Accountable Care for End-Stage Renal Disease Patients
12:00 – 1:00, March 4, 2016
Craig Schneider, Ph.D, Senior Health Researcher, Mathematica Policy Research
Doug Johnson, MD, Vice Chair, DCI
Conflict of Interest

Craig Schneider, Ph.D
and
Doug Johnson, MD
have no real or apparent conflicts of interest to report.
Agenda

• Background on end-stage renal disease (ESRD)
• Comprehensive ESRD Care (CEC) model
• Learning Systems for Accountable Care Organizations (ACOs)
• Challenges for ACOs
• Background on Dialysis Clinic, Inc.
• The ESRD care environment
• Establishing an ESRD Seamless Care Organization (ESCO)
• How to improve care for patients with kidney disease
• Empowering patients to live their dreams
• Q&A
Learning Objectives

• Describe the ESCO program requirements, payment model, and patient population
• Recognize the core competencies that ESCOs need to achieve success
• Assess the challenges in establishing a new, independent ESCO
• Identify the data sources that are made available to ESCOs and how they are used for quality and financial performance measurement
• Discuss how the learning system supports the ESCOs in achieving their objectives
An Introduction of How Benefits Were Realized for the Value of Health IT

- **S**: ESCOs assessed in part on quality of life survey, consumer survey
- **T**: Create integrated delivery system for ESRD, change reimbursement model
- **E**: Performance determined by financial efficiency and 26 quality measures
- **P**: Patient engagement is core competency; preventive services among quality measures
- **S**: If ESCO achieves sufficient savings, then shares in those savings
Background on ESRD

• 600,000 Americans w/ ESRD
• 1.1% of Medicare population but 5.6% of Medicare costs (2012 data from CMS)
• 17.5% uninsured prior to Medicare (pre-ACA data)
• Medicare enrollment quadrupled in past 30 years (110,000 in ‘85, 462,000 in ‘13)
• More than half (53%) under 65
• Disparities:
  – 48% non-white
  – Transplant rates 81% higher for whites than African-Americans (29% vs. 16%)
Advanced Kidney Disease Project

• Northwell received HCIA2 grant

• eGFR is measure of kidney function – 90+ is healthy, <30 is AKD, <16 is ESRD

• Several “modalities” for dialysis
  – Transplant
  – Home dialysis (peritoneal)
  – Conservative (palliative) care
  – Hemodialysis in a facility, with fistula
  – Hemodialysis in a facility, with catheter

• Need to intervene early enough so patient can receive AVF and avoid catheter

• More patient-centered, higher quality, lower cost
CEC Model

- 12 LDOs (>200 dialysis facilities) and 1 non-LDO
- Must include nephrologists and dialysis clinics
- Accountable for clinical quality, financial outcomes
- “This new ACO model represents a paradigm shift in care for beneficiaries with ESRD; it promotes a patient-centered approach to their dialysis and non-dialysis care needs that will accomplish our delivery system reform goals of better care, smarter spending, and healthier people.” – Patrick Conway, MD, Acting Deputy Administrator, Chief Medical Officer, CMS
<table>
<thead>
<tr>
<th>Dialysis Organizations</th>
<th>ESCO Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCI</td>
<td>Liberty Kidney Care Alliance, LLC</td>
<td>Newark, NJ</td>
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<tr>
<td>DCI</td>
<td>Palmetto Kidney Care Alliance LLC</td>
<td>Spartanburg, SC</td>
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<tr>
<td>DCI</td>
<td>Music City Kidney Care Alliance, LLC</td>
<td>Nashville, TN</td>
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<tr>
<td>DaVita</td>
<td>Phoenix-Tucson Integrated Kidney Care</td>
<td>Phoenix, AZ</td>
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<td>DaVita</td>
<td>South Florida Integrated Kidney Care</td>
<td>Miami, FL</td>
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<tr>
<td>DaVita</td>
<td>Philadelphia- Camden Integrated Kidney Care</td>
<td>Philadelphia, PA</td>
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<td>Fresenius</td>
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<td>San Diego, CA</td>
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<td>Fresenius</td>
<td>Fresenius Seamless Care of Dallas, LLC</td>
<td>Dallas, TX</td>
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**Smaller dialysis organization:**

<table>
<thead>
<tr>
<th>Dialysis Organization</th>
<th>ESCO Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rogosin Institute</td>
<td>Rogosin Kidney Care Alliance</td>
<td>New York, NY</td>
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</tbody>
</table>
## Overview of Medicare ACOs

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Pioneer</th>
<th>SSP</th>
<th>ESCO</th>
<th>Next Generation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start Date</strong></td>
<td>January 2012 (one-time)</td>
<td>January 2012 (annual enroll)</td>
<td>October 2015 (no expansion)</td>
<td>Jan. 2016 and Jan. 2017</td>
</tr>
<tr>
<td><strong>Quality Measures</strong></td>
<td>33 GPRO</td>
<td>33 GPRO</td>
<td>26 (various sources)</td>
<td>32 GPRO (no EHR measure)</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>5 options, 2-sided risk, 60-75% SS/SL, MSR/MSL 2%</td>
<td>Track 1: SS only, up to 50%.</td>
<td>LDOs: MSR 1%, SS/SL 70% PY1. SDOs: SS only (up to 50%).</td>
<td>2 options: SS/SL 80% or 100%, 1st $ risk/reward, 4 pmt. mechanisms</td>
</tr>
<tr>
<td><strong>Beneficiary attribution</strong></td>
<td>Prospective historic claims (voluntary PY4)</td>
<td>Prelim. prospective, final retro</td>
<td>Based on 1st visit to dialysis facility</td>
<td>Prospective historic claims (voluntary PY2)</td>
</tr>
<tr>
<td><strong>Number</strong></td>
<td>19</td>
<td>405</td>
<td>13 (?)</td>
<td>TBD (20 per cohort?)</td>
</tr>
<tr>
<td><strong>Minimum enrollment</strong></td>
<td>15,000 (rural 5000)</td>
<td>5000</td>
<td>350</td>
<td>10,000 (rural 7500)</td>
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</table>
CEC Quality Measures

• Patient safety – mortality ratio, document Rx in medical record, blood infections, falls plan of care

• Patient-centered experience/outcomes – KD quality of life survey, advance care plan, 6 consumer ratings from CAHPS

• Communication/care coordination – admissions, readmissions, med rec post-discharge

• Clinical quality of care – eye and foot exams, hemodialysis dosage, rate of hypercalcemia, peritoneal dialysis, AVFs, lower catheter use

• Population health – flu and pneu immunization rates, depression screening, tobacco screening/cessation
7 Steps for Managing Change

1. Establish clear aims
2. Develop explicit theory of change
3. Create context necessary for test of model
4. Develop change strategy
5. Test the changes
6. Measure progress toward aim
7. Plan for spread

Over a 3-5 year period, achieve the goals of better care, better health, and lower costs through coordinated, seamless care for Medicare FFS ESRD beneficiaries on dialysis over baseline.

1. Reduce total Medicare Part A and B per capita expenditures by 3%
2. Improve clinical quality and patient experience outcome measures compared to baseline
3. Improve patient functional status and quality of life outcome measures compared to baseline

Coordinate interdisciplinary care across settings and providers

Improve clinical processes

Improve patient and caregiver engagement and education

Improve access to care

Improve communication across providers, patients, and settings

Enhance & align financial incentives

Data driven continuous process improvement

"Whole person" care management and care planning
- Effective transitions across settings and as care needs change
- Data-driven, population care management

Effective management of dialysis-related care and co-morbid conditions
- Effective medication management

Patient self management
- Informed & shared decision making
- Patient education in areas such as transplant and dialysis modality options

Options for customized dialysis care across settings
- Appropriate variations in amounts of dialysis
- In-kind beneficiary services
- Optimal HIT use and information sharing
- Effective patient and caregiver communication

Accountability for cost and quality
- Shared savings

Peer-based, rapid cycle learning
- Data capture & analysis

CMS Sound Operations/Regulatory Environment (e.g., monitoring, evaluation, CMS infrastructure, etc.)
Challenges for All ACOs to Meet

- Patient and beneficiary engagement
- Patient attribution – who are my patients, churn
- Aligning incentives (much of care still FFS)
- Integrating multiple EHRs, interoperability
- Limited funding for transformation, eyeing return on investment
- Behavioral health
- Coordinating patient care within the ACO
- Data sharing
- Lack of timely and complete data

- Collaboration in a competitive marketplace
- Build provider network in rural areas
- Organizational transformation
- Leveraging private contracts, Medicaid
- Participating in evolving models/programs (Pioneer, ESCO, Next Gen)
- Integrating newly acquired organizations
- Optimizing use of care managers/navigators/guides in care team
Challenges for ESCOs in Particular

• High-risk/high-cost isn’t subset of patients – it’s all patients
  – Multiple comorbidities
  – Psychosocial needs
  – Under-served population
• “ESCOs” didn’t exist prior to the CEC model
  – New partnerships, financial relationships
  – Never managed comprehensive care before
• 3 major national companies – effect on collaboration unclear
• Dialysis facilities not eligible for MU – limited HIT
• New and evolving payment model
Dialysis Clinic, Inc.

- Largest non-profit dialysis provider in the U.S.
- Founded in 1971 (44 yrs ago)
- Serving over 18,000 patients with kidney disease
  - Over 15,000 patients on dialysis
  - Over 3,400 patients with CKD
- In more than 230 clinics
- Across 28 states
Changing Landscape of Healthcare
Decrease In Reimbursement

Reimbursement freeze
2014
2015
2016
2017
2018

Net financial effect on DCI of about $30 million decrease in reimbursement.
Proposed Decrease In Reimbursement Update

Can we thrive in this new environment if we keep caring for patients the same way as we have always cared for them?
CMS
Three Primary Aspects of Care

Access to Care

Quality

Cost

Celebrating 30 Years on Dialysis

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Commercial Payers

• Access to Care, Quality, & Cost concerns as well
• Significant money spent chasing sub-optimal outcomes
  ➢ Adverse economic impact to:

**Patients**
not getting the right care at the right time
…detrimental impact to family budgets.

**Employers**
Increased absenteeism…
reduced employee productivity and effectiveness…
unnecessarily higher medical costs.

**Commercial Payers**
Unnecessarily higher medical costs… want to
drive positive change for customers… like CMS,
will move towards pay-for-performance.
"I skate to where the puck is going to be, not where it has been."

-- Wayne Gretzky
ESCO: Integrated Care for Patients on Dialysis
In The Beginning…

Centers For Dialysis Care
Dialysis Clinic, Inc.
Independent Dialysis Foundation, Inc.
Northwest Kidney Centers
Satellite Healthcare, Inc.

August 4, 2011

Richard Gilfillan, MD
Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Gilfillan:

As the largest nonprofit dialysis providers in the United States, we wanted to make sure that you saw our comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule for the Medicare Shared Savings Program: Accountable Care Organizations (ACOs), submitted June 6, 2011. As we noted there, rather than establishing an end-stage renal disease (ESRD) ACO, we believe that the better course would be for the Center for Medicare and Medicaid Innovation (the Innovation Center) to launch an integrated care initiative focused on chronic kidney disease (CKD) and ESRD care. In doing so, we would urge the Innovation Center to understand the diversity of opinions in the kidney disease community about care integration. We hope that we will have an opportunity to discuss a CKD-ESRD integrated care initiative in greater detail with you in the near future.

We represent five large nonprofit providers: Centers for Dialysis Care; Dialysis Clinic, Inc.; Independent Dialysis Foundation, Inc.; Northwest Kidney Centers; and Satellite Healthcare, Inc.
In The Beginning…

“We strongly support the idea of an Innovation Center-sponsored pilot program for integrated care in chronic kidney disease and end-stage renal disease. Such a pilot program would allow dialysis providers to show their ability to provide integrated care without the administrative expense of the proposed ACO structure. We urge you to undertake a pilot program which includes a broad spectrum of providers, so that it does not become an instrument to facilitate market consolidation, but rather a tool to promote quality improvement and cost containment.”
Nonprofit Kidney Care Alliance
Promoting Best Practices for Improved Patient Outcomes
ESCOs

DCI and Rogosin:

• Only providers other than DaVita and Fresenius in the ESCO

➢ Care for less than 4% of the population

➢ Approved for 30% of the ESCOs
We Have A Seat At The Table As CMS Plans Changes in Kidney Care

“When CMS is changing the rules, you want a seat at the table.”

“If you don’t have a seat at the table, you may be on the menu.”
A Learning Organization

Healthcare Partners

- 10 Nephrology Practices
- 2 Internal Medicine Practices
- 3 Vascular Access Practices
- 2 Healthcare Systems
- Hospice Provider
- Palliative Care Provider
- Home Health Provider
- Accountable Care Organization
- Hospitalist Provider
- Hospice Provider

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Music City Kidney Care Alliance

• Owners
  - Nephrology Associates
  - Adel Saleh, MD
  - Alive Hospice
  - Aspire Healthcare (palliative care provider)
  - The Surgical Clinic, PLLC
  - Dialysis Clinic, Inc.

• Partner
  - MissionPoint (Accountable Care Organization)
Liberty Kidney Care Alliance

• Owners
  ➢ Toros Kapoian, MD
  ➢ Associated Renal & Hypertension Group
  ➢ Hypertension and Nephrology Specialists
  ➢ Mehdi Naqui MD
  ➢ Eric C. Manning, MD, PhD
  ➢ Highland Park Surgical Associates
  ➢ Dialysis Clinic, Inc.

• Owners Joining 1/1/16
  ➢ Island Nephrology Services
  ➢ Nephrology-Hypertension Associates of Central Jersey
Palmetto Kidney Care Alliance

• Owners
  ➢ Spartanburg Nephrology Associates
  ➢ Gentiva Health Services (home health provider)
  ➢ Dialysis Clinic, Inc.

• Non-owner participant joining 1/1/16
  ➢ Spartanburg Medical Center (Ari Kramer, MD; palliative care; hospitalists)
Plan To Improve Care For Patients with Kidney Disease

1. CKD care coordination
2. First 120 days
3. Increase home dialysis
4. Decrease catheters
5. Decrease hospitalization
6. Medication Therapy Management
7. Improve care for end of life
Success: Increase Transplantation

• Partnership with St. Thomas Health System

• January – June, 2013:
  ➢ 1 kidney transplant

• July, 2013 – present:
  ➢ 57 transplants
Success: Improve Transition To End Of Life

Pilot Project (4 clinics in Nashville, TN):
• Approached 60 patients
• 11 – selected hospice
• 26 – selected palliative care
  • 8 eventually transitioned to hospice care
• 5 ultimately chose palliative care
• 2 ultimately chose hospice
Empowering Patients To Live Their Dreams
A Summary of How Benefits Were Realized for the Value of Health IT

**S:** AKD care is Triple Aim – higher quality, lower costs, more patient-centered

**T:** Increased transplantation rate

**E:** Performance determined by financial efficiency and 26 quality measures

**P:** Empowering patients to live their dreams

**S:** Model launched 10/’15 – shared savings to be determined after 1\(^{st}\) PY
Questions

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