Improving Medicare's end-stage renal disease prospective payment system

Nancy Ray and Andy Johnson

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Presentation overview

- Background on ESRD PPS
- Overview of how Medicare pays for new dialysis drugs
- Policy option: Eliminating the transitional drug add-on payment adjustment (TDAPA) for new ESRD drugs in an existing ESRD functional category
- Overview of how Medicare pays dialysis facilities that are low-volume and located in rural areas
- Policy option: Replacing the low-volume and rural payment adjustments with a single payment adjustment that targets low-volume and isolated facilities
- Chairman's draft recommendations

Transitional drug add-on payment adjustment (TDAPA). Prospective payment system (PPS).

ESRD PPS implemented in 2011

- Expanded payment bundle includes ESRD-related drugs and laboratory tests that were previously paid separately
- To implement the bundle, CMS categorized ESRD drugs in *11 ESRD functional categories*
- Facility-level adjustments: low volume, rural location, and labor costs
- Patient-level adjustments: Age, body mass index, body surface area, time since dialysis onset, acute and chronic comorbidities
- Added on to the base rate: Payments for self-dialysis training and outliers; transitional drug add-on payments for calcimimetics

PPS (prospective payment system).

Overview of how Medicare pays for new ESRD drugs under a TDAPA policy

New ESRD-related drugs that:	Are *not* in an existing functional category	*Are* in an existing functional category
Initial policy year	2016	2020
How is payment set?	ASP	ASP
Length of add-on payment period	At least 2 years	2 calendar years
Is the ESRD PPS base rate updated at end of add-on payment period?	Yes	No

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Transitional drug add-on payment adjustment (TDAPA). Average sales price (ASP). Prospective payment system (PPS).

Issues with the TDAPA policy for new drugs in an existing ESRD functional category

- Paying separately for drugs in a functional category temporarily unbundles the ESRD bundle
  - Inhibits competition among drugs in the same functional category
  - Fails to provide an incentive to reduce new drug launch prices
  - Prior to TDAPA, an ESA was introduced directly into the bundle in 2015: One-quarter of patients switched in the first year and ESA costs declined
- TDAPA payment is duplicative of bundled payment
  - TDAPA covers full cost of the new drug in addition to the payment for the functional category already included in the base rate
  - Paying TDAPA on a per unit basis in addition to the bundle increases the incentive to provide TDAPA-covered drugs and may promote their overuse

ESA (erythropoiesis-stimulating agent). Transitional drug add-on payment adjustment (TDAPA).

Policy option: Eliminate the TDAPA for new ESRD drugs in an existing functional category

- At market entry, new ESRD drugs in an existing functional category would be included in the payment bundle
- No concurrent update to the base payment rate
- Monitor payment adequacy of Medicare's ESRD payments to identify need for rebasing
- Maintain the TDAPA for new dialysis drugs that do not fit into an ESRD functional category and for calcimimetics

Payment for low-volume and isolated facilities

- Why modify current low-volume and rural payment adjustment factors?
  - Concern about Medicare financial performance of low-volume dialysis facilities necessary to ensure beneficiary access to care
  - Design of low-volume payment adjustment (LVPA) and rural payment adjustment does not meet Commission principles on rural payment adjustments (2012)
    - Protect low-volume *and* isolated facilities critical to beneficiary access
    - Adjustment magnitude should be empirically justified
    - Adjustments should encourage provider efficiency

LVPA does not target isolated and low-volume facilities

- LVPA criteria:
  - Base rate of LVPA facilities is increased by 23.9 percent
  - Furnished less than 4,000 treatments in each of the 3 years before the payment year in question
  - Distance to nearest facility only considered for facilities under common ownership and within 5 miles of each other
- Concerns with design of LVPA:
  - Single threshold may encourage limiting treatment or inaccurate reporting
  - Does not address higher costs at facilities with 4,000 to 6,000 treatments
  - Does not target isolated facilities, 40 percent within 5 miles of another facility

Low volume payment adjustment (LVPA). Estimates are preliminary and subject to change.
Source: MedPAC analysis of claims and cost reports submitted by dialysis facilities to CMS, CMS's Dialysis Facility Compare file, and CMS's impact analysis for the calendar year 2019 ESRD PPS final rule.

Rural adjustment does not target low-volume and isolated facilities

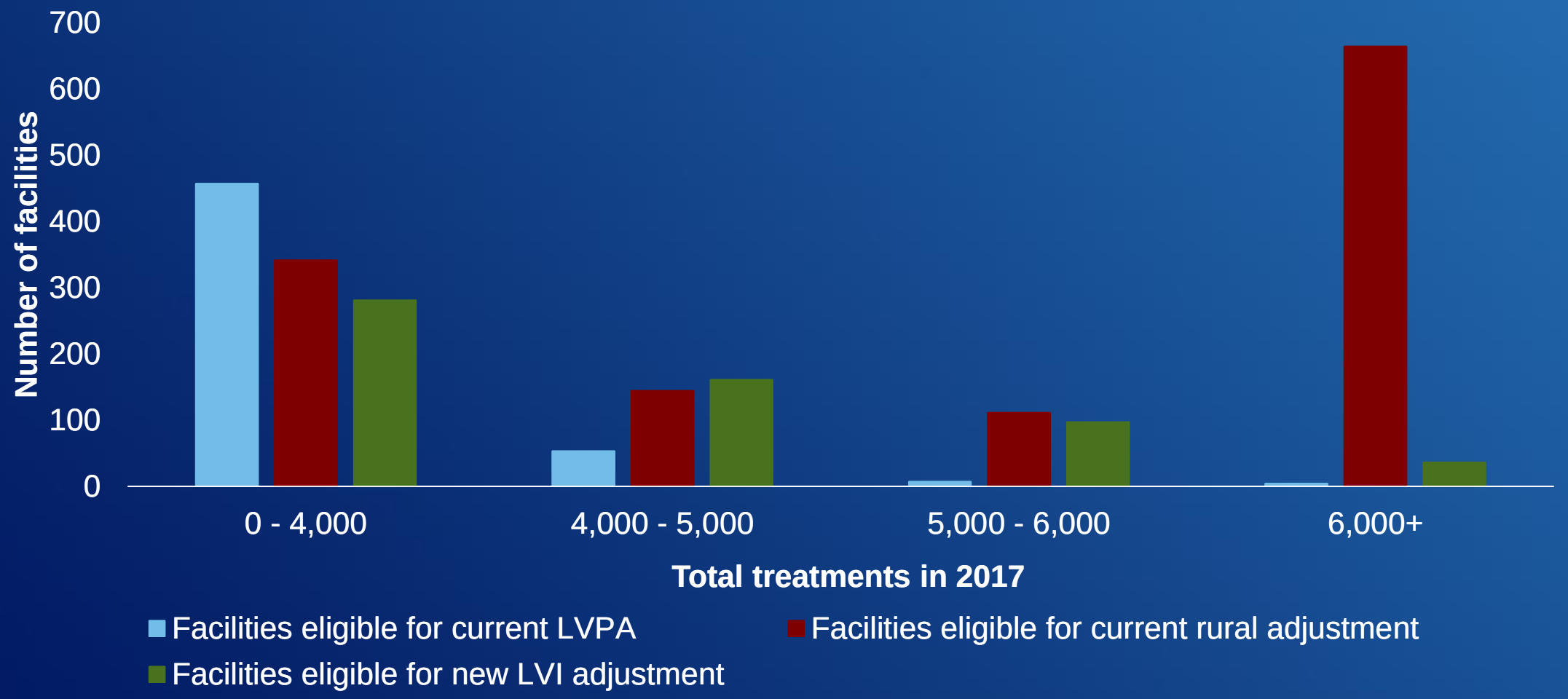
- In 2017, 18 percent of facilities received a 0.8 percent increase to their base rate for being located in a rural area
- Concerns with rural adjustment
  - About 30 percent of rural facilities were located within 5 miles of the nearest facility
  - About 50 percent of rural facilities were higher-volume, furnishing more than 6,000 treatments

Source: MedPAC analysis of claims and cost reports submitted by dialysis facilities to CMS, CMS's Dialysis Facility Compare file, and CMS's impact analysis for the calendar year 2019 ESRD PPS final rule. Data are preliminary and subject to change.

Policy option: Replace the current low volume and rural payment adjustments with a single adjustment

- The low-volume and isolated (LVI) payment adjustment would target facilities that are both low-volume and isolated
- To model the LVI adjustment:
  - Facility must be isolated
    - Farther than 5 miles from nearest facility (regardless of ownership)
  - Facility must exhibit low volume over three preceding years
    - Provide up to 6,000 treatments per year

Policy option would redistribute some payments from non-isolated and high-volume facilities



Note: (LVPA) low-volume payment adjustment. (LVI) Low-volume and isolated. Analysis includes freestanding facilities (excludes hospital-based facilities).
Source: MedPAC analysis of claims and cost reports submitted by dialysis facilities to CMS. *Preliminary and subject to change.*

Discussion

- Chairman's draft recommendations to:
  - Eliminate the TDAPA for new ESRD drugs in an existing ESRD functional category
  - Replace the current LVPA and the rural adjustment with a single facility-level adjustment for low-volume and isolated facilities
- Analyses will be included in a June 2020 chapter on ESRD PPS design issues