries who qualified for matching in each of the baseline years. So, when the baseline is reset beginning in performance year four, we would be doing that but for the updated three years.

Mike Duchell: Are you looking at the ESCO only or the entire ESCO plus fee-for-service population?

Mai Pham: We look at the ESCO only in the baseline regardless of what performance year you're talking about. But, the trend is based on the national ESRD population.

Mike Duchell: OK. So, the trend – the new baseline is (all for the) fee-for-service population. And then, whatever savings they can achieve off of that, you know, still accrues to them?

Mai Pham: The trend is based off of the national fee-for-service ESRD population. The baseline is ACO – sorry – ESCO-specific.

Mike Duchell: OK. I just – I don't to (go over) the point here. I'm just a little confused. So, the – are you saying that – just a hypothetical, if the baseline is a dollar and the ESCO can save 10 cents, the new baseline that they have that drive savings off is 90 cents?

Mai Pham: Yes.

Mike Duchell: Doesn't that – doesn't that (give in) incentive in terms of – doesn't that change the incentive? You know, the more you save, the lower the baseline goes? You're almost working against yourself, then? Or, am I misinterpreting?

Mai Pham: Right. Well – so, the most attractive sharing arrangements occur in the later years of the model. So, our hope is that providers will read this arrangement as consistently pushing them in that single right direction.

Mike Duchell: Right. But, as they push in that direction, you're – CMS – the government or CMS is going to be taking all of the productivity that they are able to achieve and forcing them to achieve more, essentially each time.

Mai Pham: That is the – that is the design of the model. We – remember, please, that it's not a permanent program when we are not proposing recurrent or continuous rebasing. But, given that it is a five-year model with other payment tracks to choose from – sorry – a variety of payment arrangements to choose from, we

believe that this is important in terms of demonstrating the effectiveness of the model to support the trust fund.

Mike Duchell: OK. Then, lastly, just – can you – can you give us any color in terms of how you arrived at – you know, the number of 10 to 15 ESCOs in terms of – you know, obviously, this is not going to address a big part of the population or was there – was there some logic behind that that you could share? Thanks.

Mai Pham: The reason for the limited scope of the model is that this is a new venture for the agency. It's a new venture for dialysis providers. And the agency believes that this is a prudent way to test the water with this type of relationship given the many considerations that we have to take into account in terms of beneficiary protection and program integrity as well as demonstrating that it's a viable business model for providers. That is why the scope of the model is what it is.

Mike Duchell: Great. Thanks for all the – I'm sorry. Thanks for all the color.

Operator: Your next question comes from the line of Philo Hall from Epstein Becker & Green.

Your line is open.

Philo Hall: Thank you. The RF states that the Comprehensive ESRD Care Initiative will result in increased used of home dialysis modalities. Can you give me a sense of how the ESCOs are going to contribute to that increased used?

Melissa Cohen: The purpose of this model is to provide better care coordination and patient communication. Patient communication is going to be one of the quality measures that is going to be utilized for shared savings payment. So, our hope is that with better patient education, if home dialysis is the right choice for a patient, then it will be selected. But, we can't state whether it will result in any increase in home dialysis.

Philo Hall: Thank you.

Operator: Your next question comes from the line of Stephen Pollak from the Rogosin Institute.

Your line is open.

Stephen Pollak: Thank you. Thank you very much for an exciting – for presenting an exciting initiative. I do have a quick question about the quality metrics. In our experience, the quality metrics that have been set forth in the past by CMS has not always resulted, in our view, in quality care for patients. In fact, in some cases, they may have been a retrograde step. Will the applicants be able to propose metrics and undergo a discussion with CMS about those metrics rather than simply having metrics unilaterally imposed upon them?

Thank you.

Melissa Cohen: We are still working out to process for development for the final set of quality metrics and we'll take your request under consideration. It really is being driven by the timelines that are involved and the many experts that we have to engage. So, we will definitely take it into consideration. We encourage you to send that to the ESCO inbox.

Stephen Pollak: Thank you very much.

Operator: Your next question comes from the line of Leslie Smith from Nurse Management EMS.

Your line is open.

Leslie Smith: Thank you. My question is kind of a technical one. On the ESO – the ESCOs, it is understood it is a unique group of people in a unique geographical area and there is no overlap. Is that correct? I mean, one ESCO would not overlap another one geographically?

Melissa Cohen: The ESCOs are able to define their market area based on the limitations prescribed in the RFA, meaning that ESCOs cannot cover more than two contiguous Medicare CBSAs and the surrounding rural countries. But, if multiple ESCOs apply with different applications, if they are – they are free to

have their market areas overlap. There is no restriction on overlapping market areas between ESCOs.

Leslie Smith: (What do you mean different) applications?

Melissa Cohen: Excuse me. Sorry. Could you repeat that?

Leslie Smith: What – is it – what do you – what do you mean different applications?

Melissa Cohen: Well, this program invites groups of providers to come together and submit an application for an ESCO. And CMS will choose 10 to 15 ESCOs based on the selection criteria and the result could be that the market areas of the ESCO do, in fact, overlap. We are not restricting that.

Leslie Smith: OK. But, (so far, that) is a minimum of 500 potential patients? So, it would be large – very large populated areas. Why are there no –

Melissa Cohen: Multiple dialysis facilities will likely have to collaborate to and come together to form an ESCO to meet the minimum beneficiary threshold requirement of at least 500 ESRD patients per ESCO.

Leslie Smith: OK. So, (there may be – there are times) the participants – (so, you can) even agree or not agree. And then, that would be the way it would work. Right?

Melissa Cohen: This is a voluntary program. So, participants are welcome to apply together in an application. And then, CMS will select the organizations that are able to participate.

Leslie Smith: Thank you.

Operator: Your next question comes from the line of (Joyce Jackson) from Northwest Kidney Center.

Your line is open.

(Joyce Jackson): Could you describe how the various state dual demo programs will interface with this demo? I'm in Washington state, (where there's capitated dual demo,

program in the county in which I am located. Would those patients be able to be in the (capitated dual demo) in this demonstration?

Melissa Cohen: If you are referring to a dual demonstration that include capitation on the Medicare side, no, because the Comprehensive ESRD Care model is a fee – Medicare fee-for-service model. So, beneficiary is in a Medicare Advantage plan. They will not be eligible for (inaudible).

Operator: Your next question comes from the line of Cathy Dave from Patient Safety.

Your line is open.

Cathy Dave: Hello. My question is how will patients be engaged and chosen to be part of the governing body? And, will there be opportunities for patients and advocates to volunteer?

Melissa Cohen: This is part of our application selection criteria. We look to the ESCO to explain to us how they are going to engage patients and include patient representation on their governing body.

Cathy Dave: Thank you.

Operator: Your next question comes from the line of Jason Gries from McGuireWoods.

Your line is open.

Jason Gries: Yes. Thank you. I think the call from J.P. Morgan help to answer some of my questions regarding the rebasing. But, in years four and five, will quality measures be taken into consideration at all in the rebasing or, going forward, basis for those years and future years?

Melissa Cohen: I'm sorry. I'm not sure I understand the question. Will the quality scores be taken account – taken into account in the rebasing?

Jason Gries: That's right. So, for years one through three, you're going to have to – you know, that the ESCOs are going to be reporting their quality results. And years four and five and onwards, if there an onward, it sounds like there are – you know, that figure, that 90 cents that was mentioned per se would be the

rebased figure. In coming up with the rebased figure, are the quality metrics from years one through three going to be taken into considerations? Or, is it just the baseline in cost savings for the particular ESCO?

Melissa Cohen: It is just the recalculated baseline. In years four and five, as in the first three years of the model, quality scores will still have an impact in terms of determining whether and how much savings or losses the ESCO can share in. But, it does not affect how the rebasing will work.

Jason Gries: Thank you.

Operator: Your next question comes from the line of John Wagner from NorthShore.

Your line is open.

John Wagner: Yes. I had a question regarding hospitals that – or health systems that engage in ACOs who also own dialysis units. Will those ACOs interfere with the ability to establish an ESCO?

Melissa Cohen: I don't believe so. If the hospital system and the dialysis facility both bill under the same taxpayer identification number, then the dialysis facility under that TIN will not be eligible to participate in an ESCO if it is also a participant in a Medicare Shared Savings Program.

John Wagner: Thank you.

Operator: Your next question comes from the line of Marshia Coe from Health Systems Management.

Your line is open.

Marshia Coe: Hi. Thank you very much. As – if – I come from an academic medical center. So, the dialysis facility and the nephrology practice are owned by the medical center. But, they all have different tax ID numbers. So, let's say the medical center was actually the legal entity that formed the ESCO. And so, their tax ID number was used. It would be fine.

If, you know, 15 of the dialysis facilities were participant-owners and the nephrology practice having it's own tax ID number, even though they are under one umbrella, they can still be participant-owners because they have separate tax ID numbers? I think that's my question, if it makes any sense.

Melissa Cohen: And I believe the answer to that question is yes. But, I would ask you to e-mail the ESRD inbox so that we could look at the specifics and respond to you.

Marshia Coe: I mean, we're all one big happy family with, you know, a lot of different tax ID numbers. So, I'm assuming that would be appropriate as one as one entity filed with the tax ID number.

Melissa Cohen: Again, I would encourage you to e-mail the inbox. Each participant-owner is required to take on a certain percentage of the (downside rep). So, that is one requirement.

Marshia Coe: Understood. Thank you.

Operator: Your next question comes from the line of Gualey van Renter from UBS.

Your line is open.

Gualey van Renter: OK. Hi. I'm just wondering whether ESCO participants – I mean, the patients, would be allowed to participate in ESRD-related clinical trials.

Melissa Cohen: I'm sorry. It was – it was hard to hear. Do you mind speaking up?

Gualey van Renter: Yes. Sorry. I am wondering if any ESCO participants or the patients will be allowed to participant in end-stage renal disease related clinical trials?

Melissa Cohen: This model doesn't affect their eligibility from our perspective in any clinical trials. Their eligibility, ultimately, would need to be decided by the sponsors of the trial.

Gualey van Renter: Thank you.

Operator: Your next question comes from the line of Robert Blaser from The Renal Physician.

Your line is open.

Robert Blaser: Yes. Thank you and thanks for a great presentation. My question is similar to what was asked a couple of questions ago. But, from the perspective of nephrology practice, (you might) already be (the same) – working in a general ACO. It seems as if the system is all TIN-based.

So, if you had a desire to participate multiple – either shared savings program entities or Pioneer ACO or the ESCO, it wouldn't really be based on having a separate TIN for each of those activities. There is a reason that that would be prohibited.

Melissa Cohen: If you are in SSP, it's a function of the final rule that a shared savings participant cannot participate in another shared savings program. And the Comprehensive ESRD Care Initiative is, in fact, a shared savings program. If a group of nephrologists is practicing – is participating in Pioneer ACO, they would be eligible to participate also in the Comprehensive ESRD Care Initiative.

Robert Blaser: OK. OK. So, it's not strictly TIN-based and there are other things you would be looking at to include or exclude practices from participating in more than one entity.

Melissa Cohen: It is dependent on the program rules for all of those other programs. So, we want to draw the distinction between the Medicare Shared Savings Program, which is the single permanent Medicare ACO program, versus other – and non-capitalized letters – shared savings initiatives or programs of which is this one.

So, the rules for the MSSP, the permanent Medicare Shared Savings Program, which is the permanent ACO program, are very clear that the same TIN cannot participate in that program and in another Medicare shared savings initiative. However, other shared savings initiative like the Pioneer ACO

model may not have those restrictions. And so, it really depends on the other programs that you're talking about.

Robert Blaser: OK. I understand that and I appreciate you giving clarity here. But, what you just said was that TIN can't do it. So, if a practice were to get another TIN, then perhaps they could. And I'm not trying to be difficult. I just want to save a potential problem down the road.

Melissa Cohen: We – so, we can't offer legal guidance on that. But, we would refer you to the shared savings program regulations.

Robert Blaser: OK. Fair enough. Thank you.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, star one on your telephone keypad.

Your next question comes from the line of Stephen Bentfield from DaVita.

Your line is open.

Stephen Bentfield: Hi there. This touches on – my question touches on legal waivers, which I don't think was really addressed in the presentation. But, you know, the question is around what additional information will be forthcoming regarding any legal waivers that are (FA) – that the sector (will issue under a) separate documentation? And, if and when that does come out, whether it is going to mirror what's set forth under the Medicare Shared Savings Program.

Melissa Cohen: Can you repeat the last part of your question?

Stephen Bentfield: Just whether the legal waivers that are – that do finally come out regarding the RFA will mirror what's set forth under the regulations related Medicare shared savings.

Daniel Farmer: That's OK.

So, we do have a response to that. As you know, the Affordable Care Act does give the Secretary the authority to waive some fraud and abuse laws as necessary to test a new model that comes out of the Innovation Center.

Beneficiary inducement, anti-kickback laws, and other fraud and abuse laws, were created to ensure that the healthcare system effectively serves Medicare beneficiaries and protects the Medicare trust fund.

In the case of the Pioneer ACO model and the Medicare Shared Savings Program, that – as you may know, CMS works closely with federal partners to identify waivers that would allow for healthcare providers to coordinate care more effectively. We are continuing to work closely with those partners to determine whether waivers are appropriate for this model.

And any waivers would be issued by CMS and the Office of the Inspector General pursuant to their respective authorities and separate documentation. And any of those waivers would apply solely to the CEC model and could differ in scope or design from other waivers.

Mai Pham: Also, obviously, (to say), that we would not expect selected applicants to sign Participation Agreements without definite information on the scope of any waivers.

We cannot provide any more information on waivers at this time.

Stephen Bentfield: All right. I appreciate that. Thanks.

Operator: Your next question comes from the line of Michael Song from DaVita.

Your line is open.

Michael Song: Yes. I actually have a follow-up question to our earlier question about (dual demos). I'm just curious with respect to the patients that would fall under a managed fee-for-service model. Would they also be eligible for the ESCO? And then, also, is an ESCO market that is selected happens to overlap with a state that has submitted a duals application – participated in a duals demo, with that impact, I guess, the – how CMS prioritizes approvals?

Melissa Cohen: The answer to the second question is that we would refer you to the Federal Coordinating Office. I do not believe that the presence of an ESCO in a market of a state, by any means, disqualify that state.

In regards to your first question about managed fee-for-service models, it depends on two factors. One is that the specific design of each demonstration varies from state to state. And so, if you have a particular state in mind, it would be helpful to send that question to the inbox.

But, the second factor that it depends upon is the general first-come-first-serve rule regarding what shared savings initiative the beneficiary participates in that we mentioned earlier. So, that – the model or the program that runs matching or assignment or alignment process earlier in the year will have first access to potential beneficiaries. But, it really depends on the specific arrangements with the state as well.

Michael Song: OK. That's very helpful. Thank you.

Operator: Your next question comes from the line of Lisa Clive from (Sansonard Bernstein).

Your line is open.

Lisa Clive: Just a follow-up question. When you were asked about the rationale for doing only 10 to 15 ESCOs and you mentioned this is a new venture for the agency and also for dialysis providers. There was a demo project that ran from 2006 to 2010. I believe that that was in about 3,000 patients. Now, I guess (the results from that were mixed).

But, I guess I was under the impression that one of the participants did clearly show a pretty meaningful savings and, clearly, I think there have been lessons learned from that. So, I'm just wondering – you know, did you look at that previous ESRD demo project and why, even though you've sort of collected some initial information from that project – why you've then decided to keep this ESCO program limited to only 10 to 15 participants?

Mai Pham: We did – thank you for that question. We did very carefully study both the experience of implementing that demonstration as well as it's results. And it did very much inform the design on this model.

However, they differ in some very important ways, not the least of which is the risk arrangement in the financial offering that are in this model as well as any potential fraud and abuse waivers and a variety of other dimension. So, we do not believe that this is a rehash of the demonstration that was run prior. This is a different scale in terms of complexity and financial incentive.

Lisa Clive: OK. Thanks for that.

Operator: Your next question comes from the line of Toni Ambrosy from Northeastern Nephrology.

Your line is open.

Toni Ambrosy: Thank you. One additional clarification to the question regarding – since small – since nephrologists and nephrology groups can participate in multiple ESCOs, do they need multiple TINs to participate in those multiple ESCOs?

Melissa Cohen: There is no requirement that a TIN can only participate in only one ESCO. So, multiple providers and suppliers can participate in multiple ESCOs other than dialysis facilities, which are limited to one ESCO because matching is based off of that.

Toni Ambrosy: OK. So, this works differently from the Medicare ACOs where one TIN, one group participates in one Medicare Shared Savings ACO. So, we would only have to have one TIN to participate in multiple ESCOs.

Melissa Cohen: That's correct.

Toni Ambrosy: OK. Thank you very much.

Operator: Your next question comes from the line of Stephen McMurry from DaVita.

Your line is open.

Stephen McMurry: Thank you. So, the question, I want to ask on the – on the ownership piece of the ESCO. Is there a certain percentage that each of the three owners have to have? Or, can that be variable in different ESCOs?

And then, the second question was, did you have anyone that you were anticipating would be the third provider since that's – the partnership between the nephrologist and the dialysis facilities certainly are very clear? I wasn't certain what your thoughts were on the third ownership piece.

Thank you.

Mai Pham: Thank you for that. We understand that the ownership structure can appear complex. The three is a minimum. So, the ESCO can have as many participant-owners as (if so chooses). There is no requirement in terms of ownership stake. We are leaving that up to the ESCOs.

And as for other Medicare providers and suppliers, we are looking to the ESCO to demonstrate to us that the participant-owners and all of the participants really can care for this complete population. Therefore, a plan that shows how they would be able to care for any ESRD population with multiple comorbidities would impress us.

Melissa Cohen: Because of the competitive selection process, we will be comparing applicants in terms of how credible and compelling the care management models and the provider networks that they propose are.

Stephen McMurry: Thank you.

Operator: One again, ladies and gentlemen, if you would like to ask a question, star one on your telephone keypad.

Your next question comes from the line of Scott Coulter from (Lone Pine).

Your line is open.

Scott Coulter: Hi. I just wanted to follow up on the rebasing question from earlier. For years four and five in the LDO ESCO model, on the document you guys put out last night, the language included something that said, you know – so, rebase for years four and five on data from year one, two and three including net shared savings dollars as baseline expenditures. So, I just wanted to re-clarify, just given the language, that if you do save 10 cents off the dollar, it

gets rebased all the way down to 90 or whether the – this language here including net shared savings dollars as baseline expenditures connotes that only a portion of the dollars are rebased.

Mai Pham: You are correct. So, for the purposes of rebasing, we consider payments made in the form of earned net shared savings to be expenditures that would be included in the baseline.

Scott Coulter: That's very helpful. So, yes – so, if you're – if you are paying out 75 percent of the savings to the LDO, then the rebase would only be for a quarter of that 10 percent. It would be that.

Melissa Cohen: Exactly.

Scott Coulter: OK. That's – (you're helpful). Thank you.

Operator: Your next question comes from the line of Kevin Bowler from Revival Home Health.

Your line is open.

Kevin Bowler: Thank you. My question was answered.

Operator: Your next question comes from the line of Michael Mosley from (Wake Fastest Health).

Your line is open.

Michael Mosley: In terms of readmissions, half of our costs are associated with social issues. So, I was wondering, under this model, would there be any reimbursement for social agencies and/or social services?

Melissa Cohen: This model doesn't include payment – Medicare payment for any currently (covered) services. However, we would encourage ESCOs and their partners to devise meaningful, creative and safe arrangement to get beneficiaries those services in a way that makes sense in terms of their overall care management plan. And there is flexibility in the model for ESCOs and their partners to do that.

Michael Mosley: Thank you.

Operator: We have no further questions.

Daniel Farmer: Well, thank you, everyone, for taking some time out of your day to join us and share your really insightful questions with us. It's been very helpful for us. I hope it's been helpful for you.

I want to remind everyone that we have a variety of resources available if you have additional questions. I'm going to talk about two specific Web pages.

First is the one I mentioned earlier about this specific Open Door Forum. If you go to our home page, innovation.cms.gov and click on the menu bar that says Webinars and Forums, you will see a link for this Open Door Forum. And that's where both you will find a slide desk and a recording and transcript of today's Webinar – or Open Door Forum will be posted there.

The other resource I wanted to let you know about is a page dedicated to this new Comprehensive ESRD Care Initiative. The easiest way to find it is to go to our home page, again, innovation.cms.gov, and click on the Initiatives tab on the menu. And you will see a long list of links come up for all our initiatives here at CMS. And one of those will be dedicated to the Comprehensive ESRD Care Initiative.

And, on that page, you will find a whole litany of information about this initiative including our Request for Application document that's been referenced several times today, a fact sheet and also links to information about how to apply. And on that subsequent application page, you'll find more detailed information if you are interested in applying to the initiative.

But, again, we wanted to thank everyone for taking some time to join us today.

And, finally, one additional resource has been mentioned several times today. We do have an e-mail inbox available at esrd-cmmi@cms.hhs.gov.

So, again, we want to thank everyone for your time today. And I think, unless there are further questions, we're prepare to wrap up.

Matthew Brown: Thank you, Daniel.

And, (Martina), I believe you have encore instructions.

Operator: I do, indeed.

Thank you for participating in today's Comprehensive ESRD Care Initiative Special Open Door Forum Conference Call. This call will be available for replay beginning at 4 p.m. Eastern Time today, February 5, 2013, through midnight on February 7, 2013. The conference ID number for the replay is 91692836. The number to dial for the replay is 855-859-2056.

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

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