

Open Door Forum End Stage Renal Disease Prospective Payment System (ESRD PPS) Proposed Rule



October 15, 2009 – 3:30-5:00 P. M. EDT



Agenda

- ◆ Background
- ◆ Features of proposed ESRD PPS:
 - Payment bundle, unit of payment, data sources, base rate, market basket, patient-level adjustments, modality, pediatric adjustments, facility-level adjustments, and outliers
- ◆ Impact analysis
- ◆ Review of existing policies
- ◆ Implementation issues
- ◆ Areas of interest for the final rule
- ◆ Quality Incentive Program (QIP)
- ◆ Q/A session



Background*

- ◆ 1972- Congress authorized the Medicare ESRD benefit
- ◆ 1983- HCFA implemented the composite payment system
 - Separately billable items and services currently paid outside composite payment system
- ◆ 2003-2008- Secretary issued Reports to Congress describing an expanded bundle of services
- ◆ 2005- CMS implemented basic case-mix adjustments
- ◆ 2008- Medicare Improvements for Patients and Providers Act (MIPPA) enacted

* 74 FR 49923



The Proposed Payment Bundle**

1. Composite rate services;
 2. ESAs (and their oral forms) used to treat ESRD;
 3. Other drugs and biologicals used to treat ESRD (including oral forms) and for which separate payment was made under Title XVIII of the Act; and
 4. Lab tests and other items and services used to treat ESRD*
- ◆ CMS proposed a per treatment unit of payment**

*§1881(b)(14)(B)(i-iv) of the Act

**74 FR 49931



Data Sources – Case-Mix Analysis*

- ◆ Composite rate services
 - Medicare cost reports from hospital-based ESRD outpatient dialysis providers and independent ESRD facilities for CYs 2004 – 2006
- ◆ Separately billable services
 - Outpatient institutional claims and carrier claims for CYs 2004 – 2006
- ◆ Drugs currently covered under Part D
 - Part D claims for CY 2007

* 74 FR 49934



Data Sources - Case-Mix Analysis (cont.)

- ◆ Patient Characteristics
 - Form 2728 - Medicare Evidence Report
 - REMIS - Renal Management Information System
 - EDB – Enrollment Database
 - SIMS - ESRD Standard Information Management System
- ◆ Facility Characteristics
 - SIMS
 - Cost Reports
 - OSCAR – Online State Certification & Reporting System



Unadjusted Base Rate*

- ◆ Based on average 2007 Medicare claims payments including:
 - Composite rate services;
 - Support services for Method II patients;
 - Dialysis training services
 - Part B drugs/biologicals;
 - Lab tests;
 - DME equipment/supplies;
 - Supplies/other services; and
 - Current Part D drugs

* 74 FR 49939



Update Factors and Adjustments to Base Rate*

- ◆ Update factors applied to components of base rate to yield projected 2011 unadjusted per treatment base rate → \$261.58
- ◆ Standardization adjustment of 0.7827 → \$204.74
- ◆ Outlier adjustment of 1 % → \$202.69
- ◆ Budget neutrality adjustment of 2 % → \$198.64

* 74 FR 49942



2-Part Transition Budget Neutrality Adjustment*

1. To ensure payments would equal what would have been made in the absence of a transition
 - Recomputed each year of transition
 - 3% in 2011
 - Would apply to payments under the current system and the proposed ESRD PPS
2. Part D drug payment adjustment to basic case-mix adjusted composite payment system portion of blended payment

* 74 FR 49944



ESRD Bundled Market Basket*

- ◆ MIPPA (section 153(b))
 - Effective 2012
 - Annual increase minus 1.0 percentage point
 - Factor reflect changes in goods and services prices
 - Update composite portion during phase-in
- ◆ ESRDB
 - All-inclusive input price index
 - Price index (cost categories), their weights & price proxy

* 74 FR 49997



Patient-Level Adjustments

- ◆ Resource use varies by patient → > costs to provide dialysis
- ◆ Patient -specific case-mix adjustment factors from 2 equations
 - Composite rate
 - Separately billable services
- ◆ Multiple regression → case-mix adjusted payments/treatment
 - age
 - BSA
 - Low BMI
 - Sex
 - Co-morbidity categories
 - Renal dialysis onset



Patient-Level Adjustments (cont.)*

- ◆ Patient Age
 - Reference Group – 45 to 59 years
 - 18-44 years = 19.4% more costly
 - > 80 years = 7.6% more costly
- ◆ Patient Sex
 - Females 13.2% more costly than males
- ◆ Body Size
 - BSA = 3.4% cost/0.1m² increase from 1.87
 - BMI = < 18.5kg/m²;
1.020 increase from 1.112

* 74 FR 49949



Patient-Level Adjustments (cont.)

- ◆ Onset of dialysis (in-facility & home)
 - ❖ Higher costs in first 4 months on dialysis (onset)
 - Stabilization need
 - Administrative & labor costs
 - Initial home training
 - ❖ Adjustment for period of time of dialysis under the ESRD benefit
- ◆ Co-morbidities
 - ❖ Used multiple claim types (SNF, HH, Hospice, etc)
 - ❖ 11 categories (substance dependence; cardiac arrest; pericarditis; HIV/AIDS; hepatitis B; infections; GI bleed; hemolytic/sickle cell anemia; cancer; myelodysplastic syndrome & monoclonal gammopathy)



Patient-Level Adjustments (cont.)

◆ Race/Ethnicity

- Data Source: REMIS (from form 2728) & EDB (from SSA and RRB)
- Concerns:
 - 2 versions of form 2728; completed by facility/physician
 - Limited data from RRB
 - Large number of “unknowns” or defaults
 - Enumeration process
 - Ill-defined terms

◆ Modality

- No distinction between HD and PD in adults



Pediatric Dialysis*

- ◆ Current Payment = 1.62 adjustment factor
- ◆ Proposed ESRD PPS = 8 categories
 - Age (< 13 years & 13-17)
 - Modality (PD and HD)
 - Co-morbidity (none or 1 or more)

* 74 FR 49981



Facility-Level Adjustments – Wage Index*

- ◆ Current method and source of wage index values
 - Based on hospital wage data
 - OMB's CBSA-based geographic area designations
 - Labor-related share – 53.711
 - Wage index budget neutrality factor
- ◆ Proposed changes
 - Would no longer have a wage index floor under the ESRD PPS
 - Wage index value for rural Puerto Rico
 - Labor-related share from the proposed ESRD PPS – 38.160

* 74 FR 49968



Facility-Level Adjustments – Low-Volume*

◆ MIPPA

- Section 1881(b)(14)(D)(iii) requires a payment adjustment that reflects the extent to which costs incurred by low-volume facilities (as defined by the Secretary) in furnishing renal dialysis services exceed the costs incurred by other facilities in furnishing such services; and
- such payment adjustment shall not be less than 10 percent

* 74 FR 49969



Facility-Level Adjustments – Low-Volume (cont.)

- ◆ Facility-Level characteristics
 - Size
 - Number of treatments
 - Ownership Type
 - LDO, Independent, Regional, & Unknown
 - Location
 - Urban/Rural status



Facility-Level Adjustments – Low-Volume (cont.)

- ◆ Low-Volume Definition
 - Furnished less than 3,000 treatments in each of the 3 years preceding the payment year; and
 - Has not opened, closed, or received a new provider number due to a change in ownership during the 3 years preceding the payment year
- ◆ Additional Criteria
 - Geographic proximity for commonly owned facilities
- ◆ Payment Adjustment
 - 20.2%



Facility-Level Adjustments – Low-Volume (cont.)

- ◆ Other issues
 - Training only facilities
 - Regional Office involvement
 - Survey and certification monitoring



Facility-Level Adjustments – Other*

- ◆ Alaska and Hawaii Facilities
 - Did not propose COLA Adjustment

- ◆ Rural Facilities
 - Did not propose a separate adjustment

* 74 FR 49978



CMS

Outlier Policy*

- ◆ Would protect facilities from losses linked to unusually high costs
- ◆ Patient-level eligibility
- ◆ Payments would be added to per-treatment payment amount
- ◆ Outlier services defined as separately billable services including ESRD-related Part D drugs

* 74 FR 49987



Outlier Policy (cont.)

- ◆ Outlier eligibility
 - Compare predicted and imputed payment amounts
 - Predicted amounts= outlier services payment adjusters times the average outlier services payment amount (\$64.54)
 - Imputed amounts= outlier services on monthly claim divided by treatments
 - Imputed payment amounts > predicted outlier services payment amount + outlier threshold (fixed dollar loss amount) would generate outlier payment
 - Adult fixed dollar loss amount - \$134.96
 - Pediatric fixed dollar loss amount - \$174.31



Outlier Policy (cont.)

◆ Outlier Payment

- Imputed payments amounts $>$ predicted outlier services payment amount + outlier threshold (fixed dollar loss amount) would generate outlier payment
- Payment would be made at 80% (loss sharing percentage) of this excess amount
- Proposed loss sharing percentage and fixed dollar loss amounts result in 1% overall reduction to the base rate



Impact Analysis*

- ◆ Show how ESRD facilities are affected by the proposed ESRD PPS
- ◆ Compared estimated payments in CY 2011 under proposed ESRD PPS to estimated payments under the current payment system
- ◆ Estimated payments in CY 2011 under proposed ESRD PPS
 - Opt in for transition
 - Opt out of transition
- ◆ Assume 36% excluded from transition

* 74 FR 50017



Existing ESRD Policies & Other Issues*

- ◆ Exceptions – Eliminate
- ◆ ESA Claims Monitoring Policy – Continue
- ◆ Network Deduction – Continue
 - 50 cents
 - Medicare Claims Processing Manual, Pub 104, chapter 8, section 110
- ◆ Bad Debt – Continue
 - Composite rate portion
 - Cap (§ 413.178(a))

* 74 FR 49997



Existing ESRD Policies & Other Issues

(cont.)

- ◆ Limitation on Review
 - Payment determination
 - Unit of payment
 - Renal dialysis services
 - Adjustments
 - Transition
 - Market basket increase factor
- ◆ 50 % Rule (Laboratory Payments)
 - Medicare Claims Processing Manual, Pub 100.04, chapter 16, §40.6
 - 50% or > covered lab tests (AMCC) → no separate payment
 - Considering exclusion from outlier eligibility
- ◆ MSP – No change



Implementation*

- ◆ MIPPA
 - 4 year transition period
 - Blended payment
 - One-time election
 - Cannot be rescinded
 - FI/MAC involvement
 - New facilities
 - Payments made during the transition are to be budget neutral

* 74 FR 50003



Implementation (cont.)

- ◆ Blended Payment
 - All-inclusive payment
 - All renal dialysis services and home dialysis items and services
 - Items and services that are currently separately payable
 - Method II DME suppliers
 - Laboratories
 - Part D plans



Implementation (cont.)

◆ Blended Payment

- Basic case-mix adjusted composite payment system portion
 - Composite rate; (adjusted by the case-mix and wage index)
 - Drug Add-on amount;
 - Payment amounts for items and services that are currently separately paid under Part B;
 - ESRD drugs and biologicals that are currently separately paid under Part D; and
 - ESRDB market basket minus 1 percentage point



Implementation (cont.)

- ◆ Blended Payment
 - ESRD PPS portion
 - Base rate;
 - Applicable patient-level and facility-level adjustments; and
 - Outlier payments
- ◆ The beneficiary coinsurance amount would be 20% of the total ESRD PPS payment or 20% of the blended payment amount for those facilities that decide to transition



Implementation (cont.)

- ◆ Claims Processing
 - Consolidated Billing Approach
 - Laboratory Tests
 - Drugs and biologicals that were formerly covered under Part D
 - ESRD facility responsibility
 - Home dialysis
 - All home dialysis would be furnished under Method I
 - Method II would be eliminated



Further Analysis

- ◆ Update of data sources
- ◆ Evaluation of comments
- ◆ Other issues
 - Retiree Drug Subsidy payments
 - 50 percent rule and ESA claims monitoring policy as related to the outlier policy



MIPPA, Section 153 (c)

Generally speaking, MIPPA, 153 (c):

- ◆ Requires Centers for Medicare & Medicaid Services (CMS) to create a Quality Incentive Program (QIP) to promote improved End-Stage Renal Disease (ESRD) patient outcomes
- ◆ As part of the End-Stage Renal Disease Prospective Payment system (ESRD PPS), which takes into account all services related to ESRD care and “*bundles*” them into one payment, the QIP helps to ensure the quality of services delivered under the “bundled payment”



What does the QIP do?

- ◆ Connects Medicare payment rate to provider/facility performance based on specific measures
- ◆ Providers/facilities that do not meet **or** exceed the specified performance standards, will receive a payment reduction of up to **2.0%**
- ◆ Payment reductions will apply with respect to the year involved and **will not** be taken into account when computing future payment rates



Goals of the QIP

- ◆ CMS expects to:
 - Improve quality and safety for beneficiaries;
 - Promote efficiency;
 - Minimize risks of unintended consequences related to a bundled payment system;
 - Encourage meaningful use of health information technology; and
 - Improve transparency for beneficiaries and other stakeholders



QIP Proposed Measures

- ◆ CMS proposes to use three claims based measures that focus on the management of anemia and the adequacy of dialysis treatment
- ◆ Rationale for the measures:
 - They fulfill the statutory requirement
 - The measures have been in use for several years by facilities
 - CMS has data available to develop and test the various models
 - Providers and stakeholders are familiar with the measures
 - Time limitations on the development of new measures for the first reporting year



Claims Based Measures

- ◆ CMS expects to use three claims-based measures for 2012
- ◆ Two measures are for anemia management (Percent of patients whose Hgb levels are less than 10g/dL and Percent of patients whose Hgb levels are greater than 12g/dL)
- ◆ One is for hemodialysis adequacy (Achieved Urea Reduction Ratio greater than 65 percent)
- ◆ Data for these measures derived from ESRD claims and have been utilized for public reporting since the release of Dialysis Facility Compare (DFC) January 2001



Next Steps

- ◆ CMS will continue development of a Quality Incentive Program
- ◆ CMS will release the details of that program in future rulemaking
- ◆ The public may submit comments on the QIP conceptual model via instructions found in the ESRD PPS NPRM



Questions?



CMS

Wrap Up

- ◆ Public comments welcome
- ◆ The proposed rule is available at:
<http://www.cms.hhs.gov/ESRDPayment/>
- ◆ Click “End-Stage Renal Disease (ESRD) Payment Regulations and Notices”
- ◆ Select the link to the proposed rule

