CY 2024 Medicare End Stage Renal Disease (ESRD) Prospective Payment System (PPS) Proposed Rule (CMS-1782-P)

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INTRODUCTORY SUMMARY AND BACKGROUND

On June 26, 2023, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule (CMS-1782-P) to 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, 2024.

This rule proposes updates to the Acute Kidney Injury (AKI) dialysis payment rate for renal dialysis services furnished by ESRD facilities to individuals with AKI. There are also proposed updates to the requirements for the End Stage Renal Disease Quality Incentive Program (ESRD QIP), as well as updates for calendar year (CY) 2026 and 2027. Changes to the ESRD Treatment Choices (ETC) Model are also included in this proposed rule. In addition, this rule also requests information regarding potential changes to the low-volume payment adjustment (LVPA) under the ESRD PPS.

ESRD Proposed Rule

The CY 2024 proposed rule is located in its entirety at the following link: https://public-inspection.federalregister.gov/2023-13748.pdf.

This document in PDF form is 301 pages in length. The format of the information is intended to summarize the proposed changes so readers are encouraged to view the document in its entirety for further details.

PROPOSED CHANGES TO ESRD PPS

Under ESRD PPS for CY 2024, Medicare expects an increase in 2024 expenditures of $130 million as compared to CY 2023. The overall impact of the CY 2024 changes is projected to be a 1.6 percent increase in payments. This includes over 7,800 hospital-based ESRD facilities as well as freestanding ESRD facilities. Section 1881 of the Social Security Act (the Act) requires the implementation of a bundled PPS for renal dialysis services provided to Medicare beneficiaries. A single per-treatment payment is made to an ERSD facility or the patient's home for all the renal dialysis services as defined in the Act. The bundled payment rate is case-mix adjusted for factors relating to:

1) Adult patient case-mix characteristics including age, body surface area, low body mass index, onset of dialysis, four comorbidity categories (pericarditis, gastrointestinal tract bleeding, hereditary hemolytic or sickle cell anemia, myelodysplastic syndrome); and

2) Pediatric patient-level adjusters consisting of two age categories (under age 22 years or 22-26) and two dialysis modalities (peritoneal or hemodialysis).

There are three facility-level adjustments for low patient volume ESRD facilities, those in rural areas and for differences in area wage levels in the wage index. The ESRD PPS also provides a training add-on payment adjustment for home and self-dialysis; transitional drug add-on payment adjustment (TDAPA); and transitional

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add-on payment adjustment for new and innovative equipment and supplies (TPNIES). For high cost patients, outlier payments may be applicable.

Base Rate Update

Historically the term "market basket" describes the mix of goods and services used for ESRD treatment; however, this term is also used to indicate the input price index - cost categories, their respective weights and prices combined. Therefore, the term ESRD bundled (ESRDB) market basket refers to the ESRDB input price index.

For CY 2024, CMS is proposing to use the finalized CY 2023 ESRDB market basket to a 2020 base year, which reflects the most recent and complete set of Medicare cost report data, as well as other publicly available data. Additionally, CMS is proposing to continue using a labor-related share of 55.2 percent, which was also finalized in the CY 2023 ESRD PPS final rule.

Under the ESRD PPS, a single per-treatment payment is made to an ESRD facility for all the renal dialysis services defined in section 1881 of the Act. The proposed CY 2024 ESRD PPS base rate is $269.99, which applies to ESRD and AKI patients receiving renal dialysis services. This proposed amount reflects the application of the proposed wage index budget-neutrality adjustment factor (0.999652) to the finalized CY 2023 ESRD PPS base rate of $265.57, and a proposed productivity-adjusted market basket increase as required by the Act (1.7 percent), equaling $269.99: ($257.90 x 0.999652) x 1.017 = $269.99.

Wage Index Update

The wage index is updated annually based on the most current hospital wage data and the latest core-based statistical area (CBSA) delineations that account for varied wage levels in ESRD facility areas. The wage index is applied to the labor-related share of the payment rate and is budget neutral. For CY 2024, the proposed labor-related share is 55.2 percent, based on the proposed 2020-based ESRDB market basket, both of which were finalized in the CY 2023 ERSD PPS final rule.

For CY 2024, CMS is proposing to update the wage index values based on the latest available data and continuing the 2-year transition to the Office of Management and Budget (OMB) delineations as described in the September 14, 2018, OMB Bulletin No. 18–04.

In addition, CMS is proposing to continue applying the wage index floor of 0.6000 and a 5 percent cap on wage index decreases, as finalized in the CY 2023 ESRD PPS final rule.

ESRD Quality Incentive Program (ERSD QIP)

The ESRD Quality Incentive Program (ERSD QIP) focuses on improved patient outcomes by establishing incentives for dialysis facilities to meet or exceed performance standards established by CMS.

For CY 2024, CMS is proposing to revise and codify the definition of "minimum total performance score" to more accurately describe the calculation of the median of national ESRD facility performance on reporting measures. CMS is also proposing if there is an insufficient quantity of data available prior to the first performance period of a new reporting measure, CMS will set a proxy median of zero for the reporting measure until there is sufficient data to calculate the median.

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Beginning in Payment Year (PY) 2026, CMS is proposing to add the Facility Commitment to Health Equity reporting measure; modify the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) reporting measure to align with updated measure specifications developed by the Centers for Disease Control and Prevention (CDC); remove the Ultrafiltration Rate reporting measure and the Standardized Fistula Rate clinical measure; and update the Clinical Depression Screening and Follow-Up measures' scoring methodology and convert that measure to a clinical measure.

Beginning with PY 2027, CMS is proposing to add the Social Drivers of Health reporting measure and the Screen Positive Rate for Social Drivers of Health reporting measure to the ESRD QIP measure set.

CMS has requested public comments on all these proposals.

ESRD Treatment Choices (ETC) Model

The ESRD Treatment Choices (ETC) Model is a mandatory Medicare payment model tested under section 1115A of the Act and operated by the Center for Medicare and Medicaid Innovation (Innovation Center). Under the ETC Model, payment adjustments are tested to encourage home dialysis, kidney transplantation, beneficiary care modality choice, preserve and enhance quality of care, all while reducing Medicare costs. The ETC model began January 1, 2021, and will end June 30, 2027. CMS estimates the ETC Model would generate $28 million in savings related to payment adjustments over 6.5 years.

For CY 2024, this proposed rule would make certain changes to the ETC Model regarding the availability of administrative review of targeted review requests, specifically that:

- The CMS Administrator may review targeted review requests when administrative review is requested by ETC Participants within 15-calendar days of a targeted review request determination made by CMS.
- Within 45 days of the date of the ETC Participant's request for administrative review, the CMS Administrator may decline to review the targeted review request determination made by CMS; render a final decision based on the CMS Administrator's review of the targeted review request determination; or choose to take no action on the request for administrative review.
- The targeted review request determinations made by the CMS Administrator are considered final if the CMS Administrator declines an ETC Participant's request for administrative review; or if the CMS Administrator does not take any action on the ETC Participant's request for administrative review by the end of the 45-day period described.
- The existing provision stating decisions based on targeted review are final, and there is no further review or appeal would be deleted.

CMS has requested comments from stakeholders on the proposed rule items.

Low-Volume Payment Adjustment

Section 1881 of the Social Security Act (The Act) provides a facility-level payment adjustment to those ESRD facilities that meet the definition of a low-volume ESRD facility based on submitted documentation that: the facility provided less than 4,000 dialysis treatments in each of the 3 reporting years; and has not open, closed

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or received a new provider number due to a change in the 3 cost reporting years preceding the payment year. The current LVPA adjustment is 23.9 percent, with the number of ESRD facilities receiving the LVPA at 353.

Concerns from interested parties including Medicare Payment Advisory Commission (MedPAC) and the Government Accountability Office (GAO) have recommended modifications to the LVPA to better target ESRD facilities that are "critical to beneficiary access to dialysis care in remote or isolated areas". Another concern is regarding the strict treatment count, which may motivate ESRD facilities to restrict their patient caseload to stay below 4,000 treatments per year, thus making them eligible for LVPA. CMS recognizes the importance of revising the ESRD PPS LVPA adjustment methodology to ensure payments accurately reflect differences in cost, and appropriately recognize low-volume facilities. Currently, the LVPA and rural adjustments result in increased payments to some geographically isolated ESRD facilities, but do not specifically recognize geographically isolated ESRD facilities. Therefore, CMS is requesting information on modification of LVPA methodology and development of a new payment adjustment based on geographic isolation.

CMs is also proposing to create an exception to the current LVPA attestation process for ESRD facilities that are affected by disasters and other emergencies. This exception would allow ESRD facilities to close and reopen in response to a disaster or other emergency and still receive the LVPA adjustment. It would also allow an ESRD facility to receive the LVPA even if it exceeds the LVPA threshold by treating patients displaced by a disaster or emergency.

Comment Period

Comments to CMS regarding the ESRD proposed rule must refer to file code **CMS-1782-P** and must be received no later than **August 25, 2023.** Electronic and mail submissions are acceptable, electronic submissions are encouraged: http://www.regulations.gov. Follow the instructions under the "submit a comment" tab.

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