Improving the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) To Protect Care for Dialysis-Dependent Medicare Beneficiaries

In the wake of enduring reimbursement deficiencies under the ESRD PPS, dramatic increases in supply and labor costs, and insurmountable staffing challenges, the dialysis provider community has reached a state of emergency.

The 3.0% increase to the CY 2023 ESRD PPS base rate remains insufficient amidst the unprecedented and persistent challenges facing the dialysis provider community. As a result, RHA members are reporting record-high losses and dialysis facilities are closing at an astounding rate. Between the January 2020 and January 2023, 383 dialysis facilities ceased operations, affecting an estimated 21,000 ESRD patients. Without immediate intervention, these alarming trends of revenue losses and facility closures will persist, further disrupting dialysis patient care in the years ahead.

Ahead of the release of the CY 2024 ESRD PPS regulation, we are seeking Congressional support for the priorities below to help protect access to life-sustaining dialysis treatments for our nation’s highly vulnerable ESRD patients.

1. **Allow for the inclusion of bad debt from Medicare Advantage (MA) patients on Medicare cost reports.** Many patients on dialysis report difficulties paying their out-of-pocket costs, including those enrolled in MA. Currently, only bad debts from Medicare FFS patients can be claimed on cost reports for which providers can collect 65% of the unpaid beneficiary cost-sharing amount. Any MA enrollee out-of-pocket bad debts do not qualify for reimbursement on a Medicare cost report, forcing providers to absorb the full amount of bad debts without recourse. With over 41% of Medicare beneficiaries with ESRD now enrolled in MA, this policy jeopardizes dialysis facilities’ ability to continue caring for these beneficiaries.

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2. **Improve the low-volume payment adjustment (LVPA) and establish a safety net adjustment** to more effectively target facilities most in need of additional financial support to deliver high-quality care. The LVPA should be restructured into a tiered payment adjustment whereby facilities with lower patient volumes – and higher per-treatment costs – would be eligible for higher payment adjustments. CMS should establish a separate, additional payment adjustment specifically targeting safety net dialysis facilities, defined as small and independent dialysis facilities that are not owned by organization with 500 or greater facilities.

3. **Revise the ESRD Treatment Choices (ETC) Model participation requirements** to exclude small, independent, and hospital-based dialysis clinics from the Model unless they voluntarily elect to participate. These facilities do not have the resources required to successfully participate in the program, nor can they sustain cuts of up to -10% under the ETC Model – particularly when most operate on small or negative Medicare margins. Without the option of opting out of the ETC Model, facilities will be forced to close or be purchased by larger dialysis organizations, which would further consolidate the dialysis industry and reduce patient choice.

4. **Provide more appropriate reimbursement for the actual costs of providing and growing home dialysis services.** With fewer resources and limited market power to negotiate, small and independent dialysis facilities face unsurmountable barriers that prevent them from offering home dialysis to their patients. Moreover, the time that dialysis clinics allocate to training patients on home therapy has been significantly underestimated, rendering the current add-on payment vastly insufficient. CMS must reevaluate the total costs of home dialysis care and must ensure that Medicare reimbursement is supplying providers with the upfront resources they need to provide and grow their home dialysis programs.

5. **Establish an ESRD market basket forecast error adjustment policy** to protect providers from underestimations of market basket increases. From CY 2020 through CY 2023, the ESRD market basket has been underestimated by a combined 3.1%, equivalent to an increase of $8.23 over the CY 2023 ESRD PPS base rate. To safeguard against these discrepancies, CMS should include a forecast error adjustment in the ESRD PPS, in keeping with the policy afforded to Skilled Nursing Facilities since 2003. We appreciate the efforts of Senators Ben Cardin and Marsha Blackburn, along with representatives Terri Sewell and Mike Kelly, who recently circulated sign-on letters to OMB and CMS requesting that they include a forecast error adjustment framework in the upcoming ESRD PPS proposed rule.

6. **Reduce the Outlier Payment Adjustment amount from 1 percent to 0.5 percent** to increase reimbursements to dialysis providers under the ESRD PPS. The ESRD PPS includes an outlier payment adjustment for high-cost outliers due to unusual variations in the type or amount of medically necessary care. Outlier payments have consistently fallen below CMS’s target, resulting in over $150 million dollars between 2019 and 2021 ultimately not released to dialysis facilities.

7. **Reform the administration of the Transitional Drug Add-on Payment Adjustment (TDAPA) and Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES).** To ensure providers have sufficient time to integrate new equipment and treatments into their business and begin timely contracting with managed care payers, TDAPA and TPNIES reimbursement amounts should be provided no less than 6 months in advance of qualifying products becoming available for patient use. Furthermore, rate-setting should be better informed to more accurately reflect how and where devices will be used, and the residual financial impact on dialysis providers. Lastly, all MA plans must adequately reimburse for TDAPA-eligible innovations, which may yield more effective treatment and a better care experience for Medicare beneficiaries with ESRD.

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