End-Stage Renal Disease Treatment Choices (ETC) Model Finalized

By Mallika Mendu and David White

In September 2020, the Centers for Medicare & Medicaid Services (CMS) and its Innovation Center (CMMI) finalized the End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model. This model will test changes to care for Americans with kidney disease within a 30%, randomized set of Medicare beneficiaries with ESRD. The stated goals are increasing patient choice, increasing utilization of home dialysis, and providing greater access to transplantation, options for which the American Society of Nephrology (ASN) has long advocated.

The government will use hospital referral regions (HRRs) to randomize participation. Within those selected HRRs, both dialysis units, "facility," and nephrologists, "managing clinicians," will be included. Nephrologists will be organized in the model at the nephrology practice level and identified based on their primary practice zip code. The model excludes ESRD patients with Medicare Advantage (MA), children, hospice and nursing facility and skilled nursing facility patients, acute kidney injury-D (AKI-D), and those with dementia. The model runs from January 21, 2021, through June 30, 2027.

The 80% combined home dialysis and preemptive transplant rate discussed in the proposed rule was not finalized. Also, after the first two years of the program, benchmarking specifics become vague. However, the model indicates that future rulemaking is likely, allowing for future changes.

ASN had strongly advocated for ways to aggregate at the HRR level to account for home dialysis–only facilities within a practice or company—particularly if an institution sends its home dialysis patients to such a provider. In the final rule, CMMI allows for aggregation of facilities owned by the same company in a selected HRR as well as nephrology practices in an HRR. CMMI, however, did not create a virtual relationship as ASN advocated to be used where, for example, an institution has an arrangement to send all its home patients to a provider not owned by the institution. ASN is investigating how to address this potential gap.

ASN has strongly urged CMMI to examine stronger methods to risk adjust for or accommodate issues such as housing insecurity, socioeconomic status, or social determinants of health. ASN is encouraged that in the final rule the Innovation Center supports examining methodology to address these vital issues that impact health equity through future rulemaking. The final rule did indicate openness on this issue: "We seek input from the public on how to construct a risk adjustment methodology for the home dialysis rate that could account for socioeconomic factors, like the one from the Hospital Readmissions Reduction Program, to inform any future rulemaking on this topic" (1). The rule also indicated CMMI "will assess use of homelessness Z-codes Z59.7–.9."

Scoring under the model is weighted to two-thirds home dialysis rate blended with a one-third transplant waitlist or living donor rate. The proposed rule had tied the transplant rate to actual transplantation rates, but the finalized rule uses a blended approach of transplant waitlisting for deceased donation with an actual living donor transplant rate.

The Home Dialysis Payment Adjustment (HDPA) remained the same as the proposed rate, with a 3% bonus in calendar year (CY) 2021, 2% in CY 2022, 1% in CY 2023, and penalty points reduced by 2% across the board. There was minor adjustment of the Performance Payment Adjustment (PPA).

"We were pleased to see that CMMI adopted many of ASN's recommendations to improve the model and ensure its success on behalf of patients," said ASN President Anupam Agarwal, MD, FASN. "The society stands ready to work with its members and kidney patient organizations to achieve high quality outcomes for kidney patients through this model. In the United States, only 12% of the total dialysis population use home dialysis despite the evidence of improved outcomes and quality of life. We can, and we will, do better."

Dr. Agarwal added, "Together, both the finalized ETC Model and the Kidney Care Choices Model represent substantive efforts to improve patient access and choice, by focusing upstream to slow the progression of kidney disease, encouraging access to and use of home dialysis, and increasing preemptive transplants and the overall transplant rate."

The ETC Model resulted from broader government efforts to realign kidney care payments to incent innovation, increased modality choices for patients, increased rates of kidney transplantation, and reduced rates of progression to kidney failure. The implementation period for the Kidney Care First (KCF) program has begun, and the program commences April 1, 2021.

At the same time CMS finalized the ETC rule, the Health Resources and Services Administration (HRSA) issued a final rule amending regulations implementing the National Organ Transplant Act of 1984 to remove financial barriers to organ donation by expanding the scope of reimbursable expenses incurred by living organ donors to include lost wages, and child- and elder-care expenses incurred by a caregiver.

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Reference

1. 42 CFR Part 512 [CMS-5527-F] RIN 0938-AT89 Medicare Program; Specialty Care Models to Improve Quality of Care and Reduce Expenditures