

CMS Perspective:

Comprehensive ESRD Care (CEC) Model

Third Annual Evaluation Report and Next Steps in CEC

November 2020

For information on CEC model and to download the independent evaluation report discussed in this document, please visit

<https://innovation.cms.gov/innovation-models/comprehensive-esrd-care>



**U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
Research and Rapid Cycle Evaluation Group & Seamless Care Model Group
2810 Lord Baltimore Drive, Suite 130
Baltimore, MD 21244**

The Centers for Medicare & Medicaid Services (CMS) launched the Comprehensive ESRD Care Model (CEC) in 2015 to test whether alternative payment arrangements would improve care and reduce the cost of care for Medicare beneficiaries with End-Stage Renal Disease (ESRD). Similar to other Accountable Care Organization models, CEC creates financial incentives for model participants to coordinate care for Medicare beneficiaries. Dialysis facilities, nephrologists, and other providers partner to form ESRD Seamless Care Organizations (ESCOs), which joined the model in two waves. Wave 1 ESCOs began in October, 2015 while wave 2 ESCOs began in January, 2017. The third annual evaluation report presents findings from the first three performance years of the model, through 2018.

CEC ESCOs reduced total Medicare Parts A&B spending through the third performance year by \$93 per beneficiary per month, or 1.5%. These changes were driven by lower payments for acute inpatient, post-acute institutional care, and hospitalizations due to ESRD complications. Reduced total spending amounts to \$115 million in gross savings. However, once CMS shares savings with CEC participants, the \$172 million of shared savings payments result in \$57 million, or 0.74%, net losses to Medicare.

Corresponding to reduced spending, CEC beneficiaries also had lower utilization. Total hospitalizations, hospital readmissions, and hospitalizations specific to ESRD complications all decreased. Conversely, primary care evaluation and management visits increased. These findings suggest that ESCOs are improving the coordination of care for beneficiaries.

CEC beneficiaries experienced improved dialysis care as well as coordination of care beyond dialysis. Catheter use was found to be lower and outpatient dialysis sessions, a measure of beneficiary adherence to dialysis, increased. Primary care office visits increased, suggesting that more appropriate utilization and Emergency Department (ED) avoidance. CEC beneficiaries were also more likely to receive preventative services, such as eye exams.

The report presented no indication of unintended consequences. There was no evidence of cost shifting to Medicare Part D, steering CEC beneficiaries away from kidney transplant wait lists, steering healthier beneficiaries into CEC facilities, or differing utilization of calcimimetics between CEC beneficiaries and those in the control group.

The third evaluation report included data from site visits to Wave 1 ESCOs, which examined several structural changes. The key staffing modification acknowledged was the importance of face-to-face care coordination of some tasks, while leveraging centralized telephonic care coordination for other tasks. ESCOs established new relationships with urgent care centers and home health agencies to decrease ED use for dialysis-related beneficiary needs. Three ESCOs reported new pilots providing diabetic eye exams in the clinic or bringing in behavioral healthcare specialists to provide counseling to patients. In addition, ESCOs refined their Electronic Health Record, medication management, and ED notification systems to better support model operations in Performance Year 3.

Though the results are promising, positive findings are not uniform across all performance years or for both waves of the model. These differences are considered to be due to differing kinds of joiners across waves. More specifically, in Wave 1 Performance Year 1 joiners were strong drivers of reduced spending, hospitalizations, readmissions, and catheter use. In contrast, Wave 2 joiners produced similar changes for these measures, but none with statistical significance. As earlier adopters, Wave 1 joiners may have been more motivated to join the model. Wave 2 joiners were potentially motivated by MACRA and seeking an alternative to MIPS participation. In addition to potential differences in motivation for change, before joining the model, Wave 1 ESCOs had higher spending than Wave 2 counterparts. Thus, there was more room to see an effect of the model in the form of reduced spending for the Wave 1 cohort. It is worth noting that only Wave 1 PY1 show statistically significant net savings to Medicare.

Findings from CEC evaluations will inform CMS and future model participants as the agency pursues new models for beneficiaries with ESRD and Chronic Kidney Disease. The ESRD Treatment Choices model (ETC), to start in January 2021, tests whether encouraging increased use of kidney transplantation and home dialysis, preserves or enhances the quality of care furnished to Medicare beneficiaries while reducing Medicare expenditures. The Kidney Care Choices model (KCC), to start in April 2021, aims to not only improve care and reduce the cost of care for beneficiaries with ESRD, but also those with late-stage chronic kidney disease to prevent or delay its progression. KCC, like CEC, is voluntary so exploring reasons for participation will be key to understanding the model's performance. Though ETC is a mandatory payment model, lessons learned from CEC can be used to see how model participants must change the provision of care to meet model goals for beneficiaries with ESRD.