Appendix B

LDO Financial Methodology
(LDO – CEC Model)

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TABLE OF EXHIBITS

GLOSSARY

Term	Definition
Annualize	To adjust expenditures to allow the summation of cost data from beneficiaries with less than one year of eligibility to reflect a full year of expenditures.
Base Year (BY)	The three years prior to the start of the CEC Initiative. BY1, BY2, and BY3 correspond to calendar years 2012, 2013, and 2014, respectively.
Beneficiary-Month	One month of time for which a beneficiary is aligned to the ESCO, a CEC LDO Entity, or a CEC Non-LDO Entity, or is a Reference Group Beneficiary
Beneficiary-Year	The sum of twelve Beneficiary-Months.
CEC Initiative	Comprehensive End-Stage Renal Disease Care Initiative.
CEC LDO Entity	An entity that: (1) has executed a CEC participation agreement with CMS; (2) has Dialysis Facility Participants that are owned in whole or in part by one or more LDOs; and (3) is not the same legal entity as the ESCO.
CEC Non-LDO Entity	An entity that: (1) has executed a CEC participation agreement with CMS; (2) has Dialysis Facility Participants that are owned in whole or in part by one or more non-LDOs; and (3) is not the same legal entity as the ESCO.
Continuously Aligned ESCO Beneficiary	An ESCO Beneficiary aligned to the ESCO in a given year and in the previous year.
Dialysis Facility	An entity that provides outpatient maintenance dialysis services (including Hospital-Based Dialysis Facilities and Home Dialysis training and support services) either as a Medicare-enrolled entity or as an operating division of a Medicare-enrolled entity that is owned in whole or in part by the Company.
Effective Date	The date specified in Section II.A of the Participation Agreement.
Eligibility Category	One of five groups of Medicare beneficiaries (for purposes of calculating Historical Expenditure Baselines) or ESCO Beneficiaries (for purposes of calculating Performance Year Expenditure Benchmarks) that are combined according to their reason for Medicare entitlement and, if applicable, Medicaid enrollment status.
Eligible Beneficiary-Months	Months in which a beneficiary was enrolled in Medicare Parts A and B and met all other CEC eligibility criteria.
Eligible BY Beneficiary	A beneficiary who would have been aligned to the ESCO during BY1, BY2, or BY3 had the CEC Initiative been operating at that time because the beneficiary meets the eligibility requirements (listed in Section 1.1.1) and receives a "first touch" dialysis treatment (discussed in Section 1.1.2) from a Dialysis Facility on the ESCO Participant List. Information for Eligible BY Beneficiaries will be used to produce Historical Expenditure Baselines.
ESCO Beneficiary	A Medicare beneficiary who has been aligned to the ESCO according to the methodology outlined in Section 1.1.2 of this Appendix.
ESCO Participant List	The list of the Participants that are approved by CMS for participation in CEC, as updated from time to time in accordance with paragraphs 3-5 of Section IV.B. of the Participation Agreement. The initial ESCO Participant List is attached as Appendix A.
ESCO Provider/Supplier	An individual or entity that (1) is a Medicare-enrolled provider or supplier identified by an NPI or CCN; (2) bills for items and services furnished to Medicare beneficiaries under a Medicare billing number assigned to the TIN of a Participant Owner or Participant Non-Owner; (3) has agreed to participate in the CEC pursuant to a written agreement with the ESCO; (4) may, but is not required, to receive Shared Savings Payments; (5) may, but is not required to, be liable for Shared Losses Payments; and (6) is included on the ESCO Participant List.

Term	Definition
ESCO Total Revenue	The total Medicare Part A and Part B claims paid to all providers or suppliers for the items and services furnished to all ESCO Beneficiaries in a given Performance Year.
Established Beneficiary	A Medicare beneficiary with 12 months of Medicare enrollment during the calendar year preceding the current Performance Year.
Financial Reconciliation	The process occurring after the end of the PY where alignment is finalized and Shared Savings is calculated using the full PY of claims data plus the run-out.
Government	The federal executive, legislative, and judicial branches of the United States of America.
Historical Expenditure Baseline	A dollar amount calculated by CMS according to the methodology set forth in Section 2 of this Appendix to establish the average annual Medicare Part A and Part B expenditures for Medicare beneficiaries who would have been aligned to the ESCO in an Eligibility Category during any of the three years prior to the start of the first Performance Year under the alignment methodology described in this Appendix.
Home Dialysis	Peritoneal or hemodialysis performed by an appropriately trained ESCO Beneficiary (and/or the ESCO Beneficiary's caregiver) at the home of the ESCO Beneficiary.
Initial Term	The period of time beginning on the Effective Date of this Agreement and concluding at the end of the third Performance Year.
Large Dialysis Organization (LDO)	An entity that, as of the Effective Date, owns, directly or indirectly, 200 or more Dialysis Facilities.
Market	A geographic area consisting of no more than two contiguous Medicare core-based statistical areas ("CBSA") in which one or more Dialysis Facilities listed in Appendix A are located, except that inclusion is allowed of contiguous rural counties that are not included in a Medicare CBSA. If the ESCO is rural and not included in any Medicare CBSA, the Market will be defined by CMS based on a geographic unit no larger than a state.
Minimum Loss Rate (MLR)	The minimum percentage of the Total Performance Year Expenditure Benchmark that the ESCO must achieve in Preliminary Shared Losses to be liable for Shared Losses.
Minimum Savings Rate (MSR)	The minimum percentage of the Total Performance Year Expenditure Benchmark that the ESCO must achieve in Preliminary Shared Savings to be eligible to receive Shared Savings.
New Beneficiary	A Medicare beneficiary with fewer than 12 months of Medicare enrollment during the calendar year preceding the current Performance Year.
Newly-Aligned ESCO Beneficiary	An ESCO Beneficiary aligned to the ESCO in a given year and not also aligned to the ESCO in the previous year.
Participant	An individual or entity that is a Participant Owner, a Participant Non-Owner, or an ESCO Provider or Supplier.
Participant Non-Owner	An individual or entity that (1) is a Medicare-enrolled provider or supplier identified by a TIN and either a NPI or a CCN; (2) does not have any direct or indirect ownership or investment interest in the ESCO; (3) has agreed to participate in the CEC pursuant to a written agreement with the ESCO; (4) may, but is not required to, receive Shared Savings Payments; (5) may, but is not required to, be liable for a portion of Shared Losses Payments ; and (6) is included on the ESCO Participant List.
Participant Owner	An individual or entity that (1) is a Medicare-enrolled provider or supplier identified by a TIN and either a NPI or a CCN; (2) has a direct ownership or investment interest in the ESCO; (3) has agreed to participate in the CEC pursuant to a written agreement with the ESCO; (4) may, but is not required to, receive Shared Savings Payments; (5) is liable for Shared Losses Payments; and (6) is included on the ESCO Participant List.

Term	Definition
Per-Beneficiary-Per-Year (PBPY)	A measurement of expenditures calculated by dividing expenditures by Beneficiary-Years. This differs from a per capita basis, which is expressed in per beneficiary terms.
Performance Year (PY)	The 12-month period beginning on January 1 of each year during the term of the Participation Agreement, except that the first Performance Year of this Agreement will begin on July 1, 2015 and end on December 31, 2016. The second Performance Year will begin on January 1, 2017 and end on December 31, 2017. The third Performance Year will begin on January 1, 2018 and end on December 31, 2018. If this Agreement is renewed, the fourth Performance Year will begin on January 1, 2019 and end on December 31, 2019, and the fifth Performance Year will begin on January 1, 2020 and end on December 31, 2020.
Performance Year Expenditure Benchmark	The ESCO's expected Medicare Part A and Part B expenditures for ESCO Beneficiaries in an Eligibility Category during the applicable Performance Year, as determined by CMS according to the parameters set forth in this Appendix.
Preliminary Shared Losses	The difference between the ESCO's Total Performance Year Expenditure Benchmark and ESCO Total Revenue when ESCO Total Revenue is greater than the ESCO's Total Performance Year Expenditure Benchmark. This number represents an interim value and is not the final estimate of Shared Losses.
Preliminary Shared Savings	The difference between the ESCO's Total Performance Year Expenditure Benchmark and ESCO Total Revenue when ESCO Total Revenue is less than the ESCO's Total Performance Year Expenditure Benchmark. This number represents an interim value and is not the final estimate of Shared Savings.
Reference Group Beneficiaries	Beneficiaries nationwide who would be eligible for the CEC Initiative according to the eligibility requirements (listed in Section 1.1.1) but who do not have a "first touch" dialysis treatment with the ESCO, a CEC-Non-LDO Entity, or a CEC LDO Entity.
Risk Adjustment	The process of adjusting for diagnoses and demographic factors that are expected to affect Medicare Part A and Part B expenditures.
Shared Losses	The amount owed to CMS by the ESCO due to ESCO Total Revenue in excess of the ESCO's Total Performance Year Expenditure Benchmark for the applicable Performance Year as determined by CMS in accordance with this Appendix.
Shared Losses Cap	The maximum percentage of Shared Losses that the ESCO must pay.
Shared Losses Floor	The minimum percentage of Shared Losses that the ESCO must pay.
Shared Losses Multiplier	The total of the Shared Losses Floor + Shared Losses Percentage – (Shared Losses Percentage × quality score) after the application of the Shared Losses Cap and Shared Losses Floor, as applicable.
Shared Losses Payment	The portion of Shared Losses owed by a Participant to the ESCO.
Shared Losses Percentage	The maximum proportion of Preliminary Shared Losses for which the ESCO can be liable, equal to 70 percent In PY1 and 75 percent in PY2 and later years.
Shared Savings	The amount owed to the ESCO by CMS due to ESCO Total Revenue below the ESCO's Total Performance Year Expenditure Benchmark for the applicable Performance Year as determined by CMS in accordance with this Appendix. This number represents the final amount paid to the ESCO.
Shared Savings Cap	The maximum amount of Preliminary Shared Savings, equal to 5% of the Total Performance Year Expenditure Benchmark.
Shared Savings Multiplier	The percentage of Preliminary Shared Savings that the ESCO will receive, equal to the product of the Shared Savings Percentage and the quality score.
Shared Savings Payments	The portion of Shared Savings distributed by the ESCO to a Participant or the Company or by a Participant Owner or Participant Non-Owner to an ESCO Provider/Supplier.

Term	Definition
Shared Savings Percentage	The maximum proportion of Preliminary Shared Savings the ESCO can receive, equal to 50% of the difference between Total ESCO Revenue and Total Performance Year Benchmark.
TIN	A federal taxpayer identification number, which in some cases may be a Social Security Number.
Total Performance Year Expenditure Benchmark	The ESCO's expected combined Medicare Part A and Part B expenditures for ESCO Beneficiaries in all Eligibility Categories during the applicable Performance Year, as determined by CMS according to the parameters set forth in this Appendix. There is one Total Performance Year Expenditure Benchmark, expressed at the ESCO level rather than the Eligibility Category Level, for each Performance Year.
Trending	The process by which expenditures are adjusted to account for national changes in expenditures over time.
Truncating	The process by which Annualized expenditures are capped to limit financial risk to the ESCO.

LIST OF ACRONYMS

Term	Definition
ACO	Accountable care organization
BY	Base year
CEC Initiative	Comprehensive End-Stage Renal Disease Care Initiative
DME	Durable medical equipment
DRS	Demographic risk score
DSH	Disproportionate share hospital
ESCO	End-Stage Renal Disease Seamless Care Organization
ESRD	End-stage renal disease
FFS	Fee for service
FRS	Full risk score
HCC	Hierarchical Condition Category
HHA	Home health agency
IME	Indirect medical education
LDO	Large dialysis organization
MLR	Minimum Loss Rate
MS-DRG	Medicare Severity Diagnosis-Related Group
MSR	Minimum Savings Rate
MSSP	Medicare Shared Savings Program
Non-LDO	Non-Large Dialysis Organization
PBPY	Per-beneficiary-per-year
PY	Performance Year
PPS	Prospective payment system
SNF	Skilled nursing facility

1. INTRODUCTION

This appendix describes the financial methodology that CMS will use to calculate Shared Savings and Shared Losses for the End-Stage Renal Disease Comprehensive Care Organization (ESCO) that has executed a Participation Agreement with CMS to participate in the Comprehensive ESRD Care (CEC) Initiative. The methodology is adapted from those used for the Medicare Shared Savings Program (MSSP) and the Pioneer Accountable Care Organization (ACO) Model.[1,2]

Section 1 of this document discusses the process by which CMS identifies beneficiaries who are eligible for the CEC Initiative and assigns them to the ESCO and provides a high-level overview of the financial methodology. Section 2 includes the methodology used to calculate the Historical Expenditure Baselines for the ESCO. Section 3 explains how the Historical Expenditure Baselines are adjusted to establish the ESCO's specific Performance Year Expenditure Benchmarks that CMS will use to calculate Preliminary Shared Savings and Preliminary Shared Losses. Section 4 describes the methodology used to calculate the expenditures required to compute ESCO Total Revenue. Section 5 explains how the Total Performance Year Expenditure Benchmark and ESCO Total Revenue are compared to determine Shared Savings. CMS will provide regular reports to the ESCO. The attachment lists examples of the types of reports that the ESCO will receive and provides an overview of the content of each report.

Exhibit 1 contains a flow chart that provides a comprehensive overview of the key calculation components and sequence in which historic expenditures will be adjusted and compared to ESCO Total Revenue to calculate Shared Savings and Shared Losses.[3] This document also contains an example that traces the inputs and outputs of key computational steps for a hypothetical Performance Year for the ESCO.

1.1 Identifying and Aligning Eligible Beneficiaries to the ESCO

CMS will use the process described below to identify eligible beneficiaries – both during Base Years and Performance Years – prior to aligning them to the ESCO operating in the Market in which they receive the majority of their dialysis care.

There are three groups of beneficiaries considered in the financial calculations:

1. *ESCO Beneficiaries* are beneficiaries who meet the eligibility requirements (listed in Section 1.1.1) and are aligned to the ESCO during the Performance Years per the first touch matching methodology (listed in Section 1.1.2).
2. *Eligible BY Beneficiaries* are beneficiaries who would have been aligned to the ESCO during BY1, BY2, or BY3 had the CEC Initiative been operating at that time because they

[1]http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-v2.pdf
[2] http://innovation.cms.gov/files/x/pioneeracobmarkmethodology.pdf
[3] For simplicity, the exhibit shows only the initial three-year performance period.

meet the eligibility requirements (listed in Section 1.1.1) and receive a "first touch" dialysis treatment (discussed in Section 1.1.2) from a Dialysis Facility on the ESCO Participant List. Information for Eligible BY Beneficiaries will be used to produce the Historical Expenditure Baseline for each Eligibility Category.

3. *Reference Group Beneficiaries* are beneficiaries who would be eligible for the CEC Initiative according to the eligibility requirements (listed in Section 1.1.1) but who do not have a "first touch" dialysis treatment (discussed in Section 1.1.2) with the ESCO, a CEC-Non-LDO Entity, or a CEC LDO Entity. Preliminary figures indicate that this nationally representative population of Reference Group Beneficiaries included approximately 317,400 individuals in 2013. Information for Reference Group Beneficiaries will be used to develop Truncation and Trending factors described in Sections 2.4, 2.7, and 3.1.

The paragraphs below describe in greater detail the key concepts and methods used to identify these three categories of beneficiaries.

1.1.1 Identifying Eligible Beneficiaries

To become aligned to the ESCO or another CEC LDO Entity, ESCO Beneficiaries, Eligible BY Beneficiaries, and Reference Group Beneficiaries must meet the following criteria at the time alignment is performed:

- Must be enrolled in Medicare Parts A and B
- Must not be enrolled in a Medicare Advantage plan, cost plan, or other non-Medicare Advantage Medicare managed care plan at the time alignment is performed
- Must be receiving maintenance dialysis services, identified using type of bill 72x
- Must be at least 18 years of age
- Must reside in the United States
- Must not be aligned to another existing Medicare shared savings program (unless otherwise determined by CMS)
- Must not have had a kidney transplant in the last 12 months
- Must have Medicare as the primary payer

1.1.2 Alignment Methodology and Timeline

Alignment through "First Touch." Beneficiaries will be aligned to the ESCO based on their first visit (identified by submission of a 72x claim) to a Dialysis Facility that is affiliated with the ESCO as documented in the claims data. This first touch approach means that a beneficiary's first visit to a given Dialysis Facility will prospectively align that beneficiary to the ESCO in which the Dialysis Facility is a Participant. Beneficiaries will be added to the ESCO via first touch even if the beneficiary has visited another Dialysis Facility previously in the PY that is not participating in a CEC-Non-LDO Entity or a CEC LDO Entity. The beneficiary will be aligned for the Performance Year and for the life of CEC Initiative, assuming that the beneficiary does not lose eligibility status and

the ESCO does not withdraw from the CEC Initiative. If eligible, the beneficiary will remain aligned to the ESCO for the Initial Term even if the beneficiary visits another Dialysis Facility after alignment.

Alignment Prior to the First Performance Year. All beneficiaries who meet eligibility requirements will be prospectively aligned. For the first Performance Year, prior to the Effective Date for the CEC Initiative, the ESCO will receive a list of all of its Eligible BY Beneficiaries. This list will include beneficiaries who meet the eligibility requirements (listed in Section 1.1.1) and who visited the ESCO Dialysis Facility between January 1, 2014 and December 31, 2014 with a three-month claims run-out.

Alignment During the Performance Years. On a monthly basis, eligible beneficiaries will be prospectively added to the aligned population for the ESCO according to the first touch rule. This will occur when a beneficiary first receives maintenance dialysis services from a Dialysis Facility participating in the ESCO and the beneficiary's first claim with that Dialysis Facility is submitted for dialysis services via a 72x claim. CMS will provide an updated list of aligned beneficiaries to the ESCO on a monthly basis. After the end of each Performance Year, CMS will finalize the ESCO's list of aligned beneficiaries for that Performance Year during the reconciliation process described below.

Financial Reconciliation. To be accurate, the alignment process needs to account for circumstances where beneficiaries initially aligned to the ESCO are partially or fully excluded due to death or because the majority of their dialysis care occurred outside of the ESCO's Market area. Alignment will be retrospectively finalized as part of Financial Reconciliation after the first quarter of the following Performance Year to allow for three months of claim run-out (i.e., time after the end of the PY for providers to submit claims for services provided during the PY). For example, the reconciliation process for Performance Year 1 will occur after the first quarter of Performance Year 2.

During reconciliation, CMS will identify the final aligned population for the ESCO, including each beneficiary's aligned months of service within the performance period, as incurred through the end of the Performance Year and allowing for a three month claim run-out. In certain cases, a beneficiary may be removed from the ESCO's list of aligned beneficiaries for the entire performance period or selected Beneficiary-Months may be removed from settlement.

Beneficiaries will be excluded for some or all months in a given Performance Year for the following reasons:

1. Medicare as a secondary payer. All the months during which a patient identifies Medicare as a secondary payer will be removed during Financial Reconciliation. In other words, the ESCO will not be held fiscally responsible for beneficiary costs during months where Medicare is a secondary payer.

2. Kidney transplant. The month in which a beneficiary receives a kidney transplant will be removed during Financial Reconciliation. In addition, the 12 months following transplant will be removed. In other words, the ESCO will not be held fiscally responsible for the costs of the transplant (evaluation, typing, organ acquisition, execution of transplant) and post-transplant care during the month of the transplant and for at least 12 months post-transplant. However, the ESCO will be fiscally responsible for all non-transplant-related costs the beneficiary incurred prior to the transplant. The beneficiary will be removed from the ESCO's list of aligned beneficiaries in the following Performance Year. After 12 months, if a beneficiary is still receiving dialysis services (indicating graft failure) and satisfies all other eligibility requirements, the beneficiary will be eligible for the CEC Initiative.

3. Geographic Exclusions. A beneficiary will be removed from the ESCO's list of aligned beneficiaries for the entire Performance Year if the patient received more than 50 percent of his or her dialysis services from one or more Dialysis Facilities outside of the Market of the ESCO during the Performance Year. The ESCO's Market is defined for the entire duration of the CEC Initiative as no more than two contiguous Medicare core-based statistical areas with permissible inclusion of contiguous rural counties that are not included in a Medicare CBSA. If the ESCO's Dialysis Facilities are not included in any CBSA, the Market is defined as no larger than a state.

1.2 Overview of Financial Calculations

This is an overview and actual calculations will be made in accordance with Sections 2 to 5.
To determine Shared Savings and Losses, CMS will use a multi-step process to assess the ESCO's financial performance annually following the close of each Performance Year.[4] This annual assessment involves a comparison of ESCO Total Revenue and the Total Performance Year Expenditure Benchmark.

The target population for the CEC Initiative is FFS Medicare beneficiaries with ESRD for whom Medicare is the primary payer. Within this population, expenditure calculations will be stratified for each of the following Medicare Eligibility Categories:

- Aged dual: ESRD beneficiaries who are aged and eligible for Medicaid
- Aged non-dual: ESRD beneficiaries who are aged but not eligible for Medicaid
- Disabled dual: ESRD beneficiaries who are disabled and eligible for Medicaid
- Disabled non-dual: ESRD beneficiaries who are disabled but not eligible for Medicaid
- ESRD: ESRD beneficiaries who are not aged or disabled, regardless of whether they are eligible for Medicaid

The calculations underlying this comparison are performed in four major steps that are described in detail below.

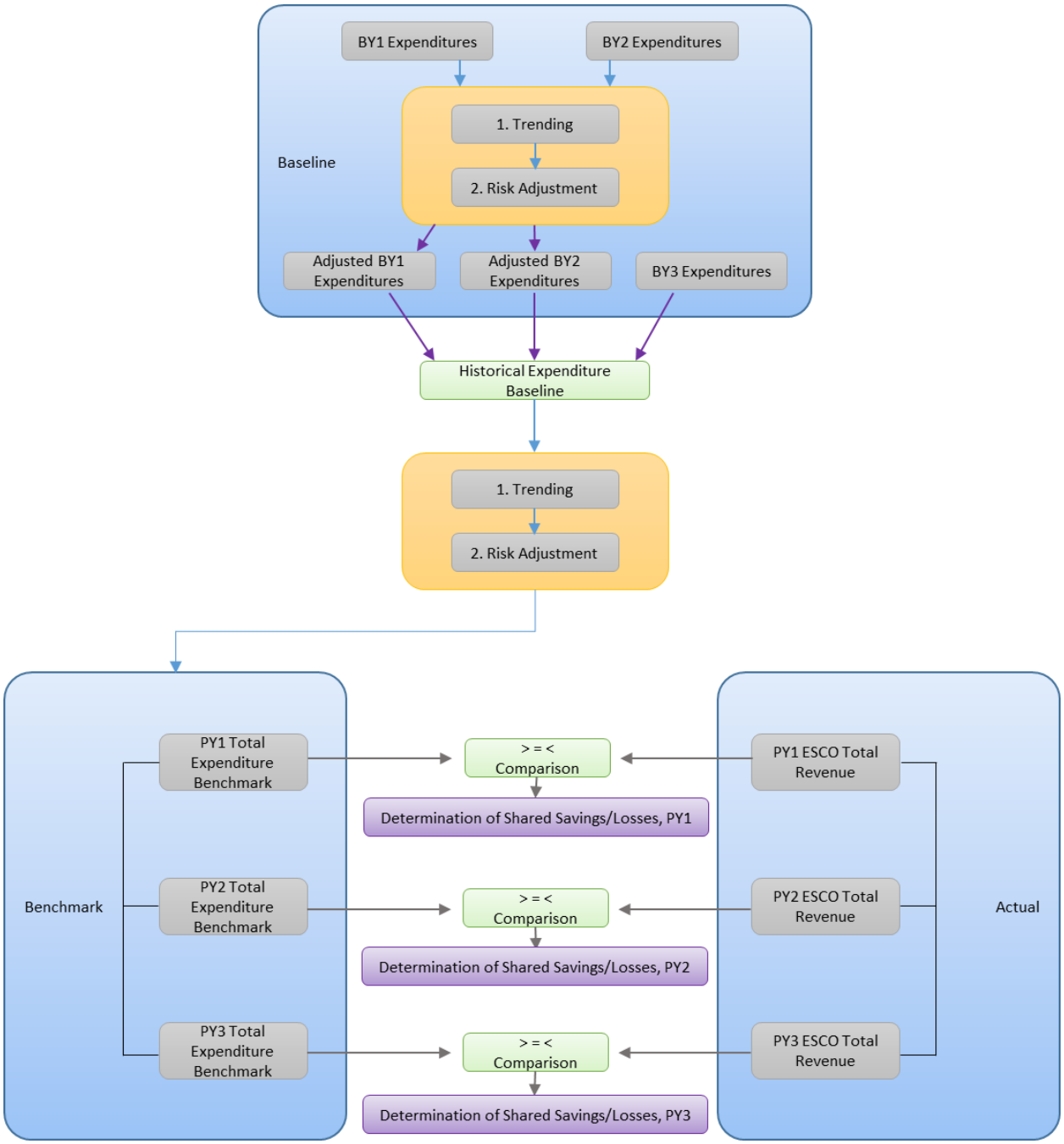
1. **Calculate the Historical Expenditure Baseline for Each Eligibility Category.** This involves adjusting Base Year (BY) 1 and 2 expenditures in a number of ways—exclusion of certain payment amounts (described in Section 2.2), adjustment for sequestration reductions, Annualization, Truncation of outliers, accounting for late-arriving claims, accounting for Eligible BY Beneficiaries with less than a full year of alignment, Trending, accounting for geographic variation in prices, and Risk Adjustment—to make them comparable to BY3 expenditures. BY3 expenditures are also subject to the same adjustments with the exception of Trending and Risk Adjustment. Next, BY1 and BY2 expenditures are averaged with BY3 expenditures to produce a Historical Expenditure Baseline for each Eligibility Category. All expenditure information will be Annualized and expressed on a Per-Beneficiary-Per-Year (PBPY) basis. Adjustments are made separately for each of the five Eligibility Categories. Section 2 explains this process in detail.

2. **Determine Performance Year Expenditure Benchmarks.** For each Performance Year, update the Historical Expenditure Baseline for each Eligibility Category (using Trending and Risk Adjustment) to derive the PY Expenditure Benchmark for each Performance Year for each Eligibility Category. Section 3 details this process.

3. **Calculate ESCO Total Revenue.** Actual Performance Year expenditures are adjusted to exclude certain claims, Annualize expenditures for beneficiaries with partial years of eligibility, Truncate outliers, and account for late-arriving claims. CMS will calculate ESCO Total Revenue. Section 4 details this process.

4. **Determine Shared Savings or Shared Losses.** ESCO Total Revenue is then compared to the Total Performance Year Expenditure Benchmark to calculate Preliminary Shared Savings or Preliminary Shared Losses in a given PY. Adjustments are made to the Preliminary Shared Savings or Preliminary Shared Losses to account for the MSR or MLR, quality scores, Shared Savings Cap or Shared Losses Cap, and sequestration. Section 5 details the determination of Shared Savings and Shared Losses.

Exhibit 1. Overview of ESCO Financial Performance Assessment Methodology



2. CALCULATING THE HISTORICAL EXPENDITURE BASELINES

For each Eligibility Category, the Historical Expenditure Baseline is calculated using Medicare claims data for services delivered during Base Years 1, 2 and 3 (calendar years 2012, 2013, and 2014, respectively) and is expressed on a Per-Beneficiary-Per-Year (PBPY) basis, for the ESCO. The following steps will be used to calculate the Historical Expenditure Baseline for each Eligibility Category:

1. Gather all claims data for Eligible BY Beneficiaries for BY1, BY2, and BY3.
2. Apply adjustments and exclusions to BY1, BY2, and BY3 claims (Sections 2.1 and 2.2).
3. Annualize, Truncate, and apply a Completion Factor to claims and compute weighted average PBPY expenditures for each Baseline Year (Sections 2.3 through 2.6).
4. Trend and Risk Adjust BY1 and BY2 expenditures to be comparable with BY3 expenditures (Sections 2.7 and 2.8).
5. Calculate the simple average of the Risk Adjusted, Trended BY1, BY2, and BY3 expenditures to produce the Historical Expenditure Baseline (Section 2.8, Step 3)

2.1 Dialysis Claims Adjustments

ESRD PPS[5] dialysis claims (billed via 72x) will be handled differently from other types of claims used in the financial calculations. In particular, rather than using the full claim payment amount included in the claims data, which is the adjusted ESRD PPS payment rate, the CEC Initiative will use the ESRD PPS base rate amount for each dialysis treatment. Doing so removes from the financial calculations all of the adjustments to the base rate that CMS uses to calculate dialysis payments under the ESRD PPS. Among other adjustments, this includes geographical price variation and payment reductions under the Quality Incentive Program. The ESRD PPS base rate changes annually and is publicly available from the ESRD PPS final rule.[6]

2.2 Exclusions and Sequestration Adjustment

[5] Beginning January 1, 2011, the Medicare Improvements for Patients and Providers Act mandated the implementation of a bundled payment system for outpatient maintenance dialysis services. This ESRD PPS bundled payment covers a set of dialysis-related items and services routinely required for dialysis treatments. It consists of a base (unadjusted) rate modified by several adjustments at the provider, patient, and claim levels (http://www.usrds.org/2012/pres/USDialysisBundle_impact_NKFCM2012.pdf). Additional information about the ESRD PPS is available from the ESRD PPS final rule: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html.

[6] Dialysis claims are the only claim type from which the CEC Initiative removes geographical variation in expenditures. In the future, CMS may choose to remove geographical variation from other claim types.

The financial calculations will exclude four types of payments — those related to indirect medical education (IME), disproportionate share hospitals (DSH), uncompensated care payments, and those for kidney transplant-related services — and will adjust claim payment amounts for sequestration reductions.[7] Aside from the adjustments discussed throughout this appendix, all other payment information included in the seven Medicare Parts A and B claims files (inpatient, outpatient, carrier, DME, hospice, SNF, and HHA) will be included in the financial calculations. These exclusions and adjustments are described below.

2.2.1 Indirect Medical Education, Disproportionate Share Hospital, and Uncompensated Care Payments

The CEC Initiative's financial calculations will exclude both the capital and operating components of IME and DSH payments applicable to inpatient claims. The uncompensated care payments will also be excluded from the financial calculations.[8]

2.2.2 Kidney Transplant-Related Services

All financial calculations will exclude expenditures related to kidney transplant services in order to avoid creating an incentive for the ESCO to limit kidney transplant services. These services fall into each of the following stages:

1. Evaluation of the recipient and donor
2. Blood and tissue typing of the recipient and donor
3. Organ acquisition
4. Execution of the transplant itself
5. Services following the transplant

Medicare ESRD beneficiaries are excluded from the CEC Initiative once they receive a transplant. The only exception is individuals who still require maintenance dialysis 12 months following the transplant.

2.2.3 Sequestration Adjustment

As part of the Budget Control Act of 2011, payments to Medicare providers were reduced by 2 percent beginning on April 1, 2013. This reduction applies both to claim payments and to Shared Savings calculated under the CEC Initiative. To avoid "double jeopardy," in which Shared Savings would first be calculated using sequestration-adjusted claim payment amounts and then the

[7] In addition to these exclusions, in the future CMS may decide to exclude material changes to provider reimbursement, such as care management fees and quality payments.

[8] Additional information on the uncompensated care payment is available from http://www.medpac.gov/documents/reports/mar14_ch03_appendix.pdf?sfvrsn=0

Shared Savings amounts would also be subject to the 2 percent reduction, the following adjustments will be made:

1. The amount of the sequestration adjustment will be added back to the claim payment amount prior to calculating Shared Savings.
2. The Preliminary Shared Savings will be subject to the 2 percent sequestration reduction, as discussed in Section 5. The resulting amount will be the Shared Savings.

2.3 Annualization

Eligible Beneficiary-Months are months in which a beneficiary was enrolled in Medicare Parts A and B and met all other CEC eligibility criteria. Eligible Beneficiary-Months will be allocated to each Eligibility Category in order to calculate total Medicare FFS expenditures (or Medicare paid amounts) as the sum of expenditures for eligible months for all FFS claims. All expenditure information will be Annualized and expressed as PBPY amounts.

Annualization is required to allow the summing of cost data from Eligible BY Beneficiaries with differing numbers of months of service and to produce PBPY estimates. To implement Annualization, spending is multiplied at the beneficiary level by an Annualization factor, which is equal to 12 divided by the number of eligible Beneficiary-Months. If the ESCO has an Eligible BY Beneficiary with 6 months of alignment, the Annualization factor would equal 12/6 or 2.

Annualized expenditures are calculated separately for each Eligibility Category so that an ESCO Beneficiary can contribute experience to multiple Eligibility Categories in the same year.

2.4 Truncation

Annualized expenditures will then be Truncated to limit financial risk to the ESCO posed by high-cost beneficiary outliers. Outlier Annualized expenditures will be Truncated by capping expenditures at a specific maximum value known as the Truncation threshold or stop-loss limit. The threshold is equal to the 99th percentile of expenditures for non-ESRD FFS Medicare beneficiaries plus the difference between average expenditures for Medicare ESRD beneficiaries (the Reference Group Beneficiaries, discussed in Section 1.1) and average expenditures for non-ESRD FFS Medicare beneficiaries. Similar to Annualization, expenditures are Truncated separately for each Eligibility Category. If an Eligible BY Beneficiary changes Eligibility Categories during a BY, the Eligible BY Beneficiary will contribute experience to multiple Eligibility Categories in the same year.

2.5 Completion Factor

Because the CEC Initiative relies on three months of claims run-out for most financial calculations, expenditure amounts will be adjusted using a Completion Factor to account for claims that may not have been processed as of 3 months after the end of a PY. The Completion Factor will be

calculated based on CY2012 incurred claims data and applied to all years. The incurred claims data would include claims for all Eligible BY Beneficiaries, and beneficiaries who would have been aligned to a CEC Non-LDO Entity or a CEC LDO Entity or who would have been a Reference Group Beneficiary.

The Completion Factor will be equal to total Medicare expenditures for CY2012 claims with processing dates before April 1, 2013, divided by total expenditures for CY2012 services that were processed as of the date that the Government runs its report. The Completion Factor will be applied separately to each Eligibility Category's Annualized and Truncated expenditures.

For example, a Completion Factor of 0.94 would indicate that, for any calendar year, the total expenditure amount available with a three-month run-out period represents 94 percent of the total expenditure amount observed after all claims have been processed. Following with this example, expenditures would be multiplied by 1.06 (that is, 1 ÷ 0.94) to obtain an estimate of the complete expenditure amount.

2.6 Weighted Average of Truncated Expenditures

This section discusses the computation of PBPY expenditures for each of the three BYs, which involves weighting each beneficiary's expenditures to account for partial years of eligibility and then averaging across beneficiaries in each Eligibility Category.

Step 1: Calculate weighting factor. The weighting factor is equal to the number of Beneficiary-Months during which each beneficiary was aligned (in the case of Eligible BY Beneficiaries) or eligible (in the case of Reference Group Beneficiaries) divided by 12.

Step 2: Apply weighting factor. The weighting factor will be multiplied by the Annualized, Truncated, and Completed expenditures resulting from the calculations described in Sections 2.1 through 2.5 to produce weighted expenditures.

Step 3: Calculate weighted average of Truncated expenditures. Weighted expenditures from Step 2 will be added within each of the five Eligibility Categories. Each sum will be divided by total Beneficiary-Years in the Eligibility Category, which is equal to the sum of the weighting factors (from Step 1) within the Eligibility Category.

The weighted average of Truncated expenditures produces PBPY figures by Eligibility Category. Unless specified otherwise, *PBPY* below refers to expenditures that have had the adjustments in Sections 2.1 through 2.6 applied. Exhibit 2 provides hypothetical data produced by these adjustments. This information will be used in the example provided throughout this document.

Exhibit 2. Annualized, Truncated, Completed, and Weighted Base Year PBPY Expenditures

Eligibility Category	BY1 PBPY [1]	BY2 PBPY [2]	BY3 PBPY [3]
Aged dual	$75,000	$80,000	$86,000
Aged non-dual	$65,000	$67,000	$70,000
Disabled dual	$80,000	$82,000	$102,000
Disabled non-dual	$70,000	$73,000	$80,000
ESRD	$50,000	$55,000	$65,000

All values are hypothetical.

2.7 Trending for the Historical Expenditure Baseline

This adjustment consists of Trending BY1 and BY2 PBPY spending forward to be comparable with BY3 spending. This process requires two steps.

Step 1: Use Reference Group Beneficiaries to compute Trending factors. Trending factors will be calculated using PBPY expenditures incurred by the Reference Group Beneficiaries (described in Section 1.1). There will be separate Trending factors for expenditures for beneficiaries in each Eligibility Category. A BY-specific Trending factor is equal to PBPY BY3 expenditures for the Reference Group Beneficiaries divided by the PBPY expenditures for the BY that will be Trended. For example, the Trending factor for BY1 expenditures for ESRD, aged dual beneficiaries will be equal to PBPY BY3 expenditures for ESRD, aged dual Reference Group Beneficiaries divided by PBPY BY1 expenditures for ESRD, aged dual Reference Group Beneficiaries.

Hypothetical Trending factors (*T*) are calculated in columns 4–6 of Exhibit 3. As described earlier, calculations will be stratified by Eligibility Category to capture national trends specific to each group.

Exhibit 3. Trending Factors for Base Years Derived from Reference Group Expenditures

	Hypothetical PBPY Spending for Reference ESRD Population			Trending Factors (Using BY3 as Baseline)		
Eligibility Category	$PBPY^{N}_{BY1}$ [1]	$PBPY^{N}_{BY2}$ [2]	$PBPY^{N}_{BY3}$ [3]	$T_{BY1,BY3}$ [4]	$T_{BY2,BY3}$ [5]	$T_{BY3,BY3}$ [6]
Aged dual	$100,000	$110,000	$120,000	1.20	1.09	1.00
Aged non-dual	$55,000	$60,000	$65,000	1.18	1.08	1.00
Disabled dual	$71,000	$85,000	$90,000	1.27	1.06	1.00
Disabled non-dual	$76,000	$80,000	$85,000	1.12	1.06	1.00
ESRD	$150,000	$170,000	$200,000	1.33	1.18	1.00

Step 2: Apply Trending factors. Trended amounts will be calculated by multiplying PBPY expenditures by the Trending factors calculated in Step 1. This is illustrated in

Exhibit 4, which multiplies the Trending factors from the previous step by the PBPY figures in Exhibit 2.

Exhibit 4. Trended BY Expenditures for Eligible BY Beneficiaries

Eligibility Category	Trending Factors (Using BY3 as Base Year)			Trended Expenditures (Using BY3 as Base Year)		
	$T_{BY1,BY3}$ [1]	$T_{BY2,BY3}$ [2]	$T_{BY3,BY3}$ [3]	*Trended BY1 PBPY* [4]	*Trended BY2 PBPY* [5]	*Trended BY3 PBPY* [6]
Aged dual	1.20	1.09	1.00	$90,000	$87,200	$86,000
Aged non-dual	1.18	1.08	1.00	$76,700	$72,360	$70,000
Disabled dual	1.27	1.06	1.00	$101,600	$86,920	$102,000
Disabled non-dual	1.12	1.06	1.00	$78,400	$77,380	$80,000
ESRD	1.33	1.18	1.00	$66,500	$64,900	$65,000

[4] = [1] × column 1 from Exhibit 2; [5] = [2] × column 2 from Exhibit 2; [6] = [3] × column 3 from Exhibit 2.

2.8 Risk Adjustment of BY Expenditures

This section describes the Risk Adjustment procedure used to adjust BY1 and BY2 expenditures to be comparable to BY3 expenditures.

Step 1: Renormalize Hierarchical Condition Category (HCC) risk scores. The Government calculates prospective HCC risk scores for all Medicare beneficiaries. These HCC risk scores—also known as full risk scores (FRS)—will be divided by a renormalization factor for each applicable beneficiary for every year. This procedure will ensure that all CMS risk scores are scaled so that the average risk score is 1.0 every year. The renormalization factor is the average risk score at the Eligibility Category level.

Step 2: Calculate weighted average risk scores for New Beneficiaries and Established Beneficiaries in every Eligibility Category. After renormalization, for each Eligibility Category, separate weighted average risk scores will be calculated for New Beneficiaries (those who were not enrolled in Medicare during all 12 months of the prior calendar year) and Established Beneficiaries (those who were enrolled for all 12 months of the prior calendar year). For Established Beneficiaries, FRS will be used. For New Beneficiaries, demographic risk scores (DRS) – a risk score calculated using a separate model that incorporates information on beneficiary demographic and entitlement eligibility – will be used. The weight for each beneficiary will be calculated as the number of Beneficiary-Months for the beneficiary divided by the total number of Beneficiary-Months for the Eligibility Category. The same procedure applies to BY2. Hypothetical weighted averages for BY1 appear in columns 1 and 2 of Exhibit 5 and those for BY3 appear in columns 1 and 2 of Exhibit 6.

Step 3: Calculate weighted average risk score for each Eligibility Category. This step calculates an overall average risk score for each Eligibility Category based on the average risk scores for both New Beneficiaries and Established Beneficiaries. The weights that will be used are the

Eligibility Category's proportions of New Beneficiary and Established Beneficiary Beneficiary-Months. In other words, the weight for the New Beneficiary group will be calculated by adding all New Beneficiary Beneficiary-Months and dividing by the total number of Beneficiary-Months for both New Beneficiaries and Established Beneficiaries. Column 4 of Exhibit 5 and Exhibit 6 illustrate for BY1 and BY3, respectively.

Exhibit 5. Weighted Average BY1 Risk Scores by Eligibility Category

Eligibility Category	BY1 Average DRS for New Beneficiaries [1]	BY1 Average FRS for Established Beneficiaries [2]	Proportion of New Beneficiary Beneficiary-Months [3]	Weighted Average Risk Score [4]
Aged dual	1.22	1.80	0.30	1.62
Aged non-dual	1.35	1.40	0.20	1.39
Disabled dual	1.84	1.90	0.40	1.88
Disabled non-dual	0.90	1.70	0.40	1.38
ESRD	1.57	1.20	0.30	1.31

[1] and [2] are hypothetical weighted average risk scores with weights based on Beneficiary-Years.
[3] represents a hypothetical proportion.
[4] = [1] × [3] + [2] × (1 – [3])

Exhibit 6. Weighted Average BY3 Risk Scores by Eligibility Category

Eligibility Category	BY3 Average DRS for New Beneficiaries [1]	BY3 Average FRS for Established Beneficiaries [2]	Proportion of New Beneficiary Beneficiary-Months [3]	Weighted Average Risk Score [4]
Aged dual	1.70	1.90	0.40	1.82
Aged non-dual	1.35	1.40	0.30	1.39
Disabled dual	1.90	2.00	0.30	1.97
Disabled non-dual	1.50	1.60	0.40	1.56
ESRD	1.30	1.20	0.20	1.22

[1] and [2] are hypothetical weighted average risk scores with weights based on Beneficiary-Years.
[3] represents a hypothetical proportion.
[4] = [1] × [3] + [2] × (1 – [3])

Step 4: Convert risk scores into risk score ratios. The overall Eligibility Category weighted average risk scores will be converted into risk score ratios, which are equal to the average risk score for the later year divided by that of the earlier year. Exhibit 7 illustrates the calculation of the BY1/ BY3 risk score ratios.

Exhibit 7. BY1, BY3 Risk Score Ratios

Eligibility Category	BY1 Weighted Average Risk Score [1]	BY3 Weighted Average Risk Score [2]	BY3,BY1 Risk Score Ratio [3]
Aged dual	1.62	1.82	1.12
Aged non-dual	1.39	1.39	1.00
Disabled dual	1.88	1.97	1.05
Disabled non-dual	1.38	1.56	1.13
ESRD	1.31	1.22	0.93

[1] is from Exhibit 5, and [2] is from Exhibit 6.
[3] = [2] ÷ [1]

Step 5: Risk Adjust Trended baseline expenditures. Next, Risk Adjustment is applied to Trended expenditures in Exhibit 4, as illustrated in Exhibit 8. Columns 4 and 5 of the exhibit provide BY1 and BY2 expenditures that are comparable to BY3 expenditures, given in column 6. The figures in columns 4, 5, and 6 form the basis for the Historical Expenditure Baseline calculation in the next step.

Exhibit 8. Risk-Adjusted Base Year Expenditures

Eligibility Category	BY3/BY1 Risk Score Ratio [1]	BY3/BY2 Risk Score Ratio [2]	BY3/BY3 Risk Score Ratio [3]	BY1 Risk-Adjusted PBPY [4]	BY2 Risk-Adjusted PBPY [5]	BY3 Risk-Adjusted PBPY [6]
Aged dual	1.12	1.03	1.00	$100,800	$89,816	$86,000
Aged non-dual	1.00	0.95	1.00	$76,700	$68,742	$70,000
Disabled dual	1.05	1.02	1.00	$106,680	$88,658	$102,000
Disabled non-dual	1.13	0.97	1.00	$88,592	$75,059	$80,000
ESRD	0.93	1.00	1.00	$61,845	$64,900	$65,000

[1], [2], and [3] are hypothetical risk score ratios. [1] comes from Exhibit 7.
[4] = [1] × column 4 from Exhibit 4; [5] = [2] × column 5 from Exhibit 4; [6] = [3] × column 6 from Exhibit 4.

Step 3: Average BY1, BY2, and BY3 Risk-Adjusted PBPY. The Historical Expenditure Baseline is the simple average[9] of the figures in columns 4, 5, and 6 of Exhibit 8, which are the BY3-comparable PBPY expenditures in each year. Column 4 of Exhibit 9 provides the Historical Expenditure Baselines.

[9] The simple average already incorporates weights to account for the number of aligned Beneficiary-Months, as described in Section 2.6.

Exhibit 9. Historical Expenditure Baselines

Eligibility Category	BY1 Risk-Adjusted PBPY [1]	BY2 Risk-Adjusted PBPY [2]	BY3 Risk-Adjusted PBPY [3]	Historical Expenditure Baselines PBPY [4]
Aged dual	$100,800	$89,816	$86,000	$92,205
Aged non-dual	$76,700	$68,742	$70,000	$71,814
Disabled dual	$106,680	$88,658	$102,000	$99,113
Disabled non-dual	$88,592	$75,059	$80,000	$81,217
ESRD	$61,845	$64,900	$65,000	$63,915

[1], [2], and [3] are Risk-Adjusted expenditures from Exhibit 8.
[4] = ([1] + [2] + [3]) ÷ 3

3. CALCULATING THE PERFORMANCE YEAR EXPENDITURE BENCHMARKS

This section describes the calculation of the Performance Year Expenditure Benchmarks that are generated at the close of the PY and used as a basis for assessing whether the ESCO reduced Medicare expenditures. The Performance Year Expenditure Benchmarks are calculated by adjusting the Historical Expenditure Baselines using Trending (Section 3.1) and Risk Adjustment (Section 3.2).

3.1 Trending for the Performance Year Expenditure Benchmarks

To calculate the PY Expenditure Benchmarks, the Historical Expenditure Baseline for each Eligibility Category will be Trended forward based on the sum of 50% of the average percentage of the national growth rate for Reference Group Beneficiary PBPY expenditures (defined in Section 1.1) and 50% of the absolute dollar amount of that growth. Trending for the PY Expenditure Benchmarks requires three steps.

Step 1: Calculate absolute difference in Reference Group Beneficiary Spending. The absolute difference in spending (*D*) is equal to the difference between PBPY Historical Expenditure Baseline for the Reference Group Beneficiaries and PBPY expenditures in the PY for the Reference Group Beneficiaries. Exhibit 10 illustrates using PY1: column 4 calculates the absolute difference in spending between the Historical Expenditure Baseline and PY1 for the Reference Group Beneficiaries.

Step 2: Calculate the Reference Group Beneficiary Trending factor. Trending factors will be calculated using PBPY expenditures for Reference Group Beneficiaries in each Eligibility Category. PY Trending factors are equal to PBPY PY expenditures for the Reference Group Beneficiaries divided by PBPY Historical Expenditure Baseline for the Reference Group Beneficiaries. Column 3 of Exhibit 10 provides hypothetical figures.

Step 3: Trend Historical Expenditure Baseline to PY. The Historical Expenditure Baseline for Eligible BY Beneficiaries will be Trended to be comparable to PY figures by adjusting PBPY using the Trending factor and absolute difference as shown in Exhibit 10. Column 7 of Exhibit 10 shows that PBPY PY1 Trended expenditures are equal to the Historical Expenditure Baseline for the Eligibility Category (Column 1), plus 50 percent of the Trend factor minus one (Column 5) multiplied by the Historical Expenditure Baseline for the Eligibility Category, plus 50 percent of the absolute difference in spending between PY3 and the Historical Expenditure Baseline for the Eligibility Category (Column 6).

Exhibit 10. Trending Historical Expenditure Baseline to PY1

Eligibility Category	Historical Expenditure Baseline PBPY		Reference Group Beneficiaries		Weighted Trending Components Based on Reference Group Beneficiaries		Historical Expenditure Baseline PBPY Trended to PY1
	$PBPY_B$ [1]	$PBPY_{PY1}$ [2]	$T_{B,PY1}$ [3]	$D_{B,PY1}$ [4]	$0.5(T_{B,PY1} - 1)$ [5]	$0.5D_{B,PY1}$ [6]	$Expend_B^{PY1}$ [7]
Aged dual	$92,205	$109,538	1.05	$16,000	0.025	$8,000	$102,510
Aged non-dual	$71,814	$74,359	1.02	$7,000	0.01	$3,500	$76,032
Disabled dual	$99,113	$99,113	0.99	$3,000	–0.005	$1,500	$100,117
Disabled non-dual	$81,217	$94,059	1.06	$4,000	0.03	$2,000	$85,654
ESRD	$63,915	$63,915	1.04	$2,500	0.02	$1,250	$66,443

[1] comes from Exhibit 9.
[2] represents hypothetical PBPY expenditures for PY1 from Exhibit 13.
[3]–[6] are components of the Trending factor, based on the Reference Group Beneficiaries.
[7] is Trended PBPY spending, equal to [1] + [1] × [5] + [6] .

3.2 Risk Adjustment for the Performance Year Expenditure Benchmarks

This section explains the approach used to Risk Adjust the Historical Expenditure Baseline for an Eligibility Category to produce the Performance Year Expenditure Benchmarks.

The Risk Adjustment approach requires the following steps:

Step 1: Choose risk score to be used for Newly-Aligned ESCO Beneficiaries. Newly-Aligned ESCO Beneficiaries can be either new to Medicare (with fewer than 12 months of claims history) or established (with 12 or more months of claims history).

- Demographic risk scores will be used for Newly-Aligned ESCO Beneficiaries in the Performance Years.
- Full risk scores will be used for Established Beneficiaries who are also Newly-Aligned ESCO Beneficiaries in the Performance Years. As described in Section 2.8, full risk scores will be divided by a renormalization factor to ensure that the average risk score is 1.0 every year. The renormalization factor will be calculated as the average risk score across the entire reference population, regardless of Eligibility Category.

Step 2: Choose risk score to be used for Established Beneficiaries who are also Continuously Aligned ESCO Beneficiaries. For Continuously Aligned ESCO Beneficiaries, either the FRS or a demographic-adjusted version of the BY3 FRS will be used. In the case of the PY1 Expenditure Benchmark, the FRS will be used if the PY1/BY3 average FRS ratio for Continuously Aligned ESCO Beneficiaries is lower than 1. Such a ratio would imply that, on average, the PY1 FRS is lower than the BY3 FRS. However, if the ratio is higher than 1 — implying that, on average, the PY1 FRS is

higher than the BY3 FRS — a demographic-adjusted version of the BY3 FRS will be used. The demographic adjustment adjusts the BY3 FRS to account for changes in demographics between BY3 and PY1. The same process will be used for the PY2 and PY3 Expenditure Benchmarks.

Step 3: Calculate weighted average risk score for each Eligibility Category. Similar to Step 3 in Section 2.8, this step calculates an overall weighted average risk score for each Eligibility Category based on the average risk scores separately selected in Step 1 and Step 2. The weights used to produce the average are the Beneficiary-Months of New Beneficiaries and Established Beneficiaries in each Eligibility Category.

Step 4: Convert risk scores into risk score ratios. Similar to Step 4 in Section 2.8, the overall Eligibility Category weighted average risk scores resulting from Step 3 will be converted into risk score ratios, which are equal to the average risk score for the later year divided by that of the earlier year. In this case, the later year is the PY for which the Expenditure Benchmark is being formed, and the earlier year is always BY3.

Step 5: Perform Risk Adjustment. Similar to Step 5 in Section 2.8, the Historical Expenditure Baseline will be multiplied by the risk score ratios. Exhibit 11 illustrates the Risk Adjustment calculations. The Trended expenditures in column 7 of Exhibit 10, reproduced in column 2 of Exhibit 11, are multiplied by the risk score ratios in column 1. The result is shown in column 3, which provides Trended and Risk Adjusted Historical Expenditure Baseline figures.

Exhibit 11. Risk Adjustment of Historical Expenditure Baselines

Eligibility Category	PY1,HB Risk Score Ratio [1]	HB PBPY Spending Trended to PY1 [2]	Trended and Risk-Adjusted PY1 Expenditure Benchmark PBPY [3]
Aged dual	1.12	$102,510	$114,811
Aged non-dual	1.00	$76,032	$76,032
Disabled dual	1.05	$100,117	$105,123
Disabled non-dual	1.13	$85,654	$96,788
ESRD	0.93	$66,443	$61,792

[1] represents hypothetical PY1/HB (Historical Expenditure Baseline) risk score ratios.
[2] shows Historical Expenditure Baseline PBPY Trended to PY1 from Exhibit 10, column [7].
[3] shows Risk-Adjusted expenditures, equal to [1] × [2].

3.3 Apply Discount

In PY2 and subsequent Performance Years, the CEC Initiative will apply a discount to the non-dialysis component of the Performance Year Expenditure Benchmarks. In PY1, the discount will be zero. It will be 1 percent, 2 percent, and 3 percent in PY2, PY3, and PY4 and following years, respectively.

Exhibit 12. Performance Year Expenditure Benchmarks with Discount Applied

	Trended and Risk-Adjusted PY Expenditure Benchmarks			PY Expenditure Benchmarks with Discount Applied		
Eligibility Category	PY1 [1]	PY2 [2]	PY3 [3]	PY1 [4]	PY2 [5]	PY3 [6]
Aged dual	$114,811	$113,932	$114,536	$114,811	$113,248	$113,162
Aged non-dual	$76,032	$80,357	$79,538	$76,032	$79,875	$78,584
Disabled dual	$105,123	$104,892	$105,923	$105,123	$104,263	$104,652
Disabled non-dual	$96,788	$95,285	$97,058	$96,788	$94,713	$95,893
ESRD	$61,792	$65,726	$62,574	$61,792	$65,332	$61,823

[1] provides Trended and Risk Adjusted PY1 Expenditure Benchmark from Exhibit 11.
[2] and [3] provide hypothetical Trended and Risk-Adjusted PY2 and PY3 Expenditure Benchmarks, respectively.
[4], [5], and [6] provide PY1, PY2, and PY3 Expenditure Benchmarks with the discount applied. The discount is zero in PY1, 1% in PY2, and 2% in PY3 and the discount is applied to non-dialysis expenditures only, which account for approximately 60 percent of expenditures for this population.

4. PERFORMANCE YEAR EXPENDITURES

Similar to the Historical Expenditure Baselines process described in Sections 2.1 through 2.6, the following steps will be used to calculate Performance Year expenditures on a PBPY basis:

- Gather all claims data for ESCO Beneficiaries for PY1, PY2, and PY3.
- Apply adjustments and exclusions to PY1, PY2, and PY3 claims (Sections 4.1 and 4.2)[10]
- Annualize, Truncate, and apply a Completion Factor to PY1, PY2, and PY3 claims and compute weighted average PBPY expenditures for each PY (Sections 4.3 through 4.6)

Unlike the Historical Expenditure Baseline, the Performance Year PBPY figures will not be Trended or Risk Adjusted.

4.1 Dialysis Claims Adjustments

As described in Section 2.1, ESRD PPS[11] dialysis claims will be handled differently from other types of claims used in the financial calculations. In particular, rather than the claim payment amount observed in the claims data, the CEC Initiative will use the base rate amount for each dialysis treatment. Doing so removes from the financial calculations all of the adjustments to the base rate that CMS uses to calculate dialysis payments under the ESRD PPS. Among other adjustments, this includes geographical price variation and payment reductions under the Quality Incentive Program. The ESRD PPS base rate changes annually and is publicly available from the ESRD PPS final rule.[12]

4.2 Exclusions and Sequestration Adjustment

The financial calculations will exclude four types of payments — indirect medical education (IME), disproportionate share hospitals (DSH), uncompensated care, and kidney transplant-related services — and will adjust claim payment amounts for sequestration reductions. Additional detail on these exclusions and adjustments is available in Section 2.2. All other expenditure information included in the seven Medicare Parts A and B claims files (inpatient, outpatient, carrier, DME, hospice, SNF, and HHA) will be included in the financial calculations.

[10] In addition to the exclusions listed in Section 4.2, in the future CMS may decide to exclude material changes to provider reimbursement, such as care management fees and quality payments.

[11] Beginning January 1, 2011, the Medicare Improvements for Patients and Providers Act mandated the implementation of a bundled payment system for outpatient maintenance dialysis services. This ESRD PPS bundled payment covers a set of dialysis-related items and services routinely required for dialysis treatments. It consists of a base (unadjusted) rate modified by several adjustments at the provider, patient, and claim levels (http://www.usrds.org/2012/pres/USDialysisBundle_impact_NKFCM2012.pdf). Additional information about the ESRD PPS is available from the ESRD PPS final rule: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html.

[12] Dialysis claims are the only claim type from which the CEC Initiative removes geographical variation in payments.

4.3 Annualization

Annualization is required to allow the summing of cost data from ESCO Beneficiaries with differing numbers of months of service and to produce PBPY estimates. To implement Annualization, spending is multiplied by an Annualization factor, which is equal to 12 divided by the number of Eligible Beneficiary-Months. Annualized expenditures are calculated separately for each Eligibility Category so that an ESCO Beneficiary can contribute experience to multiple Eligibility Categories in the same year. If an ESCO Beneficiary has 6 months of alignment, the Annualization factor would equal 12/6 or 2.

Annualized expenditures are calculated separately for each Eligibility Category so that an ESCO Beneficiary can contribute experience to multiple Eligibility Categories in the same year.

4.4 Truncation

As described in Section 2.4, Annualized expenditures will be Truncated to limit financial risk to the ESCO posed by high-cost beneficiary outliers. Outlier Annualized expenditures will be Truncated by capping expenditures at a specific maximum value known as the Truncation threshold or stop-loss limit. The threshold is equal to the 99th percentile of expenditures for non-ESRD FFS Medicare beneficiaries plus the difference between average expenditures for Medicare ESRD beneficiaries (the reference group, discussed in Section 1.1) and average expenditures for non-ESRD FFS Medicare beneficiaries. Similar to Annualization, expenditures are Truncated separately for each Eligibility Category. If an ESCO Beneficiary changes Eligibility Categories during a PY, the ESCO Beneficiary will contribute experience to multiple Eligibility Categories in the same Performance Year.

4.5 Completion Factor

Because the CEC Initiative relies on three months of claims run-out for most financial calculations, expenditure amounts will be adjusted using a Completion Factor to account for claims that may have not been processed as of 3 months after the end of a PY. As described in Section 2.5, the Completion Factor will be estimated based on CY2012 data and applied to all years. The Completion Factor will be applied separately to each Eligibility Category's Annualized and Truncated expenditures.

4.6 Weighted Average of Truncated Expenditures

This section discusses the computation of PBPY expenditures, which involves weighting each beneficiary's expenditures to account for partial years of eligibility and then averaging across beneficiaries in each Eligibility Category. The process is the same as that described in Section 2.6.

Step 1: Calculate weighting factor. The weighting factor is equal to the number of Beneficiary-Years during which each beneficiary was aligned (in the case of ESCO Beneficiaries) or eligible (in the case of Reference Group Beneficiaries), divided by 12.

Step 2: Apply weighting factor. The weighting factor will be multiplied by the Annualized, Truncated, and Completed expenditures resulting from the calculations described in Sections 4.1 through 4.5 to produce weighted expenditures.

Step 3: Calculate weighted average of Truncated expenditures. Weighted expenditures from Step 2 will be added within each of the five Eligibility Categories. Each sum will be divided by total Beneficiary-Years in the Eligibility Category, which is equal to the sum of the weighting factors (from Step 1) within the Eligibility Category.

The weighted average of Truncated expenditures produces PBPY figures by Eligibility Category. Exhibit 13 provides hypothetical PY1, PY2, and PY3 PBPY expenditures that have been Annualized, Truncated, Completed, and weighted. These expenditures will be used to estimate Preliminary Shared Savings or Losses by comparing them to their respective PY Expenditure Benchmarks. The last row of the exhibit provides an average, weighted by the Beneficiary-Years in Exhibit 14.

Exhibit 13. Hypothetical Performance Year PBPY Expenditures

Eligibility Category	PY1 PBPY	PY2 PBPY	PY3 PBPY
Aged dual	$109,538	$113,568	$120,673
Aged non-dual	$74,359	$76,257	$82,862
Disabled dual	$99,113	$100,839	$106,831
Disabled non-dual	$94,059	$96,287	$101,398
ESRD	$63,915	$65,823	$69,271
Average	**$91,900**	**$91,187**	**$98,456**

All values are hypothetical. Averages are weighted by Beneficiary-Years in Exhibit 14.

Exhibit 14. Hypothetical Performance Year Beneficiary-Years

Eligibility Category	PY1 Beneficiary-Years	PY2 Beneficiary-Years	PY3 Beneficiary-Years
Aged dual	291	166	263
Aged non-dual	260	331	316
Disabled dual	383	414	439
Disabled non-dual	444	530	526
ESRD	153	215	210
Total	**1,532**	**1,656**	**1,754**

5. DETERMINATION OF SHARED SAVINGS AND SHARED LOSSES

Shared Savings and Shared Losses will be calculated at the end of each Performance Year based on a comparison of each year's Total PY Expenditure Benchmark (from Section 3.3) to the same year's ESCO Total Revenue computed based on actual expenditures (from Section 4.6). Section 5.1 provides the steps and examples to illustrate how Shared Savings and Loss will be calculated for the ESCO if it participates in the CEC Initiative for a full Performance Year. Section 5.2 discusses Financial Reconciliation for the ESCO if it voluntarily or involuntarily terminates participation in the CEC Initiative.

5.1 Shared Savings and Shared Losses Calculations if the ESCO Participates in the CEC Initiative for a Full Performance Year

This discussion refers to Exhibit 16, which provides hypothetical figures for two scenarios:

- Scenario A produces Shared Savings
- Scenario B produces Shared Losses

Both scenarios assume the same ESCO and use PY2 figures. The following steps will be used to conduct reconciliation:

- Calculation of Total PY Expenditure Benchmark, ESCO Total Revenue for the PY, and Preliminary Shared Savings or Preliminary Shared Losses (Steps 1, 2, and 3).
- Comparison of Preliminary Shared Savings or Preliminary Shared Losses to the MSR or MLR requirement (Step 4).
- In the case of Shared Savings, the quality threshold will be applied and the Shared Savings Multiplier will be calculated and applied (Steps 5S, 6.1S, and 6.2S).
- In the case of Shared Losses, the Shared Losses Multiplier will be computed and applied (Steps 5L and 6L).
- The Shared Savings Cap or Shared Losses Cap will be applied (Step 7).
- Preliminary Shared Savings will be adjusted for sequestration (Step 8).

Step 1: Calculate Total PY Expenditure Benchmark. For each Beneficiary Category, Multiply the Performance Year Expenditure Benchmark PBPY by Beneficiary-Years for the Performance Year, and then sum across all Eligibility Categories. Column 4 of Exhibit 16 provides the Total PY Expenditure Benchmark (both Scenarios A and B use PY2 as an example, so share the same PY Expenditure Benchmark figures). The PBPY PY Expenditure Benchmark is from Exhibit 12 and includes the guaranteed discount.

Total PY2 Expenditure Benchmark = **$152,628,289**

Step 2: Calculate ESCO Total Revenue. Multiply Performance Year PBPY expenditures by Beneficiary-Years and sum across Eligibility Categories. Column 5 of Exhibit 16 provides the ESCO Total Revenue for each scenario:

Scenario A (Savings) ESCO Total Revenue = **$151,005,307**
Scenario B (Losses) ESCO Total Revenue = **$154,246,298**

Step 3: Calculate ESCO Preliminary Shared Savings or Preliminary Shared Losses. Subtract ESCO Total Revenue from the Total PY Expenditure Benchmark. This produces the following results:

Scenario A Preliminary Shared Savings = $152,628,288 - $151,005,307 = **$1,622,981**
Scenario B Preliminary Shared Losses = $152,628,288 - $154,246,298 = **($1,618,010)**

The difference between Total PY Expenditure Benchmark and ESCO Total Revenue is positive for Scenario A. Therefore, the ESCO has the potential to earn Shared Savings under Scenario A. Because the difference for Scenario B is negative, the ESCO may experience Shared Losses under Scenario B. Whether the ESCO realizes savings or losses depends on the next steps in the determination process.

Step 4: Compare Preliminary Savings or Preliminary Losses to MSR or MLR. The Minimum Savings Rate/Minimum Loss Rate is 1 percent of the Total PY Expenditure Benchmark. To remain eligible for Shared Savings or Losses, the Shared Savings or Loss amount must meet or exceed the MSR or MLR, respectively. Because both scenarios share the same Total PY Expenditure Benchmark, their minimum savings/loss requirements (i.e., the product of the Total PY Expenditure Benchmark and either the MSR or MLR) are the same:

PY2 minimum savings/loss = .01 × $152,628,289 = **$1,526,283**

Because the ESCO's Preliminary Shared Savings under Scenario A exceed the minimum savings requirement, the ESCO remains eligible for Shared Savings. Similarly, because the ESCO's Preliminary Shared Losses under Scenario B exceed the minimum losses requirement, the ESCO remains eligible for Shared Losses. If the ESCO's Preliminary Shared Savings do not meet the minimum savings requirement, the ESCO will not be eligible for a Shared Savings payment. If the ESCO's Preliminary Losses fall below the minimum losses requirement, the ESCO will not be liable for Shared Losses.

Note: Steps 5 and 6 diverge for Shared Savings and Shared Losses. The Shared Savings steps are indicated with an "S" in the step numbering while the Shared Losses steps are indicated with an "L." Steps 7 and 8 are the same for Shared Savings and Shared Losses.

<u>Shared Savings (Scenario A)</u>

Step 5S: Apply quality threshold. If the ESCO achieves Preliminary Shared Savings, CMS will first determine whether the ESCO met minimum thresholds for quality, which will be applicable beginning in PY2. If the ESCO scores below the quality threshold, the ESCO will not be eligible to earn Shared Savings. If the ESCO satisfies the minimum quality requirement, the ESCO will remain eligible to earn Shared Savings. In Scenario A, it is assumed that the ESCO satisfies the minimum quality threshold and therefore the ESCO remains eligible for Shared Savings in this scenario.

Step 6.1S: Compute the Shared Savings Multiplier. If the ESCO satisfies the quality threshold, the ESCO will receive a percentage of Preliminary Shared Savings. This percentage, the Shared Saving Multiplier, is the product of the Shared Savings Percentage and the quality score.

Shared Savings Percentage. The Shared Savings Percentage is 70 percent in PY1 and 75 percent in PY2 and later years.

Quality score. Preliminary Shared Savings will be adjusted for quality in order to provide the ESCO with a financial incentive to deliver quality care. In PY1, the ESCO will be paid for complete reporting on quality measures. There will be two reporting periods for PY1: the first six months of PY1 (July 1, 2015 – December 31, 2015) and the latter 12 months of PY1 (CY 2016). If the ESCO reports all requested quality data during both of these reporting periods and if the ESCO submits these data in a timely fashion, the PY1 quality score will be treated as "1" for the purpose of calculating the Shared Savings Multiplier. If the ESCO does not report all data in a timely fashion, the quality score will be treated as a "0" for the purpose of calculating the Shared Savings Multiplier and the ESCO will be ineligible to receive Shared Savings. In PY2 and later years, the ESCO will be held financially responsible for quality performance. The ESCO's quality score will be calculated as a percentage. For this example, the PY2 quality score is assumed to be 85 percent.

Shared Savings Multiplier. The Shared Savings Percentage and quality score are combined using the following formula to compute the Shared Savings Multiplier.

Shared Savings Multiplier = Shared Savings Percentage × quality score

Under Scenario A, the Shared Savings Percentage is 75 percent and the quality score is 85 percent. Therefore, the Shared Savings Multiplier is:

Shared Savings Multiplier = 0.75 × 0.85 = **0.6375**

Step 6.2S: Apply the Shared Savings Multiplier. The Shared Savings Multiplier is multiplied by Preliminary Shared Savings to compute the multiplier-adjusted Preliminary Shared Savings:

Scenario A multiplier-adjusted Preliminary Shared Savings =
0.6375 × $1,622,981 = **$1,034,651**

<u>Shared Losses</u>

Step 5L: Compute the Shared Losses Multiplier. In the case of Shared Losses, the Shared Losses Percentage and quality score are combined to calculate the Shared Losses Multiplier. In addition, the formula includes a Shared Losses Floor, which is the minimum percentage of Shared Losses that the ESCO must pay, and a Shared Losses Cap, which is the maximum percentage of Shared Losses that the ESCO must pay. The Shared Losses Floor is 50 percent; the Shared Losses Cap is always equal to the Shared Losses Percentage. The following formula will be used:

Shared Losses Multiplier = Shared Losses Floor + Shared Losses Percentage
– (Shared Losses Percentage × quality score)

In PY1, the Shared Losses Percentage is 70 percent; in PY2 and later years, it is 75 percent. As in the Shared Savings case, the quality score is expressed as a percentage after PY1. In PY1, the ESCO will be paid for complete reporting on quality measures. There will be two reporting periods for PY1: the first six months of PY1 (July 1, 2015 – December 31, 2015) and the latter 12 months of PY1 (CY 2016). If the ESCO reports all requested quality data during both of these reporting periods and if the ESCO submits these data in a timely fashion, the PY1 quality score will be treated as "1" for the purpose of calculating the Shared Losses Multiplier. This implies that the ESCO's Shared Losses Multiplier will be equal to the Shared Losses Floor (the ESCO would pay the minimum proportion of Shared Losses to CMS). If the ESCO does not report all data in a timely fashion, the quality score will be treated as "0" for the purpose of calculating the Shared Losses Multiplier. This implies that the ESCO's Shared Losses Multiplier will be equal to the Shared Losses Cap (the ESCO would pay the maximum proportion of Shared Losses to CMS).

For this example, a quality score of 85 percent is assumed. This results in the following Shared Losses Multiplier:

Shared Losses Multiplier = 0.5 + 0.75 – (0.75 × 0.85) = **0.6125**

Because the Shared Losses Multiplier is between the Shared Losses Floor (0.5) and the Shared Losses Cap (0.75, equal to the Shared Losses Percentage), no further adjustment to the multiplier is needed.

Exhibit 15 presents the Shared Losses Multiplier for various quality scores, assuming a Shared Losses Percentage of 75 percent. Column 1 provides the Shared Losses Multiplier prior to applying the Shared Losses Floor and Cap while column 2 provides the Shared Losses Multiplier after application of the Shared Losses Floor or Cap.

Exhibit 15. Shared Losses Multiplier

Quality Score	Shared Losses Multiplier Prior to Applying the Floor and Cap [1]	Shared Losses Multiplier with Floor and Cap Applied [2]
10%	117.50%	75.00%
20%	110.00%	75.00%
30%	102.50%	75.00%
40%	95.00%	75.00%
50%	87.50%	75.00%
60%	80.00%	75.00%
70%	72.50%	72.50%
80%	65.00%	65.00%
85%	61.25%	61.25%
90%	57.50%	57.50%
100%	50.00%	50.00%

Shared Losses Percentage and Shared Losses Cap: 75%
Shared Losses Floor: 50%
[1] = Shared Losses Floor + Shared Losses Percentage – (Shared Losses Percentage × quality score)
[2] = [1] if [1] falls between the Shared Losses Floor and Shared Losses Cap.
[2] = Shared Losses Cap if [1] > Shared Losses Cap.
[2] = Shared Losses Floor if [1] < Shared Losses Floor.

Step 6L: Apply the Shared Losses Multiplier. The Shared Losses Multiplier is multiplied by Preliminary Shared Losses to compute multiplier-adjusted Preliminary Shared Losses:

Scenario B multiplier-adjusted Preliminary Shared Losses =
0.6125 × $1,618,009= **$991,031**

Note: Steps 7 and 8 are the same for Shared Savings and Losses.

Step 7: Apply the Shared Savings or Shared Losses Cap. Preliminary Shared Savings or Preliminary Shared Losses are capped at 10 percent of the Total PY Expenditure Benchmark in PY1 and PY2, and at 15 percent in PY3 and later years. The cap for this example is:

PY2 Shared Savings or Shared Losses Cap = 0.1 × $152,628,289 = **$15,262,829**

The Scenario A multiplier-adjusted Shared Savings amount (from Step 6.2S) of $1,034,651 falls below the PY2 Shared Savings or Shared Losses Cap. Similarly, the Scenario B multiplier-adjusted Preliminary Shared Losses amount (from Step 6.2L) of $991,031 falls below the PY2 Shared Savings or Shared Losses Cap. Therefore, under both Scenarios A and B, the ESCO is subject to the full amount of quality-adjusted Preliminary Shared Savings and Losses.

Step 8: Apply the sequestration adjustment to Preliminary Shared Savings. As described in Section 2.2.3, Preliminary Shared Savings amounts are subject to the 2 percent sequestration reduction. Therefore, sequestration-adjusted Shared Savings for this ESCO under Scenario A are 0.98 × $1,034,651 = **$1,013,958**. The Preliminary Shared Losses (Scenario B) are not subject to

the sequestration adjustment. The final results from the Shared Savings and Shared Losses determination process are:

Scenario A Shared Savings = **$1,013,958**
Scenario B Shared Losses = **$991,031**

Exhibit 16. Calculation of Shared Savings or Shared Losses

Eligibility Category	PY2 Expend Benchmark (PBPY) [1]	PY2 Expend (PBPY) [2]	PY2 Bene-Years [3]	Total PY2 Expenditure Benchmark [4]	PY2 Total Expenditures [5]
Scenario A (Shared Savings)					
Aged dual	$113,248	$113,568	166	$18,753,936	$18,806,861
Aged non-dual	$79,875	$76,257	331	$26,454,553	$25,256,318
Disabled dual	$104,263	$100,839	414	$43,164,736	$41,747,346
Disabled non-dual	$94,713	$96,287	530	$50,190,467	$51,024,407
ESRD	$65,332	$65,823	215	$14,064,596	$14,170,375
Total				**$152,628,288**	**$151,005,307**
Scenario B (Shared Losses)					
Aged dual	$113,248	$119,325	166	$18,753,936	$19,760,220
Aged non-dual	$79,875	$80,624	331	$26,454,553	$26,702,669
Disabled dual	$104,263	$103,545	414	$43,164,736	$42,867,630
Disabled non-dual	$94,713	$93,258	530	$50,190,467	$49,419,279
ESRD	$65,332	$71,983	215	$14,064,596	$15,496,500
Total				**$152,628,288**	**$154,246,298**

Both scenarios use PY2 as an example.
[1] comes from Exhibit 12.
For Scenario A (Shared Savings), [2] comes from Exhibit 13. For Scenario B (Shared Losses), [2] contains new hypothetical figures.
[3] comes from Exhibit 14
[4] = [1] × [3]; [5] = [2] × [3]

5.2 Shared Savings Determination if the ESCO Does Not Participate in the CEC Initiative for a Full Performance Year

Because participation in the CEC Initiative is voluntary, the ESCO may choose to end its participation in the CEC Initiative at any time (voluntary termination). In addition, there are circumstances under which CMS will terminate the ESCO's participation in the CEC Initiative (involuntary termination). This section describes Financial Reconciliation for the ESCO if it leaves the CEC Initiative before a PY's completion. Section 5.1 describes Financial Reconciliation for the ESCO if it participates in the CEC Initiative for a full Performance Year.

Voluntary and involuntary termination have different implications for Financial Reconciliation:

- *Voluntary termination:*

- CMS will not conduct Financial Reconciliation if the ESCO gives notice of voluntary termination prior to May 1 of a Performance Year. The ESCO will not be eligible for Shared Savings or liable for Shared Losses.
- CMS may, at its discretion, conduct Financial Reconciliation if the ESCO gives notice of voluntary termination after May 1 of a Performance Year. If CMS chooses to conduct Financial Reconciliation, the ESCO may be eligible to receive Shared Savings and may be liable for Shared Losses.

- *Involuntary termination:* CMS may, at its discretion, conduct Financial Reconciliation for the ESCO if the ESCO is involuntarily terminated. If CMS chooses to conduct Financial Reconciliation, the ESCO may be eligible to receive Shared Savings and may be liable for Shared Losses.

If the ESCO only participates for part of the Performance Year and if CMS performs Financial Reconciliation for the ESCO, then Financial Reconciliation will occur at the same time, several months after the close of the Performance Year, as it does for other CEC LDO Entities. This timing will allow for three months of claims run-out, development of HCC risk scores, and calculation of quality scores. The remainder of this section discusses the details of the methodology that will be used to conduct Financial Reconciliation for the ESCO. Financial Reconciliation will occur at CMS's discretion, and CMS reserves the right to adjust the approach described herein.

5.2.1 Expenditures Included in Reconciliation

Financial Reconciliation will consider expenditures with dates of service on or after the first day of the Performance Year and prior to the date on which the ESCO discontinues participation in the CEC Initiative.

5.2.2 Risk Adjustment

Risk scores for use in the Risk Adjustment process are estimated monthly based on diagnoses from the prior calendar year. For this reason, the risk scores used for the months in which the ESCO participated will be the same as those that would have been used if the ESCO remained in the CEC Initiative throughout the Performance Year.

5.2.3 Quality Adjustment

At the end of each Performance Year, Shared Savings and Shared Losses will be calculated based on a comparison of the Total PY Expenditure Benchmark and ESCO Total Revenue. The result of this calculation is then adjusted in several steps, as described in Section 5.1. The quality score enters Financial Reconciliation because it is used to determine whether the ESCO has satisfied the quality threshold, and it is also used to calculate the Shared Savings and Shared Losses Multipliers. If the ESCO gives notice of voluntary termination on or after May 1, it will be subject to the same procedures as participating in the CEC Initiative for a full Performance Year. The quality score will be based on all the quality information available throughout the Performance

Year, including quality data collected after the ESCO left the CEC Initiative because the ESCO is required to continue quality data submission throughout the Performance Year.

If a partial-year ESCO fails to report quality information, the ESCO will receive the lowest quality score possible given the quality data already submitted during the portion of the year during which the ESCO participated. This would likely produce a quality score that fails to satisfy the minimum quality threshold. Consequently, the ESCO will likely be ineligible to receive Shared Savings. If a partial-year ESCO fails to report quality information and has Shared Losses, the Shared Losses Multiplier will be calculated using the lowest quality score possible given the quality data already submitted during the portion of the year during which the ESCO participated. This will likely result in the maximum Shared Losses Multiplier of 75 percent.

5.2.4 Minimum Savings Rate and Minimum Loss Rate

Among the other requirements described in Section 5.1, to be eligible to receive Shared Savings, Preliminary Shared Savings must exceed the MSR. To be required to pay back Shared Losses, Preliminary Shared Losses must exceed the MLR. If the ESCO terminates participation before the completion of the full Performance Year, the ESCO's MSR and MLR will be identical to the MSR and MLR applicable in a full Performance Year.

Additionally, to be eligible to receive Shared Savings, the ESCO must have at least 350 ESCO Beneficiaries for each Performance Year. If fewer than 350 ESCO Beneficiaries are aligned to the ESCO during a Performance Year, the ESCO shall be placed on a corrective action plan. CMS may terminate this Agreement if the number of ESCO Beneficiaries remains under 350 as of the date specified in the corrective action plan. Additionally, CMS may specify a higher MSR or MLR if the ESCO has fewer than 350 ESCO Beneficiaries for a Performance Year.

ATTACHMENT: FINANCIAL REPORTING TO THE ESCO

CMS plans to report to the ESCO on a continuous basis to support care improvement efforts. Exhibit 17 outlines examples of the types of reports that CMS plans to share with the ESCO. CMS intends to work with the ESCO to better understand reporting needs; hence, the information reported may change over the course of the CEC Initiative.

Exhibit 17. Examples of Financial Reporting

Report	Frequency	Overview of Content
Historical Expenditure Baseline report	Prior to the start of PY1	▪ Information on BY1, BY2, and BY3 ▪ Number of ESCO Beneficiaries and aligned Beneficiary-Years ▪ ESCO Beneficiary expenditures by Eligibility Category ▪ ESCO Beneficiary per capita expenditures ▪ ESCO Beneficiary Per Beneficiary Per Year expenditures ▪ Trending and Risk Adjustment information
Quarterly expenditure report	Quarterly (Including a three month claims run-out)	▪ Number of ESCO Beneficiaries and aligned Beneficiary-Years for the current PY quarter ▪ ESCO Beneficiary expenditures for the current quarter ▪ Historical Expenditure Baseline amount by Eligibility Category, repeated from the Historical Expenditure Baseline report ▪ Aligned beneficiary proportions for the current PY quarter
Utilization report	Quarterly (Including a three month claims run-out)	▪ Use rates for ESCO Beneficiaries ▪ Use metrics cover inpatient, emergency, post-acute, diagnostic, laboratory, outpatient, vascular access, dialysis, physician, durable medical, and ambulance services.
Monthly expenditure report	Monthly (Does not include a three month claims run-out)	▪ Number of ESCO Beneficiaries and aligned Beneficiary-Years for the current PY month ▪ Actual expenditures per ESCO Beneficiary by Eligibility Category ▪ Actual expenditures per ESCO Beneficiary, disaggregated by: - Part A: Inpatient, skilled nursing facility (SNF), home health agency (HHA), hospice - Part B: Carrier, outpatient, durable medical equipment (DME)
Initial beneficiary list	Once (Prior to beginning of PY1)	▪ The ESCO prospectively aligned list of beneficiaries for the start of PY1 ▪ Includes each ESCO Beneficiary's identifier (HICN), last name, first name, state of residence, ZIP code of residence, birth date, and first-touch Dialysis Facility name

Report	Frequency	Overview of Content
Monthly beneficiary list	Monthly	▪ Cumulative list of ESCO Beneficiaries provided to the ESCO monthly during the Performance Year ▪ Beneficiaries who lose eligibility throughout the Performance Year will remain on the list ▪ Includes each aligned beneficiary's identifier (HICN), last name, first name, state of residence, ZIP code of residence, birth date, and first-touch Dialysis Facility name
Performance Year beneficiary list	Annually (In April of each PY starting in PY2)	▪ List of aligned beneficiaries with whom the ESCO will begin the Performance Year ▪ Beneficiaries who lose eligibility in the previous Performance Year will be excluded from the list ▪ Includes each ESCO Beneficiary's identifier (HICN), last name, first name, state of residence, ZIP code of residence, birth date, and first-touch Dialysis Facility name
Reconciled beneficiary list	Annually (In April after the three month claim run-out)	▪ Finalized list of aligned beneficiaries for the previous Performance Year. ▪ Beneficiaries who lose eligibility in the previous Performance Year will be excluded from the list ▪ The reasons for beneficiary exclusions will be specified ▪ Includes each ESCO Beneficiary's identifier (HICN), last name, first name, state of residence, ZIP code of residence, birth date, and first-touch Dialysis Facility name
Monthly claims lag report	Monthly	▪ Actual expenditures using debit-credit methodology ▪ Total calendar-year-to-date expenditures ▪ Total uncapped expenditures ▪ Comparison of the month in which a payment was made vs. the month in which the service was delivered, disaggregated by inpatient, SNF, HHA, hospice, carrier, outpatient, and DME
Claim and claim-line feeds	Monthly	▪ Claims for all services covered by Part A and Part B that were provided to beneficiaries who agreed to data sharing and were processed during the prior month ▪ The ESCO will receive one Part A claim header file including Part A diagnosis and Part A procedure codes; a claim line file consisting of the line details from Parts A, B, and D; a beneficiary demographics file; and one beneficiary Health Insurance Claim Number cross-reference file.
Expenditure Benchmark report	Annually (Includes a three month claims run-out)	▪ Historical Expenditure Baseline information (repeated from the Historical Expenditure Baseline Report) ▪ Trend and Risk Adjustment factors ▪ ESCO Beneficiaries and Beneficiary-Years ▪ Performance Year Expenditure Benchmark to be used in Financial Reconciliation

Report	Frequency	Overview of Content
Annual settlement reports	Annually (Includes a three month claims run-out)	▪ Number of ESCO Beneficiaries and aligned Beneficiary-Years ▪ Per capita and Per Beneficiary Per Year ESCO Beneficiary expenditures and per capita and Per Beneficiary Per Year PY Expenditure Benchmarks ▪ Total ESCO Beneficiary expenditures and PY Expenditure Benchmarks ▪ Shared Savings, MSR, and Preliminary Shared Savings calculations