New value-based payment incentives from the Centers for Medicare and Medicaid Services (CMS) may entice more nephrologists and possibly dialysis organizations to participate in ESRD Seamless Care Organizations (ESCOs). CMS recently announced a second round of applications for participation in ESCOs; those accepted would begin the model in January 2017.

A proposed rule published in April provided a first peek at how CMS’ new system for paying physicians might work, including for physicians participating in “Alternative Payment Models” (APMs) such as ESCOs. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the Sustainable Growth Rate formula previously used to establish Medicare payments for physicians. It provides incentives for doctors to participate in care delivery models that count as “Advanced APMs,” which allow them to earn bonus payments and avoid potential Medicare reimbursement cuts. Under the proposed rule, nephrologists who participate in ESCOs on the “Large Dialysis Organization” track would count as participating in an Advanced APM.

“It will definitely incentivize participation in ESCOs,” said Suzanne Watnick, MD, a member of the ASN Public Policy Board and a professor at Oregon Health & Science University in Portland.

Thirteen dialysis organizations currently participate in ESCOs, the Comprehensive ESRD Care (CEC) Model launched in 2015. The CEC Model was intended to help evaluate and improve ESRD care. In the program, dialysis clinicians, nephrologists, and other care providers partner to coordinate care for a population of Medicare beneficiaries with ESRD. Participating organizations reap the benefits of more streamlined and improved care for the population by sharing a portion of the savings to Medicare. Participants in the Large Dialysis Organization track, those with 200 or more dialysis facilities, also are liable for losses if they fail to yield cost savings. Small dialy

New Physician Pay Program May Give ESCOs a Boost
By Bridget M. Kuehn

Nephrology Goes All-In: An Update on the Match
By Michael J. Ross and Kurtis Pivert

In the first year of the All-In Nephrology Match, the number of participating programs and training tracks rose to the highest level since the specialty joined the National Residency Matching Program’s (NRMP’s) Medical Specialties Matching Program. Although there was a slight increase in applicants choosing nephrology, the recent trend of increasing numbers of unfilled positions and programs continued. Nearly 60 percent of training tracks and over 40 percent of positions were left open on Match day.

The vast majority of nephrology training programs participated in All-In and potential nonparticipation was circumscribed. NRMP’s final Match data report released on March 7 noted that a total of 140 programs offered 158 training tracks (Clinical, Clinical Research, Research, and Other) and a record 466 fellowship positions for appointment year (AY) 2016. All-In’s first year was therefore quite successful in increasing the number and percentage of nephrology fellowship positions offered through the Match.

Despite an increase in the overall number of candidates choosing nephrology (298, up from 252 in AY 2015), the number of non-US international
Physician Pay Program

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sions were not asked to take on this level of risk in CMS’ first round of requests for ESCO participation—but those small dialysis organizations’ ESCOs would not count as Advanced APMs under the new proposed rule.

Despite the lower risk requirements, the hurdles to participation in the ESCO program proved too much for many small dialysis organizations, and only one—the New York City–based Rogosin Institute—chose to participate. Many didn’t have the resources to create necessary infrastructure or provide enough personnel to monitor patient care, Watnick said. Small organizations were also concerned that the outcomes they were being graded on weren’t available upfront, she noted.

“It was going to be hard for small organizations with the resources they had,” Watnick said. “People weren’t clear they could realize a financial benefit.”

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The opportunities were being graded on weren’t available upfront, she noted.

But success relies on full participation of nephrologists and other members of the care team, said McMurray. “It just doesn’t work if the whole team isn’t involved,” he said.

Financial incentives in the MACRA rule as well as changes to the ESCO model are likely to entice more nephrologists and dialysis organizations to join the program, Watnick said.

Under the MACRA rule, beginning in 2019 physicians will be reimbursed either through the Merit-based Incentive Payment System (MIPS) or participation in an Advanced APM. Physicians participating in Advanced APMs, entities that take on financial risk as well as benefit and meet certain other financial, electronic health record (EHR), and quality criteria, would be eligible for their Medicare reimbursement plus a 5% bonus, Watnick explained. Physicians participating in MIPS could see their reimbursement increase—or decrease—4% in 2019 and up to 9% in subsequent years depending on their performance on four criteria (quality, clinical practice improvement activity, resource use, and EHR use).

Large dialysis organizations participating in ESCOs automatically qualify as an APM, according to the MACRA rule. Small organizations must take on some risk in order to qualify as an advanced APM, Silberzweig noted.

“We do think it’s a good outcome for our participating nephrologists that our ESCO will be classified as an Advanced APM,” said Lohmeyer. “The opportunity to participate in the Advanced APM track and possibly earn a bonus is a nice benefit.”

But Lohmeyer said it wasn’t clear whether these incentives for nephrologists alone would be enough to encourage organizations to form an ESCO. He noted that geography, startup costs, and other factors may make forming an ESCO impossible for some organizations.

Silberzweig noted that 2 to 3 small dialysis organizations have expressed interest in joining in the second round of the program.

CMS is accepting its second round of applications for participation in ESCOs through July 15. This time it has provided more detailed information about performance measures upfront, according to Watnick.

“It’s not 100% clear, but it’s a lot clearer than in the first round,” she said.

Plus, dialysis organizations participating in the second round of ESCOs will have the advantage of learning from experienced programs, Silberzweig said. He also noted that CMS has been very responsive to his organization’s concerns and has been willing to adapt the program.

“It makes us very enthusiastic about continuing to work with them,” he said.

Many questions remain about the final form the MACRA rule will take. Among them are whether MACRA payments will start in 2019 based on 2017 performance as proposed or be pushed back, noted Lohmeyer. It’s also unclear how the agency will calculate bonus eligibility for nephrologists participating in an ESCO, he said.

“CMS encourages and welcomes all interested parties to submit their suggestions on the proposed rule during the comment period, and is listening to the feedback we are receiving,” said a CMS official in an emailed statement.

This provides an opportunity for nephrologists and dialysis organizations to really shape the MACRA rule to make sure their patients have access to the best care, said Watnick. For example, she said, it should be easy for patients to receive kidney transplants or palliative care if that’s the best choice for them.

“Patients with ERSD are some of the most chronically ill patients and are among the most chronically ill patients. Any new changes have to be patient-centric and improve not just quantity of life but also quality of life.”

CMS is accepting comments on the MACRA rule through June 27.