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CMMI End-Stage Renal Disease Treatment Choices Model
HFMA Overview

Summary
On July 10, 2019, the Center for Medicare & Medicaid Innovation (CMMI) proposed the End-Stage Renal Disease (ERSD) Treatment Choices (ETC) Model, a six-and-a-half-year mandatory payment model focused on beneficiaries with ESRD. The model is designed to increase the use of in-home dialysis (as opposed to in-facility, which is the predominant model) and kidney transplantation rates by adjusting payments to clinicians and ESRD facilities based on their patients' rates of home dialysis and transplantation.

The model will run from January 1, 2020 through June 30, 2026. The Center for Medicare & Medicaid Services (CMS) estimates:

- The ETC Model will save a net total of $185 million from the Performance Payment Adjustment (PPA) and the Home Dialysis Payment Adjustment (HDPA).
- CMS also expects the ETC Model would cost an additional $15 million, resulting from increases in education and training costs.
    - Therefore, the net impact to Medicare spending is estimated to be $169 million in savings as a result of the ETC Model.

Participation
All Medicare-certified ESRD facilities and Medicare-enrolled managing clinicians located in a selected geographic area are required (unless they qualify for a low-volume exclusion, described below) to participate in the ETC Model. CMS will establish the geographic areas by selecting a random sample of 50% of Hospital Referral Regions (HRRs), stratified by Census-defined regions (Northeast, South, Midwest and West), as well as all HRRs for which at least 20% of the component zip codes are located in Maryland. CMS excludes all U.S. territories from the selected geographic areas. CMS will identify the HRRs in the final rule.

CMS excludes an ESRD facility that has fewer than 11 attributed beneficiaries from a measurement year (MY) from payment adjustments related to the model in the corresponding payment period. Managing clinicians who fall below the low-volume threshold during a MY are also excluded from payment adjustments in the corresponding payment year. The low-volume threshold is set at the bottom 5% of ETC participants who are managing clinicians in terms of the number of beneficiary-years for which the managing clinician billed the Monthly Capitation Payment (MCP) during the MY.

Payment model
The ETC Model will test the effectiveness of adjusting Medicare payments to ESRD facilities and managing clinicians — clinicians who bill the MCP paid under the ESRD Prospective Payment System (PPS) for managing ESRD Beneficiaries — to encourage greater utilization of home dialysis and kidney transplantation, support beneficiary modality choice, reduce Medicare expenditures and preserve or enhance the quality of care.

The proposed ETC Model would include two payment adjustments. The first adjustment, the HDPA, would be a positive adjustment to the MCP paid to the managing clinician on certain home dialysis and

home dialysis-related claims (CPT codes 90965 and 90966) during the initial three years of the model (CY2020 +3%, CY2021 +2% and CY2022 +1%).

The second adjustment, the PPA, would be a positive or negative adjustment on dialysis and dialysis-related Medicare payments, for both home dialysis and in-center dialysis, based on ESRD facilities' and managing clinicians' rates (as calculated from claims data, Medicare administrative data and transplant registry data) of kidney and kidney-pancreas transplants and home dialysis among attributed beneficiaries during the applicable measurement year (MY). Each MY would have a corresponding PPA period — a six-month period, which would begin six months after the conclusion of the MY. CMS would adjust certain payments for ETC participants during the PPA period based on the ETC participant's home dialysis rate and transplant rate during the corresponding MY.

The first MY begins on January 1, 2020, and the final MY ends on June 30, 2025. The first PPA period begins on July 1, 2021, and the final PPA period ends on June 30, 2026. Table I in the appendix maps measurement years to performance payment adjustment years.

CMS will measure home dialysis rates for ESRD facilities and managing clinicians in the ETC Model by calculating the percent of dialysis treatment beneficiary years during the MY in which attributed beneficiaries received dialysis at home. The home dialysis rate will be risk adjusted using the most recent final risk score for the beneficiary available at the time of the calculation of the home dialysis rate, calculated using the CMS-HCC (Hierarchical Condition Category) ESRD Dialysis Model used for risk adjusting payment in the Medicare Advantage program.

Transplant rates for ESRD facilities and managing clinicians will be based on the number of attributed beneficiaries who received a kidney or kidney-pancreas transplant during the MY (including pre-emptive transplants) out of all attributed dialysis treatment beneficiary years during the MY. The transplant rate is risk adjusted by beneficiary age with separate risk coefficients for the following age categories of beneficiaries, with age computed on the last day of each month of the MY:

- 18 to 55
- 56 to 70
- 71 to 74

The transplant rate is adjusted to account for the relative percentage of the population of beneficiaries attributed to the ETC participant in each age category relative to the national age distribution of beneficiaries not excluded from attribution.

CMS assesses the home dialysis rate and transplant rate for each ETC participant against the applicable benchmarks to calculate an achievement and improvement score. Each ETC participant's MPS is the weighted sum of the higher of the achievement score or the improvement score for the ETC participant's home dialysis rate and transplant rate.

CMS assesses ETC participant performance on the home dialysis rate and transplant rate against benchmarks constructed based on the home dialysis rate and transplant rate among ESRD facilities and managing clinicians located in comparison geographic areas during the benchmark year. CMS uses the following scoring methodology to assess an ETC participant's achievement score as illustrated in the table below.

ETC Achievement Score Methodology

Points	Benchmark Percentile
2 Points	*90th+ Percentile of benchmark rates for comparison geographic areas during the benchmark year*
1.5 points	*75th+ Percentile of benchmark rates for comparison geographic areas during the benchmark year*
1 Point	*50th+ Percentile of benchmark rates for comparison geographic areas during the benchmark year*
.5 Points	*30th+ Percentile of benchmark rates for comparison geographic areas during the benchmark year*
0 Points	*<30th Percentile of benchmark rates for comparison geographic areas during the benchmark year*

CMS assesses ETC participant's improvement on the home dialysis rate and transplant rate against benchmarks constructed based on the ETC participant's historical performance on the home dialysis rate and transplant rate during the benchmark year. CMS uses the following scoring methodology to assess an ETC participant's improvement score.

ETC Improvement Score Methodology

Points	Benchmark Percentile
1.5 points	*Greater than 10 percent improvement relative to the benchmark year rate*
1 Point	*Greater than 5 percent improvement relative to the benchmark year rate*
.5 Points	*Greater than 0 percent improvement relative to the benchmark year rate*
0 Points	*Less than or equal to the benchmark year rate*

CMS calculates the ETC participant's MPS as the higher of ETC participant's achievement score or improvement score for the home dialysis rate, together with the higher of the ETC participant's achievement score or improvement score for the transplant rate, weighted such that the ETC participant's score for the home dialysis rate constitutes two-thirds of the MPS, and the ETC participant's score for the transplant rate constitutes one-third of the MPS. CMS uses the following formula to calculate the ETC participant's MPS:

= 2 x (higher of home dialysis rate achievement or improvement) + (higher of transplant rate achievement or improvement score)

The magnitude of the positive and negative PPAs for ETC participants would increase over the course of the model for facilities and managing clinicians as illustrated in Tables II and III in the appendix. These PPAs would begin July 1, 2021, and end June 30, 2026.

Quality measures/impact on payment

As part of the monitoring strategy, CMS proposes using two quality measures for the ETC Model:

- Standardized Mortality Ratio (SMR); NQF #0369
- Standardized Hospitalization Ratio (SHR); NQF #1463

Beneficiary attribution and impact
CMS attributes ESRD beneficiaries to an ETC participant for each month during a MY based on the ESRD beneficiary's receipt of dialysis services during that month, for the purpose of assessing the ETC participant's performance on the home dialysis rate and transplant rate during that MY.

An ESRD beneficiary is attributed to the ESRD facility at which the ESRD beneficiary received the plurality of his or her dialysis treatments in that month, as identified by claims with Type of Bill 072X, with claim through dates during the month. If the ESRD Beneficiary receives an equal number of dialysis treatments from two or more ESRD facilities in a given month, CMS attributes the ESRD beneficiary to the ESRD facility at which the beneficiary received the earliest dialysis treatment that month. CMS does not attribute pre-emptive transplant beneficiaries to ESRD facilities.

An ESRD beneficiary is attributed to a managing clinician who is an ETC participant for a month if that managing clinician submitted an MCP claim for services furnished to the beneficiary, identified with CPT codes 90957, 90958, 90959, 90960, 90961, 90962, 90965 or 90966, with claim through dates during the month. A pre-emptive transplant beneficiary is attributed to the managing clinician with whom the beneficiary had the most claims between the start of the MY and the month in which the beneficiary received the transplant for all months between the start of the MY and the month of the transplant.

CMS does not attribute an ESRD beneficiary or a pre-emptive transplant beneficiary to an ETC participant for a month if, at any point during the month, the ESRD beneficiary or the pre-emptive transplant beneficiary:

1. Is not enrolled in Medicare Part B
2. Is enrolled in Medicare Advantage, a cost plan or other Medicare managed care plan
3. Does not reside in the United States
4. Is younger than 18 years of age
5. Has elected hospice
6. Is receiving dialysis for acute kidney injury (AKI) only
7. Has a diagnosis of dementia

The ETC Model will not allow beneficiaries to opt out of the payment methodology; however, the model would not restrict a beneficiary's freedom to choose an ESRD facility or managing clinician, or any other provider or supplier. ETC participants would be subject to the general provisions protecting beneficiary freedom of choice and access to medically necessary services.

Program waivers
CMMI proposes using its authority to implement the following waivers to execute the model:

1. *Beneficiary cost sharing.* The payment adjustments under the ETC Model described in this subpart do not affect the beneficiary cost-sharing amounts for Part B services furnished by ETC participants under the ETC Model.

2. *Kidney Disease Education (KDE) benefit waivers.* CMS waives the requirement that only doctors, physician assistants, nurse practitioners and clinical nurse specialists can furnish KDE services to allow education to be provided by clinical staff under the direction of, and incident to the services of, the managing clinician who is an ETC participant.

CMS waives the requirement that the KDE is covered only for Stage IV chronic kidney disease (CKD) patients to permit beneficiaries diagnosed with CKD Stage V or within the first six months of receiving a diagnosis of ESRD to receive the KDE benefit.

Additional information

CMMI is posting additional materials on the model's webpage. It can be accessed at: https://innovation.cms.gov/initiatives/esrd-treatment-choices-model/

Appendix

Table I: MODEL SCHEDULE OF MEASUREMENT YEARS AND PPA PERIODS

Model Year	Measurement Year (MY)	Performance Payment Adjustment (PPA) Period
Beginning CY 2020	MY 1 - 1/ 1/2020 through 12/31/2020	PPA Period 1 - 7 /1/2021 through 12/31/2021
	MY 2 - 7/1/2020 through 6/30/2021	PPA Period 2 - 1/1/2022 through 6/30/2022
Beginning CY 2021	MY 3 - 1/1/2021 through 12/31/2021	PPA Period 3 - 7 /1/2022 through 12/31/2022
	MY 4 - 7/1/2021 through 6/30/2022	PPA Period 4 - 1/1/2023 through 6/30/2023
Beginning CY 2022	MY 5 - 1/1/2022 through 12/31/2022	PPA Period 5 - 7/1/2023 through 12/31/2023
	MY 6 - 7/1/2022 through 6/30/2023	PPA Period 6 - 1/1/2024 through 6/30/2024
Beginning CY 2023	MY 7 - 1/ 1/2023 through 12/31/2023	PPA Period 7 - 7/1/2024 through 12/31/2024
	MY 8 - 7/1/2023 through 6/30/2024	PPA Period 8 - 1/1/2025 through 6/30/2025
Beginning CY 2024	MY 9 - 1/1/2024 through 12/31/2024	PPA Period 9 - 7/1/2025 through 12/31/2025
	MY 10 - 7/1/2024 through 6/30/2025	PPA Period 10 - 1/1/2026 through 6/30/2026

Table II: FACILITY PPA AMOUNTS AND SCHEDULE

	MPS	Performance Payment Adjustment Period				
		1 and 2	3 and 4	5 and 6	7 and 8	9 and 10
Facility Performance Payment Adjustment	≤ 6	+5.0%	+6.0%	+7.0%	+8.0%	+10.0%
	≤ 5	+2.5%	+3.0%	+3.5%	+4.0%	+5.0%
	≤ 3.5	0.0%	0.0%	0.0%	0.0%	0.0%
	≤ 2	-4 .0%	-4.5%	-5.0%	-6.0%	-6.5%
	≤ .5	-8.0%	-9.0%	-10.0%	-12.0%	-13. 0%

Table III: CLINICIAN PPA AMOUNTS AND SCHEDULE

	MPS	Performance Payment Adjustment Period				
		1 and 2	3 and 4	5 and 6	7 and 8	9 and 10
Clinician Performance Payment Adjustment	≤ 6	+5.0%	+6.0%	+7.0%	+8.0%	+10.0%
	≤ 5	+2.5%	+3.0%	+3.5%	+4.0%	+5.0%
	≤ 3.5	0.0%	0.0%	0.0%	0.0%	0.0%
	≤ 2	-3.0%	-3.5%	-4.0%	-4.5%	-5.5%
	≤.5	-6.0%	-7.0%	-8.0%	-9.0%	-11.0%