THE CMS QUALITY PAYMENT PROGRAM: A NEPHROLOGIST’S PERSPECTIVE

Terry Ketchersid, MD, MBA
Chief Medical Officer
Integrated Care Group
Fresenius Medical Care North America

DISCLOSURES

- Full time employee Fresenius Medical Care North America
- Board Member, Renal Physicians Association

The statements contained in this presentation are mine and do not necessarily reflect the views or policies of CMS.

EVOLUTION OF THE HEALTHCARE SYSTEM

Insurers are changing how providers get paid

Past
- See more patients
- Prescribe more services

Present
- Managing costs while providing better health outcomes
Why Value Based Healthcare?

56 yo WM c/o cough and mild dyspnea during dialysis.

Joe

• Hx of fever/sputum
• Dx of pneumonia
• Rx Abx
• Patient recovers

Terry

• Hx - missed the fever/sputum
• Dx - worsening CHF
• Decrease TW, ECHO
• Day 2 in ER, admit to ICU/vent, d/c day 8

Cost of Care

<table>
<thead>
<tr>
<th></th>
<th>Neph</th>
<th>Dialysis</th>
<th>Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Terry</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

56 yo WM c/o cough and mild dyspnea during dialysis.

CMS CHARTING A PATH TOWARDS GREATER RISK

MACRA (2015)

Medicare Access and CHIP Reauthorization Act of 2015
- Repealed the Sustainable Growth Rate formula
- Sunset PQRS, MU and the VM at the end of 2018
- Created the Quality Payment Program (QPP)

Creates 2 classes of providers
1. Enhanced FFS (MIPS)
2. Advanced Alternative Payment Model (AAPM) qualifying participants
NEW WORLD: THE QUALITY PAYMENT PROGRAM

MERIT BASED INCENTIVE PAYMENT SYSTEM

MIPS CATEGORIES

https://qpp.cms.gov/
YOUR PERFORMANCE IN 2018 IMPACTS YOUR 2020 FEE SCHEDULE

Composite Performance Score

Quality
Cost
Improving Care Information
Improvement Activities

2018
2019
2020

Performance Period
Performance Period
Performance Period
Payment Adjustment

2018 CPS
2020 CPS

2018 CPS
1. Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)
2. Comprehensive Care for Joint Replacement (CJR) Payment Model
3. Comprehensive ESRD Care (CDOI) Model (LDO arrangement)
4. Comprehensive ESRD Care (CDOI) Model (non-LDO two-sided risk)
5. Comprehensive Primary Care Plus Model
6. Medicare ACO Track 1+
7. Medicare ACO Track 2
8. Medicare ACO Track 3
9. Next-Gen ACO Model
10. Oncology Model of Care (two-sided risk)
11. Vermont Medicare ACO Initiative

https://www.cms.gov/Medicare/Quality-Payment-Program/Resources/Comprehensive-APMs.pdf

The model served 46,000 beneficiaries in 28 states and DC (approximately 10% of all Medicare ESRD beneficiaries)

37 ESCOs
1,300 physicians
800 dialysis clinics
7 dialysis organizations

All Eligible Clinicians within the ESCO model last year were Qualifying Participants within the CMS Quality Payment Program.
**THE PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)**

- Established by MACRA
- 11 member committee
- Review and make recommendations to the Secretary of HHS regarding Physician-Focused Payment Models
- Incident ESRD Clinical Episode Payment Model 4 PTAC recommended for implementation during their 12/18/2017 meeting

[https://aspe.hhs.gov/ptac](https://aspe.hhs.gov/ptac)

---

**ESCO EXAMPLE**

**End Stage Renal Disease Seamless Care Organization or ESCO**

- Partnerships between nephrologists and dialysis providers
- Accountable for all facets of their matched beneficiaries’ care
- Share savings with CMS if matched beneficiaries’ expenditures decrease and quality is maintained or improved
- Share losses if beneficiaries’ expenditures increase

---

**ESCO OVERVIEW**

<table>
<thead>
<tr>
<th>CMS</th>
<th>ESCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialysis Units</td>
<td>Nephrology Practices</td>
</tr>
<tr>
<td>Medicare FFS Beneficiaries</td>
<td>Others</td>
</tr>
</tbody>
</table>
ALIGNMENT
Enrolled in Medicare Parts A and B
Medicare is primary payer
Not be enrolled in a Medicare Advantage plan, cost plan, or other non-Medicare Advantage Medicare managed care plan
Not be affiliated with an existing shared savings program
At least 18 years of age & reside in the US
Not received a kidney transplant in the last 12 months
Matching through “first touch”
Receive at least 50% of annual dialysis services in the ESCO’s market area

HYPOTHETICAL 575 PATIENT ESCO

Expenditure
Benchmark

$50 million
$7.5 million
$7.5 million

Upside and Downside risk is capped at 15%

HYPOTHETICAL SHARED SAVINGS

Expenditure
Benchmark

$50 million
$47 million
$3 million

Shared savings opportunity if answer ‘yes’ to both questions.

Does shared savings exceed 1% of benchmark?

Did the ESCO satisfy the minimum quality requirement?
**Shared Savings**

- CMS keeps at least 25%
- ESCO keeps 50-75%
- The percentage is based on the ESCO’s Quality Score

**Hypothetical Shared Loss**

- Expenditure Benchmark: $50 million
- Actual Expenditures: $53 million
- The ESCO will share this loss with CMS

**Shared Loss**

- The ESCO’s share of the loss is determined by the shared loss multiplier (SLM)

\[
\text{Shared Loss Multiplier (SLM)} = \text{shared loss floor} + \text{shared loss percentage} \times \text{Quality score}
\]

- The ESCO is on the hook for 50-75% of the loss
- The actual percentage depends on the ESCO’s Quality Score
QUALITY CATEGORIES: 2018

<table>
<thead>
<tr>
<th>Measure Type</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hybrid Measures</td>
<td>Combination of claims data and medical record</td>
</tr>
<tr>
<td>Institutional Ratio Measures</td>
<td>Based on claims or other CMS documentation</td>
</tr>
<tr>
<td>Surveys of Surveys</td>
<td>- ICH CAHPS - dialysis surveys conducted for Dialysis Clinic Quality</td>
</tr>
<tr>
<td></td>
<td>- KDQOL - separate from dialysis unit (ICRU)</td>
</tr>
<tr>
<td>Transplant Measures</td>
<td>Based on dialysis facility data</td>
</tr>
<tr>
<td>Total of 19 Measures</td>
<td></td>
</tr>
</tbody>
</table>

2016 RESULTS

- Millions of Dollars Saved
  - 12 ESCOs: $72
  - 23 Pioneer ACOs: $68
  - 18 Next Gen ACOs: $68

ESCO LESSONS LEARNED

Pros
- The ESCO shares in savings created by reducing hospitalizations
- Waivers permit interventions that are not allowed in FFS
- Aligns the interests of nephrologists and dialysis organizations

Cons
- Shared savings vs prospective payment
- Challenging quality framework
- Late-stage EOD and transplant are not overtly addressed

http://www.modernhealthcare.com/article/20171018/NEWS/171019867

http://cjasn.asnjournals.org/content/12/12/2050.short
**SUGGESTIONS**

- Where are you in the Venn diagram?
- Where do you want to be?
- Select/recruit a QPP Champion
- Know your data (quality and cost)
- Understand the rules of engagement
- Capitation vs. shared savings
- Population vs. episodes of care
- Alignment/attributions
- Rebalancing, risk adjustment, quality
- Trending and truncation
- The “credible number”
- MLR (medical loss ratio)
- Find a trusted partner
- Examine your staffing models
- Consider your risk tolerance