RENAL HEALTHCARE ASSOCIATION
SUPPORTING DIALYSIS FACILITIES AND PROFESSIONALS

OMB Meeting with RHA

Discussing Key Challenges Facing RHA Members and Recommendations to Protect Beneficiary Access to High-Quality Care under the ESRD PPS

October 23, 2023

About Us

The Renal Healthcare Association (RHA) is a member-based trade organization representing over 150 dialysis providers throughout the United States that provide life-sustaining dialysis services to nearly 135,000 Medicare beneficiaries.

RHA membership primarily includes small and independent for-profit and not-for-profit providers serving patients in urban, rural, and suburban areas in both free-standing and hospital-based facilities.

Currently, RHA has nearly 200 active member companies that operate over 1,200 dialysis facilities and 130 hospital-based dialysis centers, treating both adult and pediatric patients.

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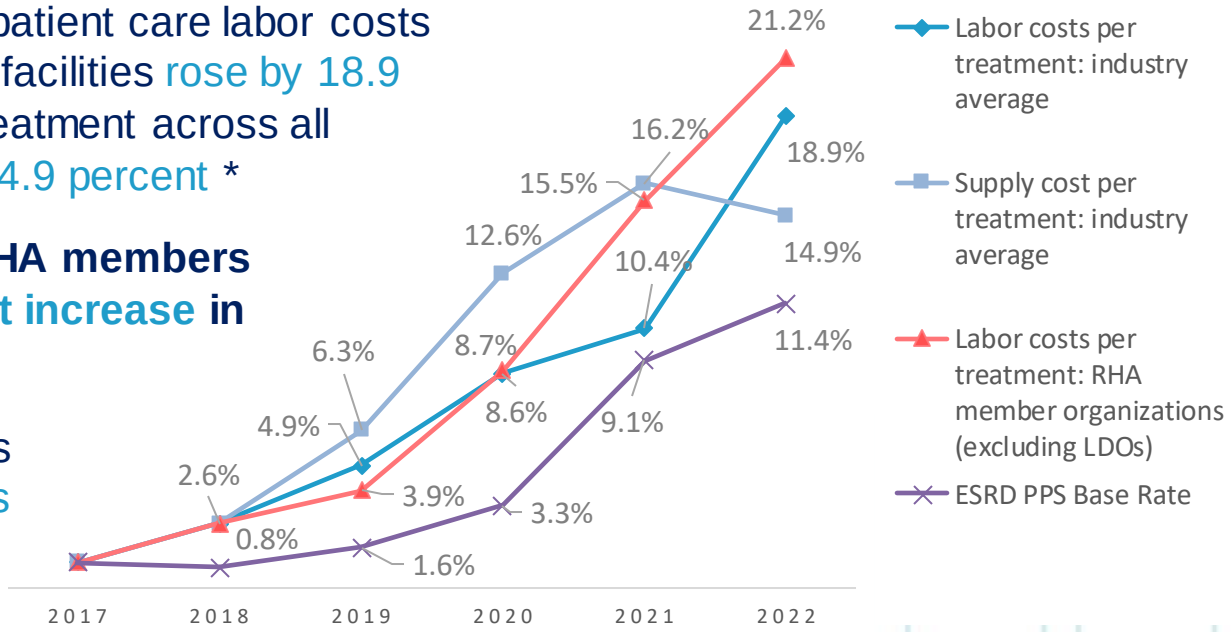
ESRD PPS Rates Have Failed to Keep Up With Increasing Provider Costs

- Between 2017-2022, direct patient care labor costs per treatment for all dialysis facilities rose by 18.9 percent. Supply costs per treatment across all dialysis modalities rose by 14.9 percent *
- **During this time period, RHA members experienced a 21.2 percent increase in labor cost growth.***
- Between 2017-2022, dialysis providers have seen updates of only 11.4 percent to their ESRD PPS base rates.^



The proposed increase of 1.7 percent to the ESRD PPS base rate is not sufficient to cover rising ESRD facility costs. Without more significant CMS intervention in CY 2024, these alarming trends will result in further dramatic disruptions to dialysis patient care in the years ahead.

*Analysis of 2017-2022 Medicare Cost Reports conducted by Prima Health Analytics, Weymouth, MA. Prepared for RHA in August 2023; ^ESRD PPS Final Rules, CY 2017-2022

Dialysis Providers Are in a State Of Emergency

Facility Margins*

- The net Medicare operating margin for RHA members was **-10.3%** in 2022, compared to **-4.8%** in LDOs.
- The total operating margin (all payers) for RHA members in 2022 was **6.2%**, compared to **15.4%** reported by LDOs.

Operating Losses*

Between 2019 – 2021:

- 40% of independent ESRD facilities and 34% of SDOs reported net losses, compared to only 22% of all LDOs.
- Independent ESRD facilities experienced an average net loss of $446,876.
- Average net loss for SDOs amounted to $593,536 – (more than double the average net loss of $290,387 reported by LDOs)

Facility Closures^

- From January 2020 – January 2023, 383 dialysis facilities closed, affecting an estimated 21,000 ESRD patients.
- Of the 383 closures identified, nearly 200 of them occurred in 2022 alone.

*Analyses of Medicare Cost Reports conducted by Prima Health Analytics, Weymouth, MA. Prepared for RHA in November 2022 and August 2023; ^Analysis of Medicare's Dialysis Facility Care Compare (DFCC) database between 2020 and 2022 conducted by Prima Health Analytics, Weymouth, MA. Prepared for RHA in February 2023.

Key RHA Recommendations to OMB

1. Reform Key ESRD PPS Payment Policies
2. Improve Efficacy of ESRD PPS Payment Adjustments
3. Preserve Integrity of ESRD Quality Incentive Program

1 Reform ESRD PPS Payment Policies (1/2)

1. **Provide a One-Time, Non-Budget Neutral Adjustment to Increase the ESRD PPS Base Rate**

- The ESRD PPS does not adequately address the needs of the dialysis provider community during this time of economic and staffing instability.
- To continue delivering high-quality care amidst the growing costs of labor and supplies, **dialysis providers desperately need additional funds beyond those that CMS has proposed**.
- Medicare Advantage (MA) plans and other commercial payers set their reimbursement rates for most small and independent providers based on the ESRD PPS, often excluding many of the patient and facility-level adjustments offered in the ESRD PPS.

  → In June 2022, **41.6% of Medicare beneficiaries with ESRD were enrolled in MA,** up from a total of 23.8% in 2020.*

- CMS has established non-budget neutral policies in the past (the Transitional Drug Add-on Payment Adjustment (TDAPA), the home dialysis training add-on payment, etc.). The RHA urges the agency to do so again to **course-correct the ESRD PPS base rate and preserve patient access to dialysis care.**

*Analysis of Master Beneficiary Summary File data between June 2020 and June 2022 by ATI Advisory, Washington, DC. Prepared for RHA in March 2023.

1 Reform ESRD PPS Payment Policies (2/2)

2. Establish an ESRD Market Basket Forecast Error Adjustment

- From CY 2021 through CY 2023, the market basket update has been underestimated by a combined **3.1 percent**, equivalent to an increase of **$8.37** over the CY 2024 ESRD PPS base rate.
- This is in keeping with a policy afforded to Skilled Nursing Facilities (SNFs) since 2003.* According to CMS, the SNF market basket forecast was under-forecast because *"wages and benefits for nursing home workers increased more rapidly than expected."* ESRD facilities are facing a very similar experience and should be granted parity in policies offered to SNFs.

3. Align Dialysis Facility Wage Index Standards with Inpatient Hospital Policies

- The current wage index system exacerbates the disparities between high and low wage index facilities.
- With a high proportion of their base rate being adjusted based on the wage index, lower wage index facilities have fewer resources with which to provide dialysis care.
- To remain competitive with hospitals and recruit and retain high-quality clinical staff, dialysis facilities must be able to have access to the same wage index standards as inpatient hospitals.

*FY 2004 SNF Final Rule

2 Improve Efficacy of ESRD PPS Payment Adjustments (1/2)

1. Modify LVPA to Target Low-Volume and Geographically Isolated Facilities

- The LVPA does not sufficient cover costs of low-volume, non-LDO facilities, and the adjustment only captures a portion of facilities reporting fewer than 4,000 treatments – the low-volume adjustor threshold amount.
- RHA agrees with MedPAC that CMS should replace the current LVPA with a single adjustment for dialysis facilities that are low-volume and geographically isolated.
- A new payment adjustment targeting dialysis facilities from which some of Medicare's most vulnerable beneficiaries receive care would **protect access and choice in dialysis care** for these patients.

2 Improve Efficacy of ESRD PPS Payment Adjustments (2/2)

2. Forgo Proposed "Time on Machine" Reporting Measure

- This measure would require ESRD facilities to report on ESRD PPS claims the duration of time in minutes each of their patients spent in-center receiving hemodialysis.
- A number of external factors impact how a person dialyzes:
  - ➢ Patients with chronic pain, complex co-morbidities, or other physical limitations may require shorter, more frequent dialysis treatment sessions.
  - ➢ While certain patients may benefit clinically from longer dialysis treatment times, they may refuse to remain on dialysis for longer periods

Supplies used and costs incurred by providers remain the same, regardless of patients' time on machine

- Time on machine reporting measure may:
  - ✓ **Misinform** future payment policy refinements,
  - ✓ Incentivize providers to **abuse the system**, and
  - ✓ Introduce additional **reporting burden** for providers

- RHA disagrees with the value of this data and recommends strongly that the Time on Machine reporting measure **not be finalized**.
- If this measure is finalized, RHA urges CMS to provide comprehensive guidance regarding administrative and implementation requirements in advance of finalization.

3 Preserve Integrity of ESRD Quality Incentive Program (1/2)

1. **Consider Administrative Burden Associated with Proposed *Facility Commitment to Health Equity* Reporting Measure**
   - RHA is concerned that this measure may not lead to meaningful clinical outcomes while adding significant administrative burden to dialysis facility staff.
   - RHA also questions the applicability of some domain elements to dialysis providers:
     - While not all dialysis facilities use certified EHR technology, an affirmative attestation under *Domain 2: Data Collection*, indicates that a facility:

     "*inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using certified EHR technology.*"
   - If finalized, CMS should revise measure language to prevent dialysis providers with more limited technological capabilities from being unduly penalized.

2. **Exclude *Social Drivers of Health (SDOH) Measures* from the CY 2027 ESRD Quality Incentive Program (QIP)**
   - Dialysis facilities conduct SDOH screenings as part of comprehensive care plans.
   - RHA remains concerned with reporting burden on providers, particularly those who care for a disproportionate share of vulnerable ESRD patients.
   - We recommend that CMS **leverage already collected SDOH data sources** to help ensure that a patient's needs are understood and addressed appropriately.

3 Preserve Integrity of ESRD Quality Incentive Program (2/2)

3. Maintain Clinical Depression Screening and Follow-Up Measure Under the ESRD QIP Reporting Domain (Instead of Converting to Clinical Domain)

- Modifying dialysis payment through the QIP based on the ability to screen for depression and document follow-up plans may result in fewer resources for facilities caring for patients with higher rates of depression or other social needs.
- Before converting to a clinical measure, CMS should remove existing reimbursement barriers and allow licensed clinical social workers (LCSWs) and other mental health professionals to **treat and bill for mental health services** while onsite at a dialysis facility.
  - ⇒ There is evidence within the Medicare Advantage program of allowing primary care and behavioral health services to be co-located within dialysis facilities.
- Having a trained mental health professional develop a follow-up plan but also support a patient throughout the plan's implementation would **close existing gaps in comprehensive ESRD care and improve outcomes for dialysis patients** who screen positive for clinical depression.
- RHA members would welcome mental health professionals into their facilities to assist in identifying and addressing the mental health needs of their patients while they are dialyzing onsite.

Thank You

We look forward to working with OMB to strengthen the ESRD PPS and protect beneficiary access to high-quality care.

If you have any questions concerning our comments or recommendations, please do not hesitate to contact RHA Board President Rob Bomstad.

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APPENDIX

Additional RHA Recommendations for the CY 2024 ESRD PPS

Improve Efficacy of ESRD PPS Payment Adjustments

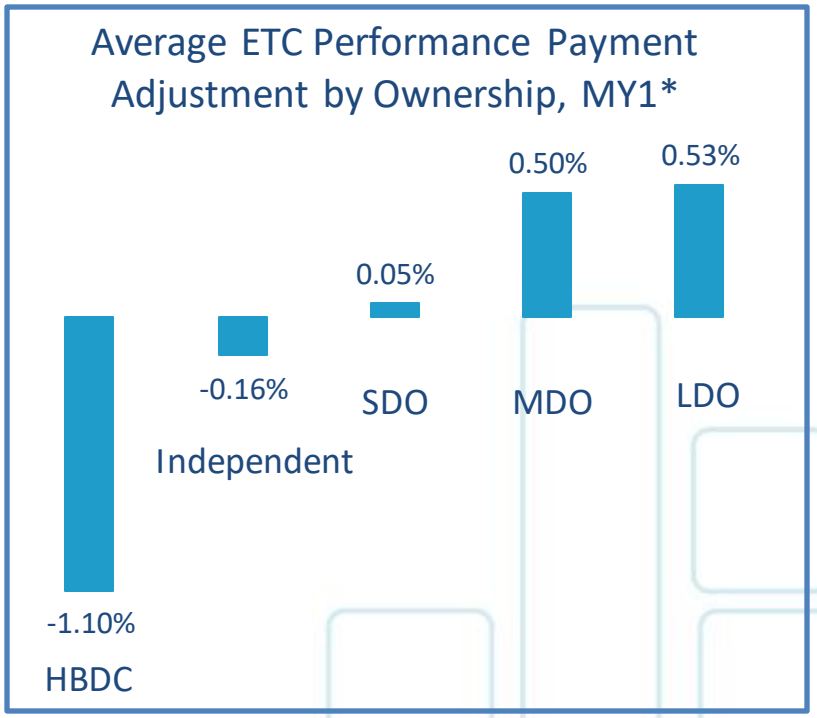
1. **Finalize Transitional Pediatric ESRD Add-on Payment Adjustment (TPEAPA) as Non-Budget Neutral**
   - RHA agrees that **30 percent** cost is a reasonable estimate of the unaccounted-for costs incurred in treating pediatric ESRD patients compared to adult ESRD patients
   - Add-on payment adjustments under section 1881(b)(14)(D)(iv) of the Act are not statutorily required to be budget neutral under the ESRD PPS*
   - We do not recommend reducing the ESRD PPS base rate to account for the new allocation of costs and urge CMS to finalize the TPEAPA as **non-budget neutral**

2. **Finalize and Make Permanent the Post-TDAPA Payment Adjustment at 100 Percent of the Average Sales Price for the Given Renal Dialysis Drug or Biological Product**
   - The ESRD PPS bundle does not contain sufficient funding to support the adoption of innovative treatment options. Extending an add-on adjustment for only three years will not resolve that problem.
   - As proposed, a post-TDAPA payment adjustment set at 65 percent of expenditure levels will **inadequately reimburse providers** for the costs incurred by the provision of these new drugs.
   - RHA members will be unable to make up this difference on their own and thus prohibited from integrating these new drugs and biological products into their facilities.

*https://public-inspection.federalregister.gov/2023-13748.pdf, p.68

Revise the ETC Model Participation Requirements to Preserve Patient Access to Dialysis Care

- The ETC Model requires dialysis facilities to make costly, fundamental, and time-consuming care changes to avoid substantial payment reductions under the Model.
- Small and independent dialysis groups are at an unfair and immediate disadvantage under the ETC Model. In 2020, fewer than 40% of small and independent providers had a home program established.
- CMS should modify the low-volume threshold to exclude ESRD facilities with fewer than **350 attributed ESRD beneficiary years** during a measurement year from the applicability of the ETC Model's facility performance payment adjustment (PPA) for the corresponding PPA period.
- The current low-volume threshold is set at **11 attributed ESRD beneficiary years**, consistent with the ESRD QIP program. We recommend a much higher threshold to align with thresholds used in the Kidney Care Choices (KCC) and Comprehensive ESRD Care (CEC) models.



*Analysis of ETC Model MY1 performance results, conducted by Prima Health Analytics, Weymouth, MA. Prepared for RHA in March 2023.