DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
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FACT SHEET

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CMS PROPOSALS TO UPDATE POLICIES AND PAYMENT RATES FOR END-STAGE RENAL DISEASE PROSPECTIVE PAYMENT SYSTEM FOR CY 2014

OVERVIEW: On July 1, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2014. The rule also proposes changes to the ESRD Quality Incentive Program (QIP) for payment year (PY) 2016 that provides payment incentives to dialysis facilities to improve the quality of dialysis care. Under the ESRD QIP, facilities that do not achieve a minimum total performance score with respect to quality measures established in regulation receive a reduction in their payment rates under the ESRD PPS. This rule also addresses issues related to the coverage and payment of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

This Fact Sheet addresses the general provisions of the ESRD PPS for CY 2014 and the issues related to DMEPOS in the proposed rule. The ESRD QIP is discussed in a separate fact sheet.

ESRD PPS BACKGROUND: Section 153 (b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended the Social Security Act to require CMS to implement a fully bundled PPS for renal dialysis services furnished to Medicare beneficiaries for the treatment of ESRD effective January 1, 2011. The ESRD PPS replaced a payment methodology which provided a composite rate payment for routine dialysis items and services, plus separate payment for other ESRD-related items and services, such as drugs and biologicals that were not included in the composite rate.

The bundled payment under the ESRD PPS includes all renal dialysis services furnished for outpatient maintenance dialysis, including ESRD-related drugs and biologicals (with the exception of certain oral-only ESRD drugs until 2016) and other ESRD-related items and services that were formerly separately payable under the previous payment methodologies. The bundled payment rate is adjusted for a number of factors relating to patient characteristics, such as complicating conditions that affect the cost of treatment. There are additional adjustments for ESRD facilities that have a low patient volume and for facilities that offer home dialysis training. For high-cost patients, an ESRD facility may be eligible for outlier payments.

While the ESRD PPS was effective for renal dialysis services furnished on or after January 1, 2011, the statute provided for a 4-year transition period. During the transition, ESRD facility payment rates would be based on a blend of the composite rate methodology and the new PPS rate for those ESRD facilities that did not elect to be paid 100 percent under the ESRD PPS starting on January 1, 2011. CY 2014 is the final year of the 4-year transition period. Therefore, all ESRD facilities must be paid 100 percent of the ESRD PPS rate for renal dialysis services furnished on or after January 1, 2014.

PROPOSED CHANGES TO THE ESRD PPS FOR CY 2014:

Updated Payment Rates for the ESRD PPS: CMS projects that the updated CY 2014 ESRD bundled market basket increase will be 2.9 percent. As required by the statute, this increase will be reduced by an estimated multi-factor productivity (MFP) adjustment for CY 2014 of 0.4 percent. Therefore, CMS is projecting an update of 2.5 percent to the ESRD PPS base rate in CY 2014, although this may change in the final rule based on more recent data. In addition to the payment update, CMS would also apply a proposed wage index budget-neutrality adjustment factor of 1.000411.

Proposed Adjustment to the ESRD PPS Base Rate to Reflect Change in Utilization of ESRD-Related Drugs and Biologicals Required by the American Taxpayer Relief Act of 2012: On December 7, 2012, the Government Accountability Office (GAO) issued a report that discussed the decline in utilization of ESRD-related drugs and biologicals since the implementation of the ESRD PPS. Following that report, Congress enacted section 632(a) of the American Taxpayer Relief Act of 2012 (ATRA) which added section 1881(b)(14)(I) to the Social Security Act. Section 1881(b)(14)(I) requires the Secretary to make reductions to the ESRD PPS base rate to reflect the Secretary's estimate of the change in the utilization of ESRD-related drugs and biologicals by comparing per patient utilization data from 2007 with such data from 2012. Section 1881(b)(14)(I) further requires that in making the adjustment, CMS is

required to take into account the most recently available data on Average Sale Prices (ASP) and changes in prices for drugs and biologicals reflected in the ESRD market basket. Therefore, for this proposed rule, CMS analyzed the utilization of ESRD-related drugs and biologicals and any oral forms of these drugs and biologicals (except ESRD oral-only drugs) that are currently in the bundle, such as erythropoiesis stimulating agents (ESAs), for CY 2007 and compared it with such data from CY 2012.

CMS's analysis showed an average payment per treatment of $83.76 for drugs and biologicals based on the 2007 claims and $51.42 for drugs and biologicals based on the 2012 claims. The average payment per treatment for drugs and biologicals for CY 2012 is subtracted from that of CY 2007, which results in a difference of $32.34 ($83.76 - $51.42 = $32.34). This amount is then reduced by the standardization, the one percent outlier, and the 98 percent budget neutrality adjustments, which results in an amount of $29.52 ($32.34 x .9407 x .99 x .98 = $29.52). The CY 2014 proposed base rate per treatment of $246.47 would be reduced by $29.52, the adjusted difference between the 2007 and 2012 per treatment amount, resulting in the CY 2014 proposed ESRD PPS base rate of $216.95. This adjustment results in an overall 12 percent reduction in Medicare payments for CY 2014. In summary, based on the application of the ESRD bundled market basket update reduced by the MFP adjustment, the wage index budget-neutrality adjustment, and the drug utilization adjustment the proposed CY 2014 ESRD PPS base rate is $216.95.

We are seeking comment on a potential transition or phase-in period of the reduction amount over more than one year.

Outlier Policy: Under the ESRD PPS, ESRD facilities may qualify for outlier payments for high cost patients. For CY 2014, CMS proposes to use CY 2012 claims data to update the outlier services' fixed-dollar loss and Medicare Allowable Payment (MAP) amounts. As a result, CMS is proposing to increase the fixed-dollar loss amount for pediatric patients from $47.32 to $54.23 and the MAP amount will remain $38.65. For adult patients, CMS is proposing to decrease the fixed-dollar loss amount from $110.22 to $94.26 and decrease the MAP amount from $61.38 to $52.45. CMS believes this update to the outlier MAP and fixed dollar loss amounts for CY 2014 will increase payments to ESRD facilities for ESRD beneficiaries requiring higher resource utilization in accordance with a 1 percent outlier policy.

Wage Index and Wage Index Floor: In CY 2014, CMS is not proposing any changes to the application of the wage index and will continue to apply the adjustment to the labor-related portion of the base rate when making payments under the ESRD PPS.

Over the past several years, CMS has been gradually decreasing the wage index floor by .05 in an effort to gradually phase out the floor. Therefore, in CY 2014, CMS is proposing to reduce the wage index floor from 0.50 to 0.45 and in CY 2015 from 0.45 to 0.40.

Impact Analysis: CMS projects that the proposed updates for CY 2014 would decrease total payments to all ESRD facilities by 9.4 percent compared with CY 2013. For hospital-based ESRD facilities, CMS projects a decrease in total payments of 9.3 percent, while for freestanding facilities; the projected decrease in total payments would be 9.4 percent. CMS also projects that urban ESRD facilities will receive an estimated decrease in payments of 9.4 percent while rural facilities will receive a 9.5 percent decrease. CMS projects that ESRD facilities in Puerto Rico and the Virgin Islands will receive an 11.5 percent decrease in estimated payments.

Application of ICD-10-CM: Effective October 1, 2014, CMS will implement the 10th revision of the ICD coding scheme. CMS discusses and applies a crosswalk from ICD-9-CM to ICD-10-CM for codes that are subject to the comorbidity payment adjustment. CMS proposed that all ICD-10-CM codes to which ICD-9-CM codes that are eligible for the comorbidity payment adjustment crosswalk will be eligible for the comorbidity payment adjustment with two exceptions. The two exceptions are D89.2 Hypergammaglobulinemia, unspecified and K52.81 Eosinophilic gastritis or gastroenteritis.

PROPOSED CHANGES REGARDING DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) FOR CY 2014:

Clarification of the grandfathering provision related to the 3-year Minimum Lifetime Requirement (MLR): To assist in determining when an item is durable and can be classified as DME, CMS finalized a rule adding a 3-year minimum lifetime requirement (MLR) for new items classified as DME after January 1, 2012. This rule proposes to clarify that the grandfathering provision allows for continued coverage of equipment that has been covered under the Medicare benefit for many years to avoid disruption in the continuity of care for beneficiaries with a medical need for these items. Effective with respect to items classified as DME after January 1, 2012, an item is not considered durable unless it has an expected life of at least 3 years. Therefore, the 3-year MLR applies to new items after January 1, 2012, and does not apply to items covered under the DME benefit on or prior to January 1, 2012, regardless of whether they meet the 3-year minimum lifetime requirement. If an item covered as DME on or before January 1, 2012 is modified (i.e., redesigned, upgraded or reengineered), so that

the product would no longer last or function for at least the same period of time as the grandfathered item, then that modified product would be considered a new item and subject to the 3-year MLR.

Definition of routinely purchased DME: This rule would clarify the distinction between of routinely purchased DME and capped rental items in response to questions raised by stakeholders.

Implementation of budget neutral fee schedules for splints and casts, and IOLs inserted in a physician's office: For CY 2014, we are proposing the implementation of budget neutral fee schedule amounts for splints, casts, and IOLs inserted in a physician's office. The statute provides authority at section 1842(s) to implement fee schedule amounts for these items if they are established so that they are initially budget neutral. In 2011, total allowed charges for splints and casts were $5.6 million, while total allowed charges for intraocular lenses inserted in a physician's office were $76 thousand. This will eliminate the need to calculate reasonable charges on an annual basis, will lower administrative expenses, and help simplify the program.

The proposed rule will be published in the *Federal Register* on July 8, 2013. CMS will accept comments on the proposed rule until August 30, 2013, and will respond to comments in the final ESRD PPS rule for CY 2014.

For more information, please see:
http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

For more information about the ESRD PPS and QIP, please see:
https://www.cms.gov/Center/Special-Topic/End-Stage-Renal-Disease-ESRD-Center.html

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