

DaVita - Where Should It Add Kidney-Care Capacity?

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Decision scope: 2021-22 operating capacity for home dialysis, transplant coordination and in-center care

Case convention: This is an author-created decision exercise. The adviser role and alternatives are hypothetical; public company and CMS statements are historical. No later implementation or outcomes are included.

The decision

On 29 September 2020, CMS published the final rule for the End-Stage Renal Disease Treatment Choices (ETC) Model. The mandatory model would change payments for selected dialysis facilities and managing clinicians beginning in 2021. Its first phase positively adjusted certain home-dialysis claims; a later adjustment could reward or penalize performance on home-dialysis and transplant measures, including payments for in-center treatment.

Classroom role: You are an outside adviser to DaVita's U.S. operating leadership. This role is fictional. Recommend how to allocate 2021-22 operating capacity among three alternatives: broad home-dialysis expansion; targeted investment in selected ETC markets paired with transplant coordination; or selective home growth while protecting in-center quality and capacity. State what information DaVita should collect before scaling, what patient and caregiver safeguards belong in the plan, and what evidence should trigger a change in course. Use only information available by the cutoff.

DaVita's existing platform

At year-end 2019, DaVita reported 2,753 U.S. outpatient dialysis centers and approximately 206,900 U.S. patients. The network count included centers DaVita operated or supported administratively; 2,709 were consolidated in its financial statements. DaVita described home care as home hemodialysis (HHD) and peritoneal dialysis (PD), supported by center-based equipment and supplies, training, monitoring, on-call help and follow-up. Nurses trained patients and caregivers. [P1], Item 1, pp.3-4.

DaVita reported that home-based dialysis accounted for 13% of U.S. treatments and 16% of U.S. dialysis patient-service revenue in 2019. The company did not disclose modality contribution margin; treatment and revenue shares are not comparable units. In its second-quarter 2020 filing package, DaVita said it served more than 28,000 home-dialysis patients through more than 1,750 U.S. locations, with remote monitoring and a HIPAA-compliant telehealth platform. "Locations" does not mean training programs or distinct centers, and the figures do not reveal available training capacity or profitability. [P1], "Treatments and revenues by modality" chart, pp.4-5; [P2], COVID-19 response, p.7.

In April 2020, DaVita reported an 11% increase in patients electing home dialysis in 2019. This was the company's relative growth figure; the release did not provide a denominator, modality split or number completing training and starting treatment. It is not an 11-percentage-point increase in the home share. [P3], opening highlights.

Exhibit 1. DaVita's disclosed home-care base

Disclosure	Reported value	What it does not tell management
U.S. centers, year-end 2019	2,753 operated or administratively supported; 2,709 consolidated	How many are ETC-selected, home-training ready or have spare staff capacity
U.S. patients, year-end 2019	About 206,900	Payer mix and ETC-attributed share by market
Home-based treatment share, 2019	13% of U.S. treatments	Modality margin, patient-level eligibility or incremental capacity cost
Home-based revenue share, 2019	16% of U.S. dialysis patient-service revenue	Contribution profit or avoided in-center costs
Home cohort, Q2 2020	More than 28,000 patients supported through more than 1,750 U.S. locations	Training throughput, technique retention, caregiver capacity or local market mix

Sources: [P1], Item 1, pp.3-5; [P2], COVID-19 response, p.7. Company-reported figures use different dates and denominators as shown.

During the COVID-19 pandemic, DaVita described PPE and testing measures, telehealth, clinician redeployment and continued outpatient care for nearly 70% of patients with suspected or confirmed COVID-19. The disclosure shows that operating capacity and quality were active concerns. It does not establish normalized staffing or future home-dialysis demand. [P2], COVID-19 response, pp.6-7.

What CMS finalized

ETC was a mandatory model for ESRD facilities and managing clinicians located in selected geographic areas. CMS planned to randomly select Hospital Referral Regions (HRRs), stratified by region, so the selected areas represented approximately 30% of adult ESRD beneficiaries across the 50 states and District of Columbia. CMS also included HRRs where at least 20% of component ZIP codes were in Maryland, subject to the rule's exclusions. Some low-volume providers were excluded from certain interventions. The 30% figure describes the model's intended beneficiary coverage; it does not mean that 30% of DaVita's centers, patients, treatments or revenue were exposed. The accepted research has not mapped DaVita's sites or payer mix to selected HRRs. [P5], narrative HRR-selection discussion, pp.61279-81/PDF pp.165-167; codified §512.325(b), printed pp.61375-76/PDF pp.261-62; [P4], beneficiary attribution and selection.

The payment schedule had two phases:

- **Home Dialysis Payment Adjustment (HDPa):** a positive adjustment on specified home-dialysis and home-related payments for claim service dates from 1 January 2021 through 31 December 2023. CMS set the facility/clinician adjustment at 3% in 2021, 2% in 2022 and 1% in 2023. This was a payment adjustment on certain claims, not a guaranteed margin on every home patient. [P5], §512.350, printed p.61376/PDF p.262.

- **Performance Payment Adjustment (PPA):** based on participants' home-dialysis and transplant performance among attributed beneficiaries, with transplant performance combining waitlisting and living-donor transplant rates. The PPA could be positive or negative and applied to specified home and in-center dialysis and dialysis-related claims for service dates from 1 July 2022 through 30 June 2027. The data period used for PPA measurement began 1 January 2021 and ended 30 June 2026. [P5], §512.355, printed pp.61376-77/PDF pp.262-63; summary, pp.61116-17.

CMS described monthly attribution: generally, a beneficiary was attributed to the facility accounting for the most dialysis treatments that month and to the managing clinician billing the first monthly capitation payment. The model covered Medicare fee-for-service beneficiaries, not all DaVita patients. The rule included exclusions from performance-rate calculations for certain beneficiaries, including those under 18, in hospice, living in nursing homes or skilled nursing facilities, diagnosed with dementia, or receiving dialysis only for acute kidney injury. Beneficiaries retained freedom of provider choice; CMS said it would monitor coercion, steering and inappropriate referrals. [P4], beneficiary attribution and protections; [P5], §§ IV.B-C.

CMS estimated \$23 million in net Medicare savings over the model period under its assumptions, which included a return to pre-pandemic billing and treatment patterns by the start of 2021 and changes in home use. This is a federal program projection, not a DaVita revenue, saving or margin estimate. COVID-19's duration and effects remained uncertain. [P5], pp.61351-53, § VII.C.2.b.

Exhibit 2. ETC timing and operating implications

Period	CMS rule	Operating implication to assess
1 Jan 2021-31 Dec 2023	Positive HDPA on specified home-dialysis and related claims; 3%, 2% and 1% in model years 2021, 2022 and 2023	May support readiness and training investment for selected facilities/clinicians; does not establish local economics
1 Jan 2021-30 Jun 2026	Measurement period for home-dialysis and transplant performance	Requires attribution and outcome tracking among eligible Medicare FFS beneficiaries
1 Jul 2022-30 Jun 2027	Positive or negative PPA on specified home and in-center claims, based on home use, transplant waitlisting and living-donor measures	Home volume alone is not the full performance objective; quality and in-center execution remain relevant

Sources: [P5], §512.350, printed p.61376/PDF p.262 (HDPA); §512.355, printed pp.61376-77/PDF pp.262-63 (PPA). Dates and adjustment percentages are from the final rule; local DaVita exposure is unknown.

More home care is not a single operating choice

Evidence on payment incentives suggests that provider behavior can respond to policy, but does not forecast DaVita's response to ETC. Lin and coauthors studied adults starting dialysis from 2006 to 2013 around the 2011 ESRD prospective payment system. They estimated home-dialysis use was 5.0 percentage points above a modeled no-policy trajectory by the end of the study period (95% CI 4.0-6.0). The study could not separate PD from HHD because the HHD sample was too small; the authors said the observed increase was likely driven by PD trends. This observational result under a different national payment design is not HHD-specific, ETC-specific or DaVita-specific. [A1], Figure 2, Table 3 and discussion.

Clinical evidence also leaves room for patient choice. A VA systematic review found low-strength evidence for some apparent HHD survival differences in registry studies, but no compelling evidence that home HHD or PD differs from in-center HD in survival, quality of life, hospitalizations or costs after considering selection and residual confounding. Education, patient knowledge and preference, family support, and clinical and psychosocial suitability were associated with modality selection. Barriers included living alone, insufficient space, fear of isolation, and a preference for clinical supervision. [A2], “Key Findings,” limitations and selection factors.

A qualitative review of 24 studies reported that patients and caregivers valued autonomy and flexibility, while also describing fear of self-needling or complications, isolation and transferring care work into the home. Communication, monitoring, readiness and clinician validation mattered. These are recurring themes, not estimates of how common each experience is. [A3], abstract.

DaVita's transplant coordination opportunity was similarly uncertain. CMS's measure included waitlisting and living-donor transplants. Dialysis providers can educate and refer patients, but transplant eligibility, donor availability, transplant-center capacity and wait times are not fully within DaVita's control. The company had not disclosed baseline waitlisting, referral conversion or its attributable share of transplant outcomes in the materials reviewed.

A competitor had made a related capability move: Fresenius Medical Care said its 2019 acquisition of NxStage combined home-dialysis equipment with its clinic network and care-coordination capabilities. This is the competitor's stated rationale, not evidence of realized synergy or proof DaVita should copy the move. [P7], acquisition completion release.

Three capacity plans

1. **Expand home programs broadly.** Add training staff, equipment access, remote monitoring and caregiver support across the network. This may build capacity ahead of ETC and expand choice, but could place resources in markets outside the model or beyond local demand and suitability.
2. **Target selected ETC markets and build transplant coordination.** Direct added home capacity to selected markets after mapping facilities and Medicare attribution; expand education, referral and coordination with transplant centers. This aligns resources with the rule but requires local exposure data and depends partly on external transplant systems.
3. **Grow home selectively while protecting in-center quality.** Expand where readiness and patient preference support it, while maintaining in-center staffing and quality capacity as the later PPA also covers in-center claims. This limits disruption but could underbuild home access where the payment model or patient demand supports more.

These are hypothetical alternatives for the exercise. CMS's incentives do not require home dialysis or transplantation for any individual, and patient clinical suitability and preference remain central.

Your recommendation

As the fictional adviser, prepare a short operating memo selecting a plan or a specified combination. Explain how you would allocate training teams, home-program access, monitoring and caregiver support, in-center staffing, and transplant education or coordination. Identify what site- and payer-level data DaVita needs before setting market targets. Define measures for patient preference and suitability, training completion, home starts and retention, technique failure, transplant referrals and waitlisting, caregiver burden, quality outcomes and in-center performance.

State which evidence would expand, pause or redirect investment. Distinguish ETC-wide coverage from DaVita's unknown selected-site and Medicare exposure. Do not infer company economics from CMS's \$23 million projected Medicare savings or treat the Lin study as an HHD response estimate.

Sources and conventions

P1. DaVita, [2019 Form 10-K](#), filed 21 February 2020; Item 1 and Item 1A, printed pp.3-5.

P2. DaVita, [Q2 2020 filing package](#), filed 30 July 2020; COVID-19 response, pp.6-7.

P3. DaVita, [“Reports on 2019 Corporate Social Responsibility Initiatives”](#), 29 April 2020; opening highlights.

P4. CMS, [ETC Model Fact Sheet](#), 18 September 2020; overview, dates, selection, attribution and protections.

P5. CMS, [Specialty Care Models Final Rule](#), 85 FR 61114, published 29 September 2020; narrative HRR-selection discussion pp.61279-81/PDF pp.165-167; codified §512.325(b), printed pp.61375-76/PDF pp.261-62; HDPA schedule §512.350, printed p.61376/PDF p.262; PPA dates and measures §512.355, printed pp.61376-77/PDF pp.262-63; ETC summary pp.61116-17; economic impact §VII.C.2.b, pp.61351-53.

P7. Fresenius Medical Care, [“Completes acquisition of NxStage Medical”](#), 26 February 2019; completion and stated strategic rationale.

A1. Lin et al., “Home Dialysis in the Prospective Payment System Era,” *Journal of the American Society of Nephrology* 28(10), 2993-3004 (2017). [Full text](#); methods, Figure 2, Table 3 and discussion.

A2. Ishani et al., *Comparative Effectiveness of Home-Based Kidney Dialysis Versus In-Center or Other Outpatient Kidney Dialysis Locations: A Systematic Review* (VA ESP, 2015). [Summary and discussion](#).

A3. Walker et al., “Patient and caregiver perspectives on home hemodialysis: a systematic review,” *American Journal of Kidney Diseases* 65(3), 451-463 (2015). [PubMed abstract](#); abstract-level use only.

DaVita and CMS values are labeled by source and denominator. The model's beneficiary coverage is not a DaVita exposure estimate. No information after 29 September 2020 is included.