Health Law Daily Wrap Up, END-STAGE RENAL DISEASE—FINAL RULES: ESRD payments, quality program updated, (Nov. 6, 2015)

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Providers of end-stage renal disease (ESRD) services should expect to see a payment increase of about 0.2 percent based on the amendments to the payment rates and adjustments to the ESRD prospective payment system (PPS) which will become effective January 1, 2016. In a Final rule, CMS noted that it used a regression analysis to update its payment system using the most recent available information as required by section 632 of the American Taxpayer Relief Act of 2012 (ATRA) (P.L. 112-240) and implemented several other pieces of legislation (Final rule, 80 FR 68968, November 6, 2015).

Legislative requirements. Soc. Sec. Act sec. 1881(b)(14), as amended by, among others, sec. 3401 of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), requires CMS to adjust the base payment amount by the increase in the ESRD market basket, reduced by the productivity adjustment factor provided in Soc. Sec. Act sec. 1886(b)(3)(B). ATRA sec. 632 also requires CMS to reduce the single payment amount to reflect the use of ESRD-related drugs and biologicals that had been paid separately and to make other changes to the case-mix adjustments by January 1, 2016.

Base payments, outliers, and limits. The base rate for calendar year 2016 will be $230.39. The fixed-loss amount for pediatric patients will rise from $54.35 to $62.19, while the Medicare allowable payment will drop from $43.57 to $39.20. For adult patients, the fixed loss amount will be $86.97, up from $86.19, and the Medicare allowable payment will be $50.81, down from $51.29.

Other adjustments. The comorbidity adjustments for bacterial pneumonia and monoclonal gammopathy are removed. The grandfathering requirement is eliminated from the low-volume payment adjustment (LVPA), and the proximity requirement for LVPA eligibility is changed. A new rural adjustment will be introduced based on the agency’s updated regression analysis.

As required by sec. 217(c) of the Protecting Access to Medicare Act (PAMA) (P.L. 113-93), a drug designation process will be used to determine when a drug is no longer an oral-only drug and to include new injectable and intravenous dialysis drugs in the bundled payment.

Quality incentives. The agency is reinstating a requirement that facilities attest to the patients that are ineligible for inclusion in the consumer assessment. Although facilities have had difficulty making timely and accurate attestations, CMS is not aware of any reliable, independent source of data that would identify which patients are ineligible because they are in prison or in hospice care, for example. Changes also will be made to the small facility adjustment as suggested by a commenter. Facilities that treat between 11 and 25 patients and that score below the 90th percentile on a national measure of clinical performance would receive an adjustment calculated in accordance with the final rule.