



# HOME DIALYSIS REIMBURSEMENT AND POLICY

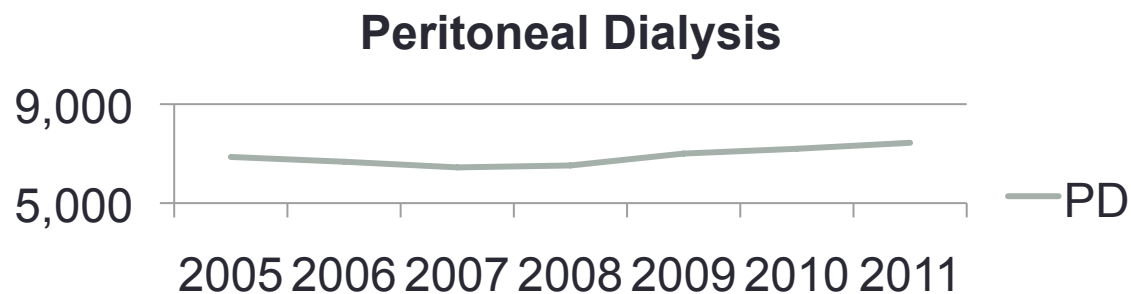
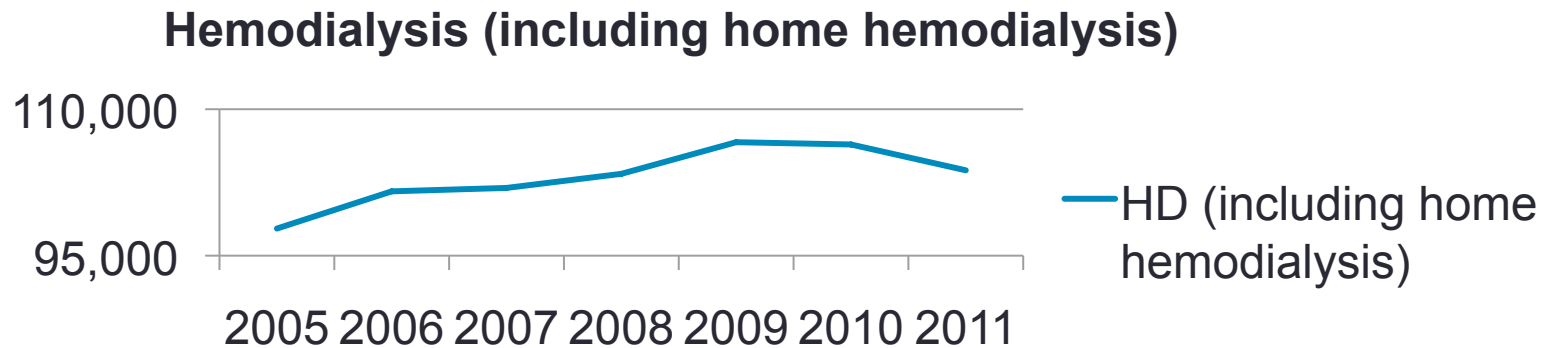
---

Tonya L. Saffer, MPH  
Senior Health Policy Director  
National Kidney Foundation

# Objectives

- Understand the changing dynamics of use of home dialysis
- Know the different payers for dialysis
- Learn how Medicare payment is structured and how it may effect use of home dialysis
- Understand the economics of dialysis and how it may effect home dialysis use
- Gain insight on future policy and legislative changes that could further effect PD use

# More Patients are Starting Therapy on PD



**For the first time in thirty years, the number of patients beginning hemodialysis (HD) has declined as more patients initiate dialysis on peritoneal dialysis (PD)**

# Current Shortage of Baxter PD Solutions Poses Challenges for Patients

- Current patients able to receive their solutions, but disruptions and delays are occurring
  - Obstacles to traveling
- New patients are waiting to begin treatment have a PD catheter, but haven't been able to start PD – many may have to start hemodialysis instead



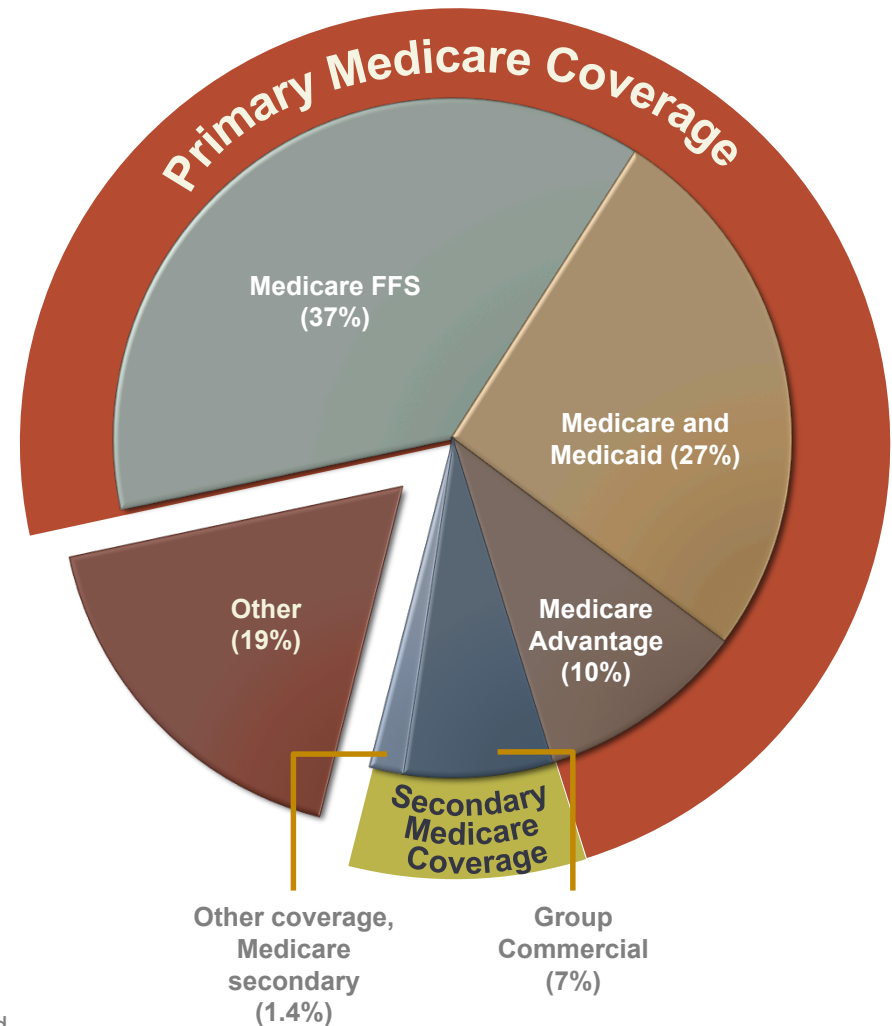
# INSURANCE COVERAGE FOR END-STAGE RENAL DISEASE

---

# Who Pays for Dialysis?

- Medicare is the primary or secondary payer for 82% of dialysis patients<sup>1</sup>
- Medicare is the secondary payer for about 7-15% of dialysis patients who have coverage through an Group Health Plan (GHP) at the time of end-stage kidney disease (ESRD) diagnosis
  - For those individuals, GHP will be the primary payer and Medicare secondary for up to 33 months after the start of dialysis as long as the individual maintains GHP coverage\*
- 26% of all dialysis patients are dually eligible for Medicare and Medicaid
  - Less than 3% of dialysis patients have Medicaid as their only insurance

## Payer Mix for Dialysis Patients

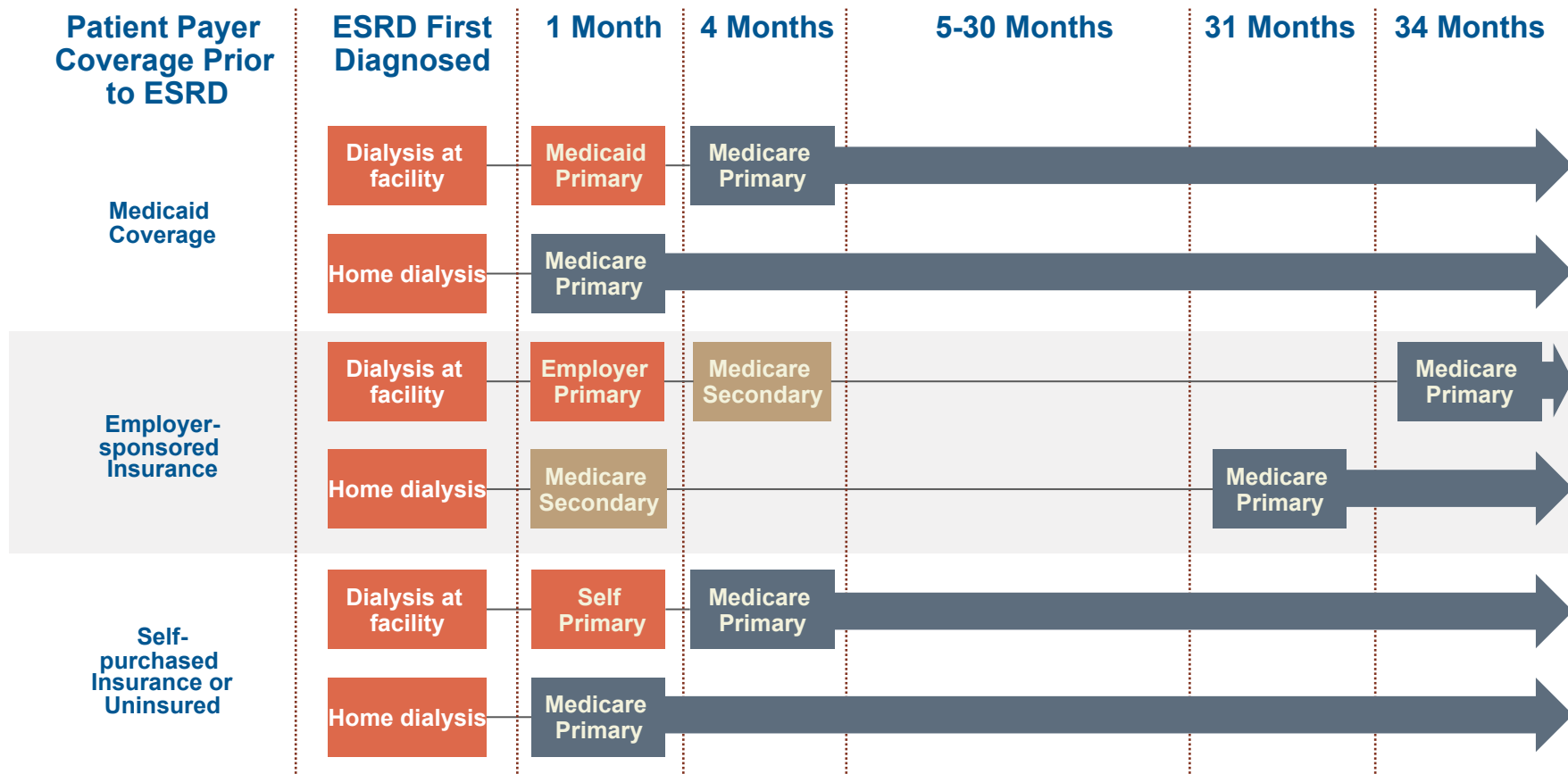


USRDS 2012 ADR Table D.21

\*After 33 months GHP becomes secondary to Medicare if GHP premiums are paid

"Other" coverage includes Veteran's Affairs (VA), Medicaid, individual commercial, uninsured

# Immediate Medicare Coverage for PD Patients



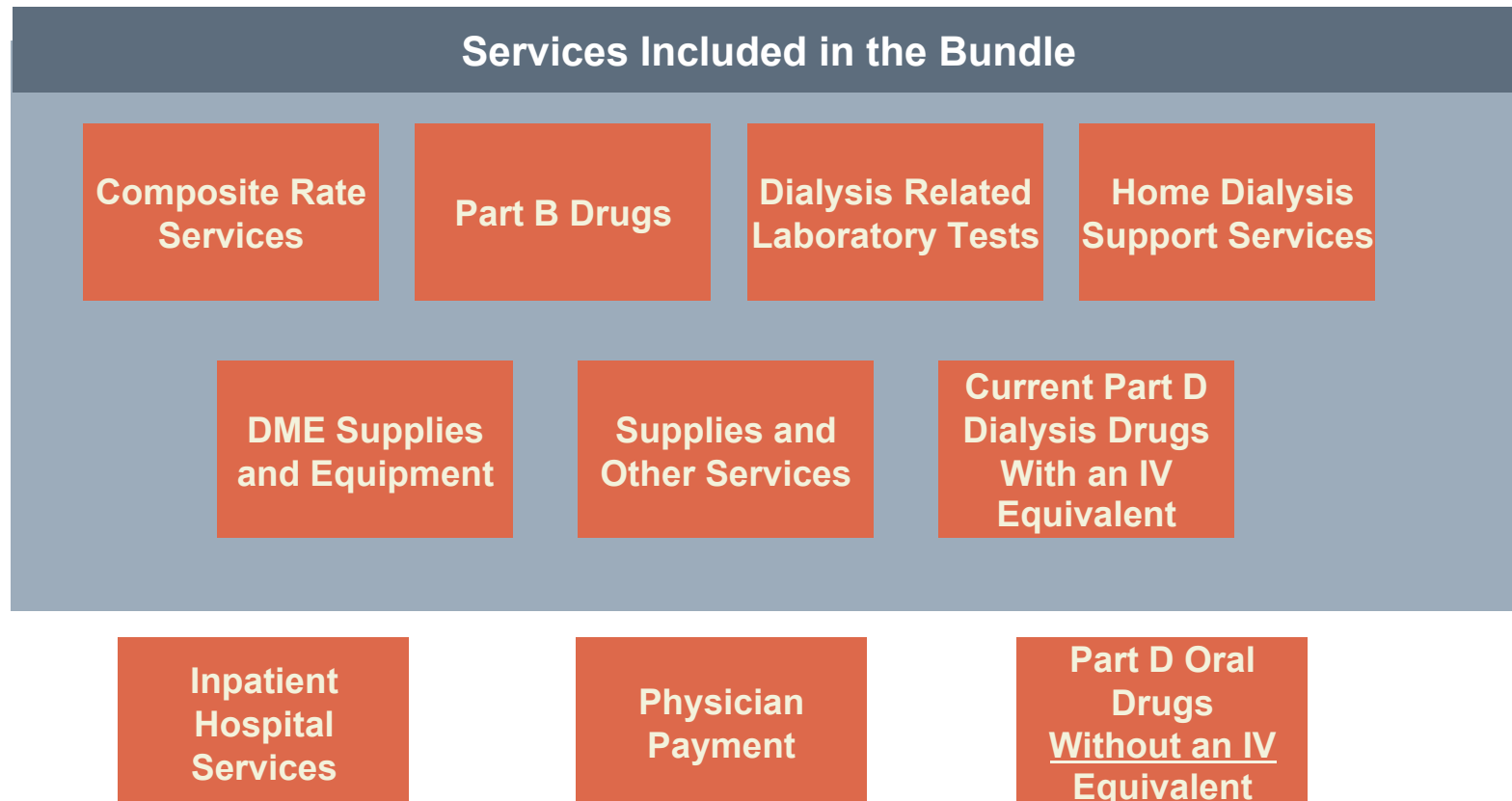
**Medicare Coverage Begins As Soon As Home Training Begins, Regardless of Any Other Dialysis Treatments**



# MEDICARE ESRD PROSPECTIVE PAYMENT SYSTEM (PPS)

---

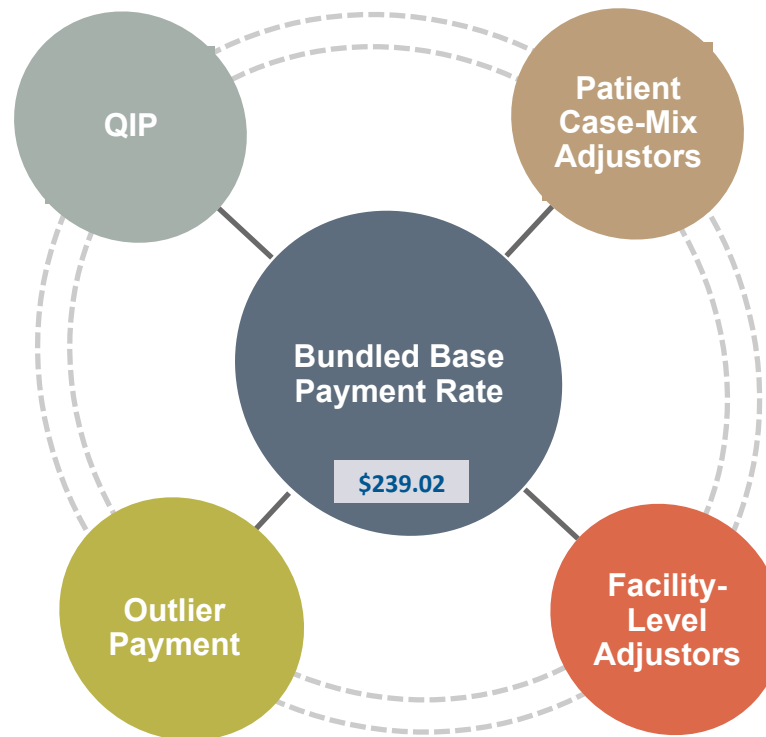
# Most Dialysis Services Included, but Excludes Physician, Hospital Services, and most Oral Drugs



# The Payment Includes Several Adjustments

- Payment reduction to the facility based on performance of defined quality measures
- Maximum payment reduction is two percent

- One percent of aggregate PPS payments set aside for outlier cases
- Facility-specific outlier payments equal 80 percent of the amount by which the facility's imputed costs exceeds a fixed-dollar loss threshold

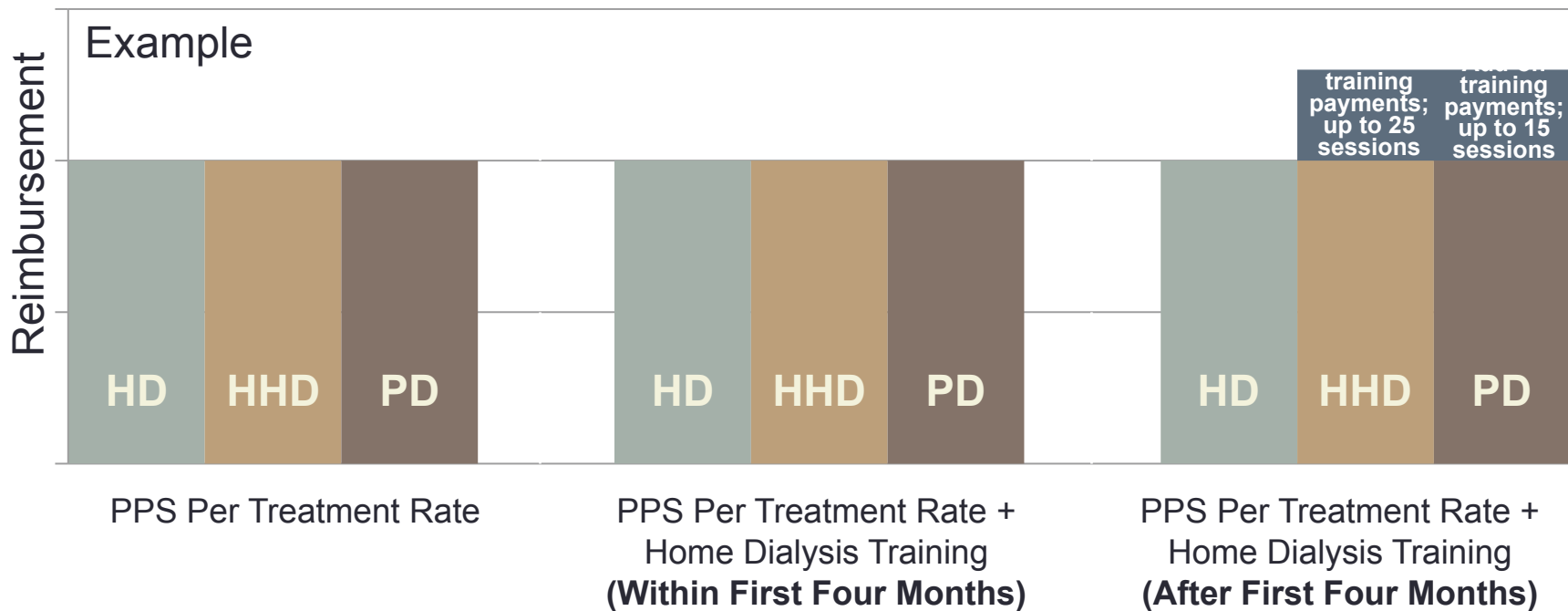


- Patient Age
- Body Mass Index
- Onset of Dialysis
- Body Surface area
- Comorbidities

- Geographical wage index
- Low volume facility adjustment of 18.9 percent increase to the base rate for dialysis services furnished on or after January 1, 2011, and before January 1, 2014

# Medicare Reimburses All Dialysis Modalities at the Same Payment Rate

- Peritoneal dialysis (PD) and home hemodialysis (HHD) offer patients the ability to receive dialysis treatments in their homes as an alternative to receiving hemodialysis treatments in facilities three times per week



The current Medicare payment system equalizes reimbursement for PD compared to hemodialysis, which is correlated with increase use of PD.

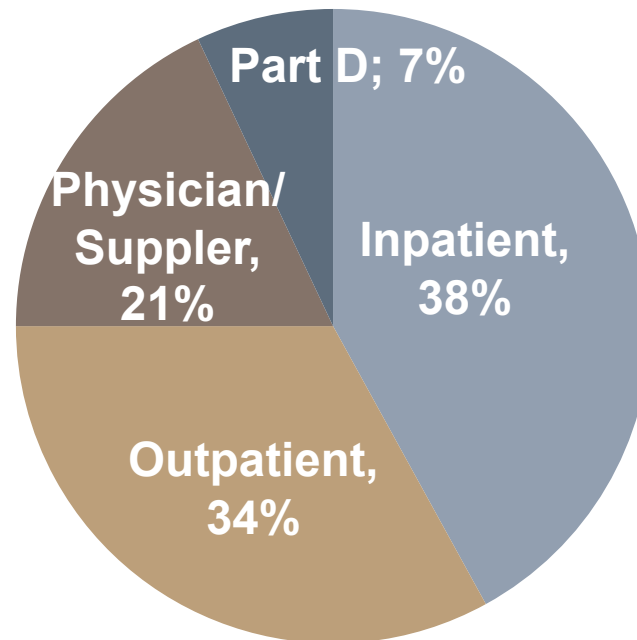


# ECONOMICS OF DIALYSIS

---

# Hospital Stays are the Largest Portion of Medicare Costs Patients

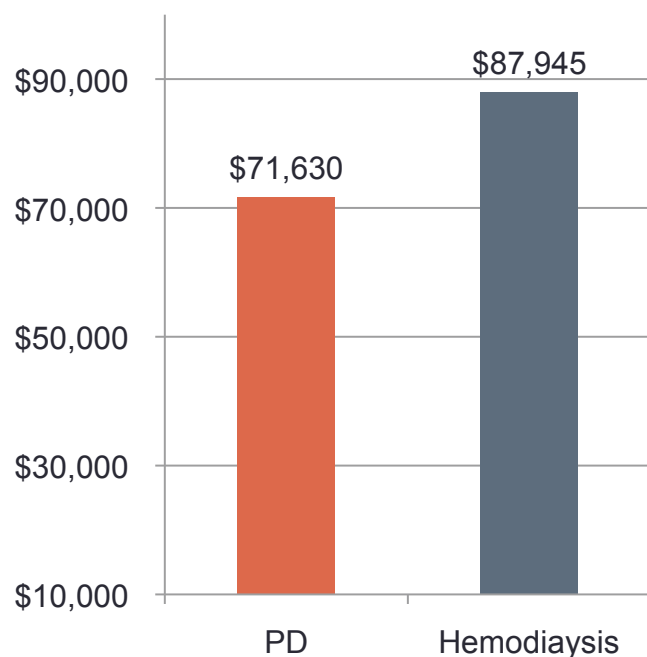
**Medicare ESRD Costs**



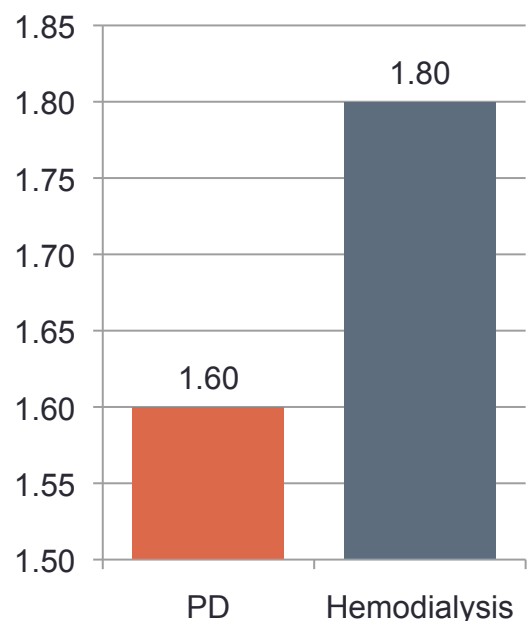
To lower costs, CMS is likely to emphasize reduced hospitalization and readmission rates. CMS has proposed to include a standardized readmissions ratio measure in the QIP for payment year 2018

# Hospital Costs Lower for PD

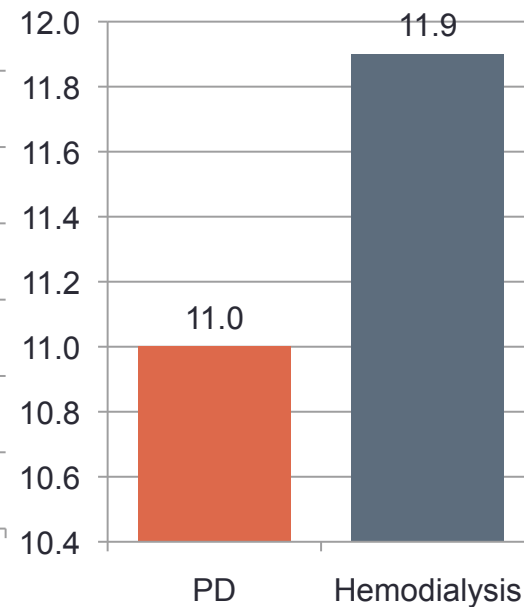
2011 Medicare Spending



2011 Hospital Admissions Rate



2011 Hospital Length of Stay Per Patient Year



Fewer hospitalizations and shorter stays result in savings to Medicare. A quality metrics in the QIP related to hospitalization could further drive increases PD use.

# Medicare Margins Are Slim, But Positive for Most Facilities

Facility Type	Medicare Margins
All	3.9
2 largest dialysis organizations	4.2
All others	3.5
Rural (all)	-.08

Source: Report to the Congress: Medicare Payment Policy. MedPAC, 2008-2012.

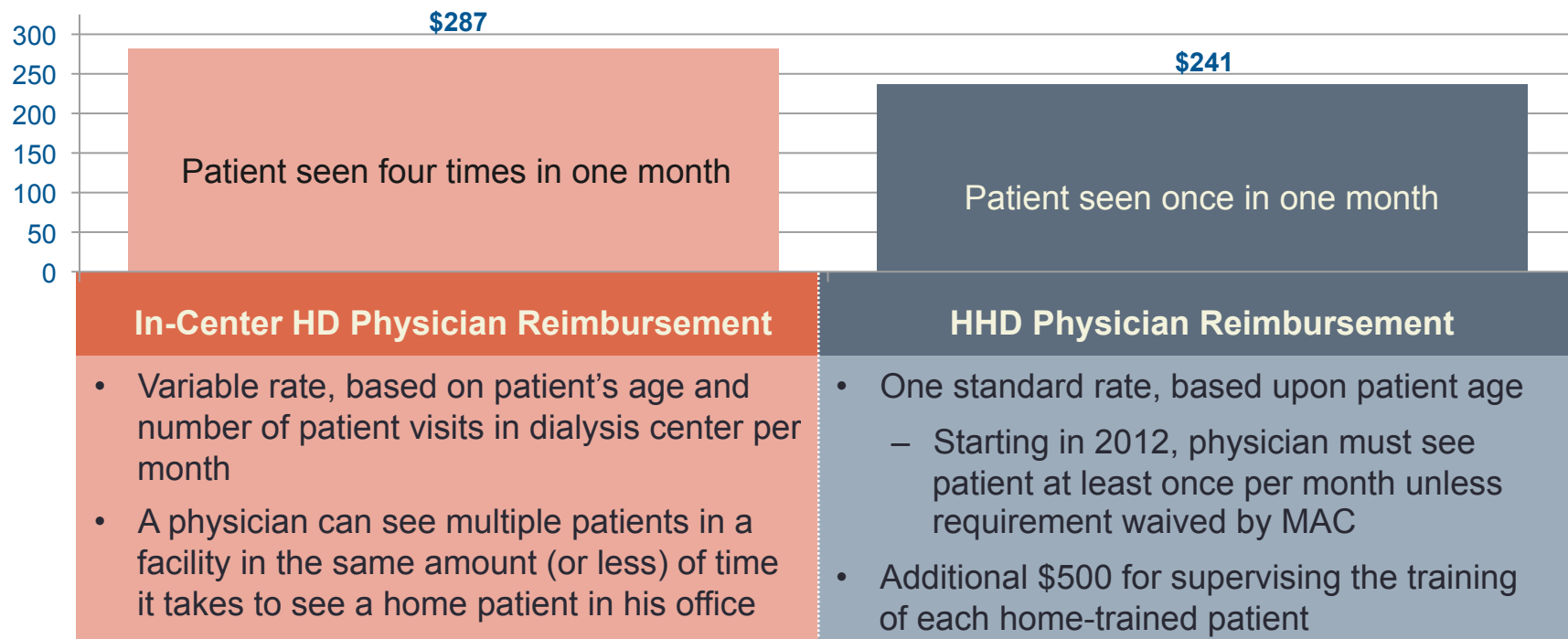


# PHYSICIAN ROLE IN TREATMENT AND EDUCATION

---

# Physicians Receive an MCP for Management of Dialysis Patients

Example: Physician manages patient 30 years old and sees patient one time in one month



# Education Linked to an Increase in Use of Home Dialysis

- National Kidney Foundation (NKF) Kidney Disease Outcomes Quality Initiative (KDOQI) guidelines, clinical action plans vary by stage of chronic kidney disease
  - At stage 3 of CKD, physicians should be evaluating and treating complications
  - At stage 4 of CKD, physicians should be preparing patients for kidney replacement therapy
- To help patients with CKD stage 4 prepare for future dialysis, Medicare will reimburse a physician, physician assistant, nurse practitioner, or clinical nurse specialist for up to six kidney disease education (KDE) sessions covering the following topics:
  - Management of comorbidities
  - Prevention of uremic complications
  - Therapeutic options, treatment modalities, and settings, including a discussion of the advantages and disadvantages of each treatment option and how the treatments replace the kidney
  - Opportunities for beneficiaries to actively participate in the choice of therapy



QUALITY

---

# The Bundled PPS QIP Affects Dialysis Facility Reimbursement

- MIPPA required CMS to develop a Quality Incentive Program (QIP) for the bundled PPS
  - Medicare began **reducing** payments by up to two percent starting January 1, 2012, to dialysis facilities that do not meet certain performance standards based on 2010 calendar year (CY) facility performance
  - For payment year (PY) 2013, over 90% of facilities successfully met the quality measure thresholds and have not received any reductions in payment in 2014<sup>1</sup>
- To determine the amount of the payment reduction, CMS assigns points to facilities based on their performance on specified quality measures
  - In calculating total performance score, clinical measures are weighted higher than reporting measures
- For the PY2014 ESRD QIP, CMS finalized a scoring methodology in which the performance of each provider and facility was calculated by assigning 0-10 points for each measure (performance year 2012)

Total Performance Score	Finalized Payment Reduction PY 2014
53-100	0.0%
43-52	0.5%
33-42	1.0%
23-32	1.5%
0-22	2.0%

# Not all Measures in the QIP Apply to Home Patients

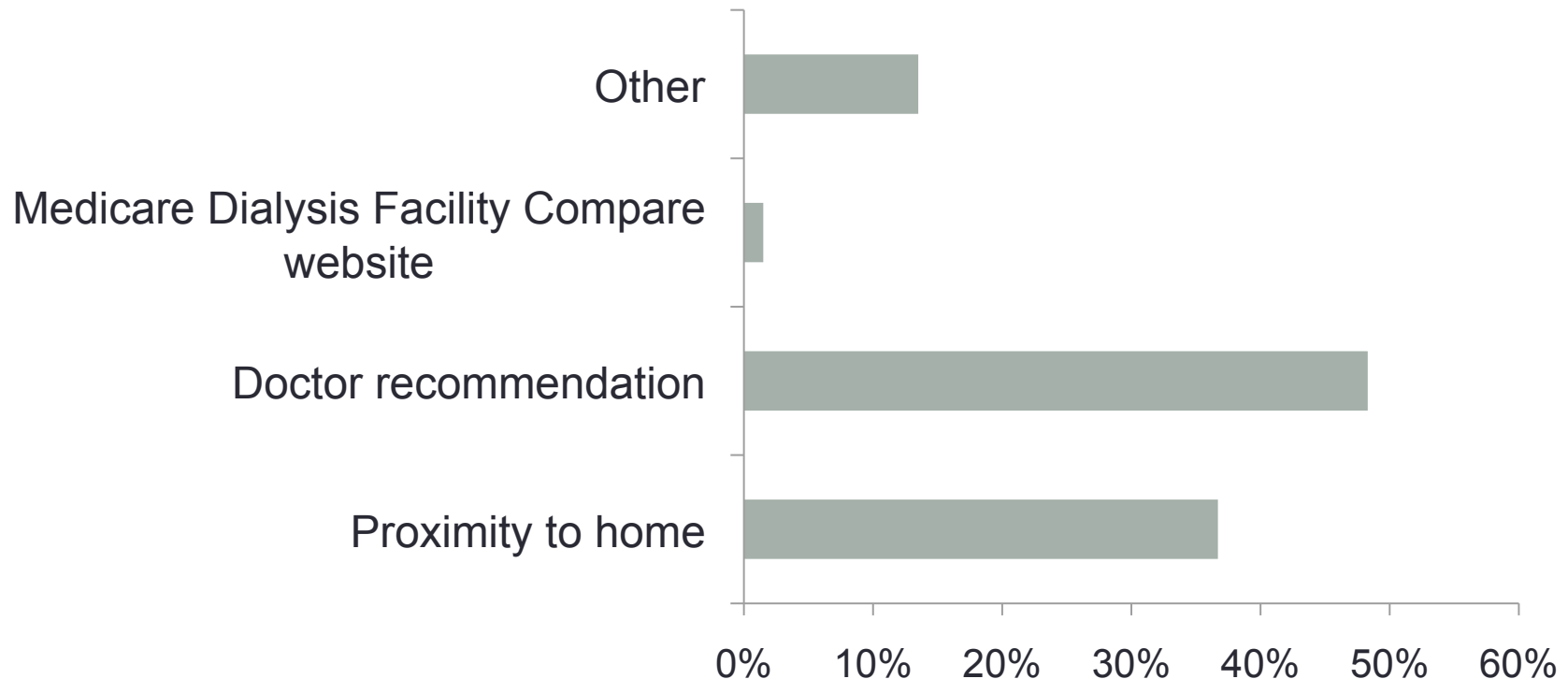
Measure and Description	Payment Year		
	2014	2015	2016
<b>Dialysis Adequacy Measure - URR</b> Percentage of patients with an average Urea Reduction Ratio (URR)>65 percent <sup>b</sup>	C	N/A	N/A
<b>Dialysis Adequacy Measure Kt/V</b> (adult hemodialysis, adult peritoneal dialysis, pediatric hemodialysis – 3 separate measures)	N/A	C	C
<b>Hemoglobin &gt; than 12 g/dL</b> Percentage of patients with an average Hemoglobin >12.0g/dL <sup>b*</sup>	N/A	C	C
<b>Vascular Access Type Measure (Average of fistula and catheter sub-measures)</b> Percentage of patients receiving AV fistula treatment Percentage of patients receiving treatment with catheter	C	C	C
<b>Hypercalcemia</b>	N/A	N/A	C
<b>NHSN Bloodstream Infections in Hemodialysis Patients</b>	R	R	C
<b>Patient Experience of Care Survey</b>	R	R	R
<b>Mineral Metabolism Reporting Measure</b> Measure serum calcium and serum phosphorus levels of Medicare patients	R	R	R
<b>Anemia Management</b>	R	R	R

# Dialysis Facility Five Star

- CMS plans to assign each dialysis facility star ratings in January 2015 (originally slated for October 2014, but delayed by three months to educate consumers).
- Measures will be a mix of those used in dialysis facility compare, new measures, and QIP measures
- Idea is to create an easy way for the public to compare the quality of care delivered in dialysis facilities
- Many patient groups, providers, professional societies are unhappy with the program

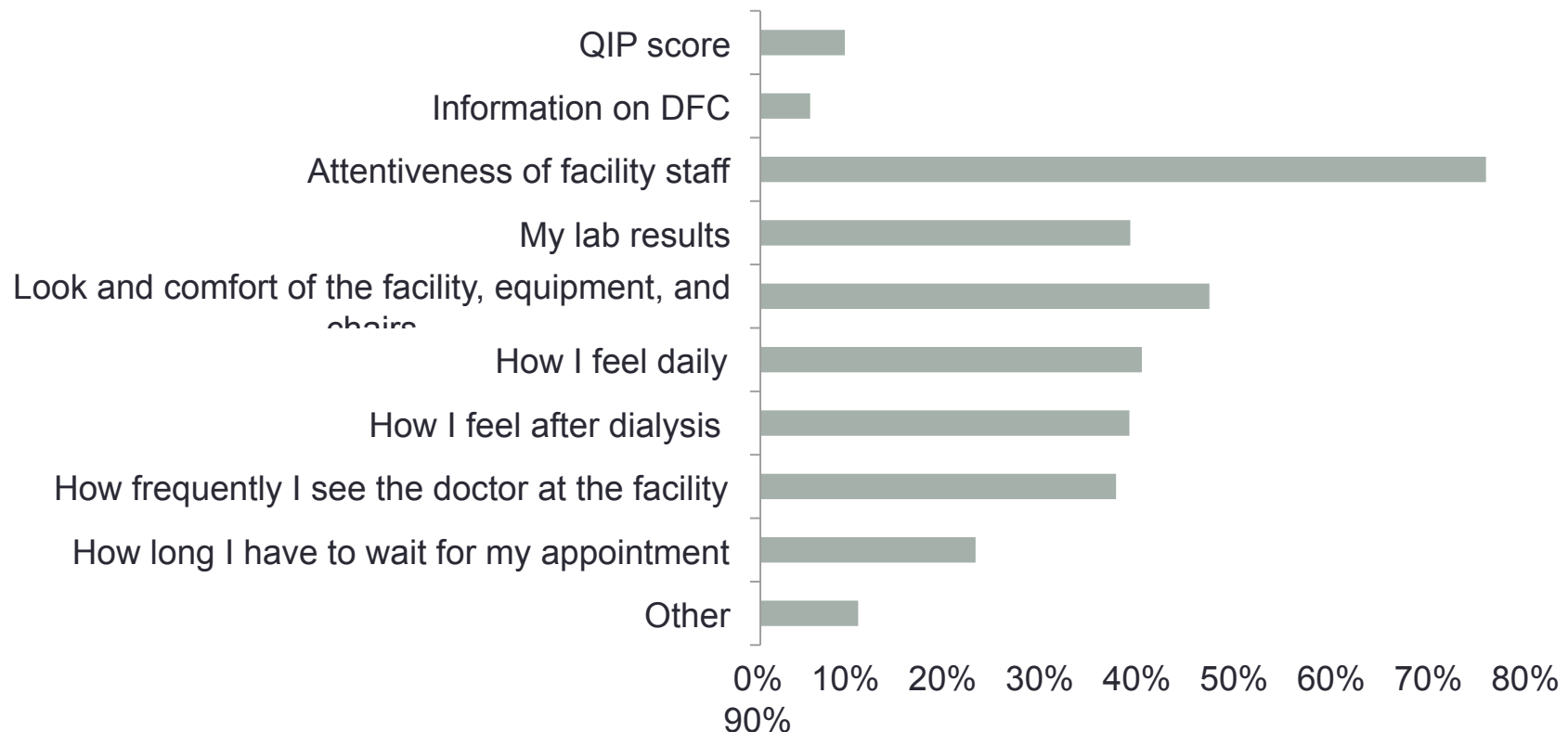
# Patients Select Facilities Based on their Doctors' Recommendations

How did you decide which dialysis facility to choose

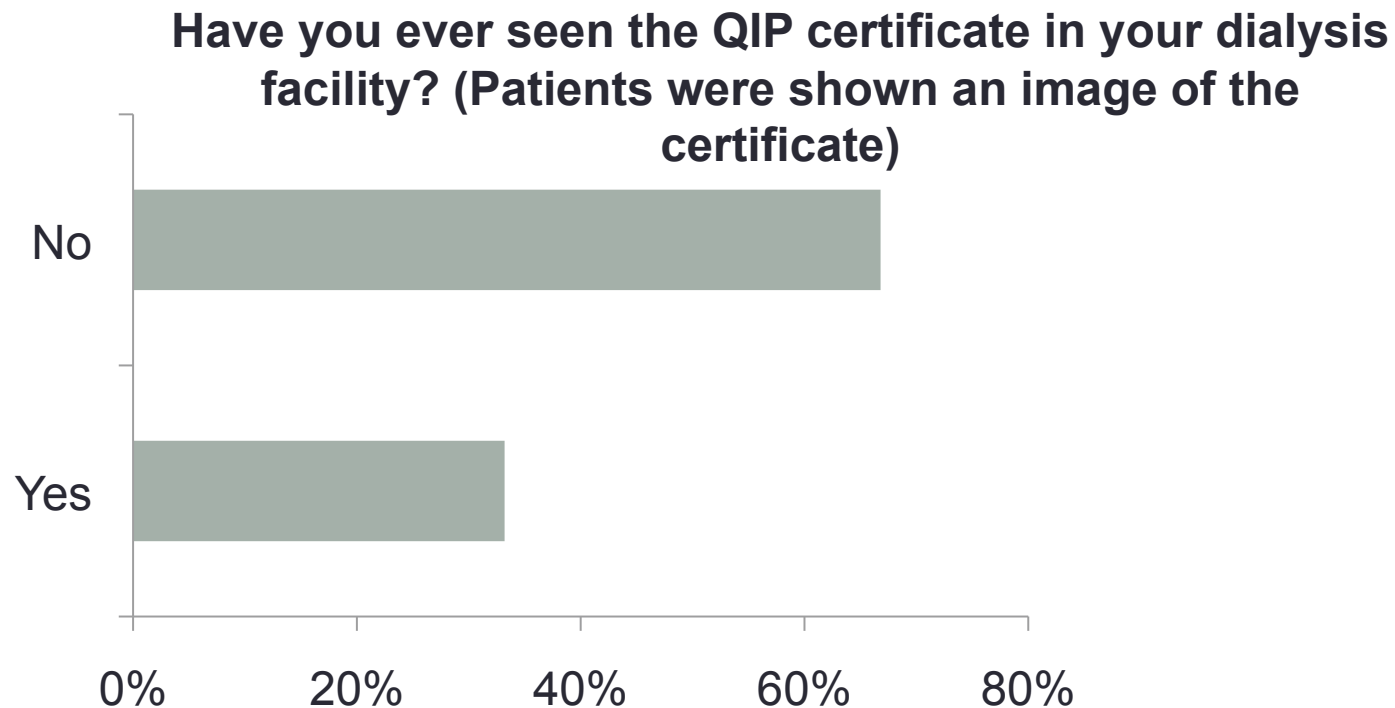


# Patients Judge Quality Based on Attentiveness of Facility Staff

**How do you judge the quality of care the dialysis facility provides?**

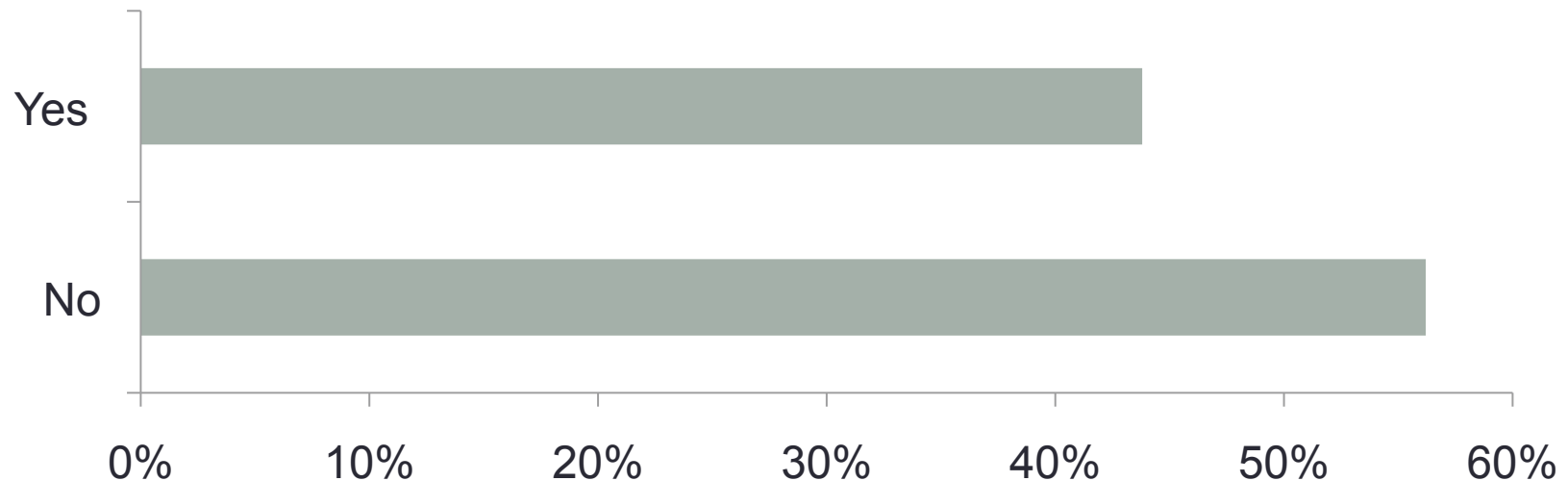


# A Little Over 1/3 of Patients Report Seeing the QIP Certificate in Their Facilities



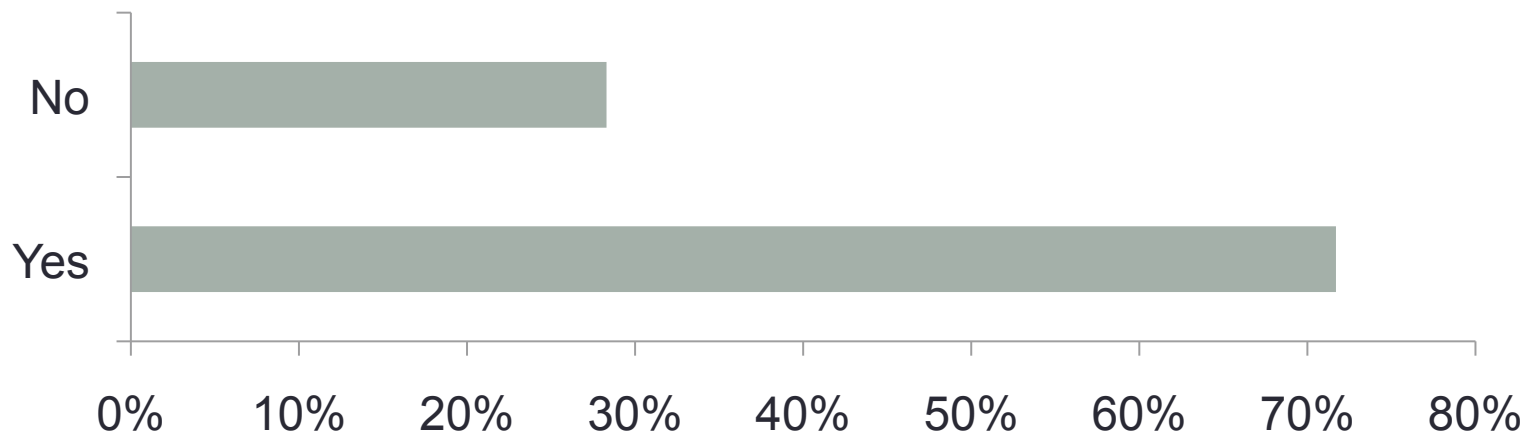
# And Fewer Than Half of Those Patients Understood the Information on the Certificate

**Regarding the certificate in the previous question, do you know what the information on the certificate means?**



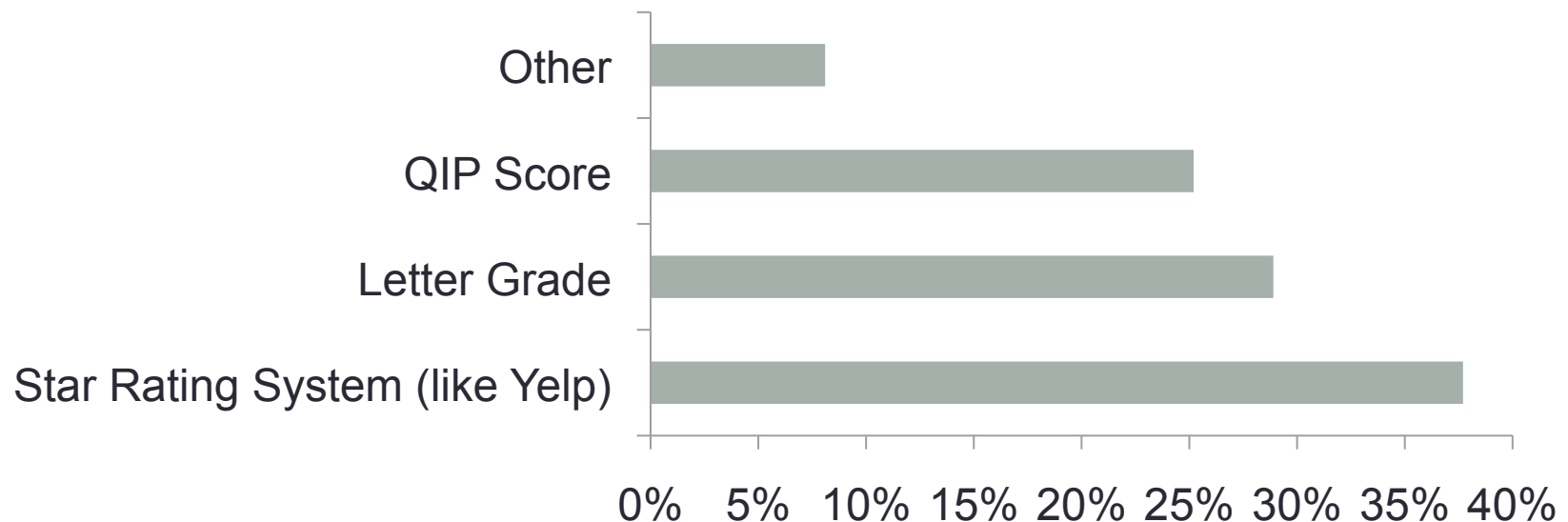
# Patients want Medicare to Provide a Way for Patients to Publicly See the Quality of Care Provided in the Dialysis Facility

**Do you wish Medicare would provide a different way for patients to publicly see the quality of care provided in the dialysis facility?**



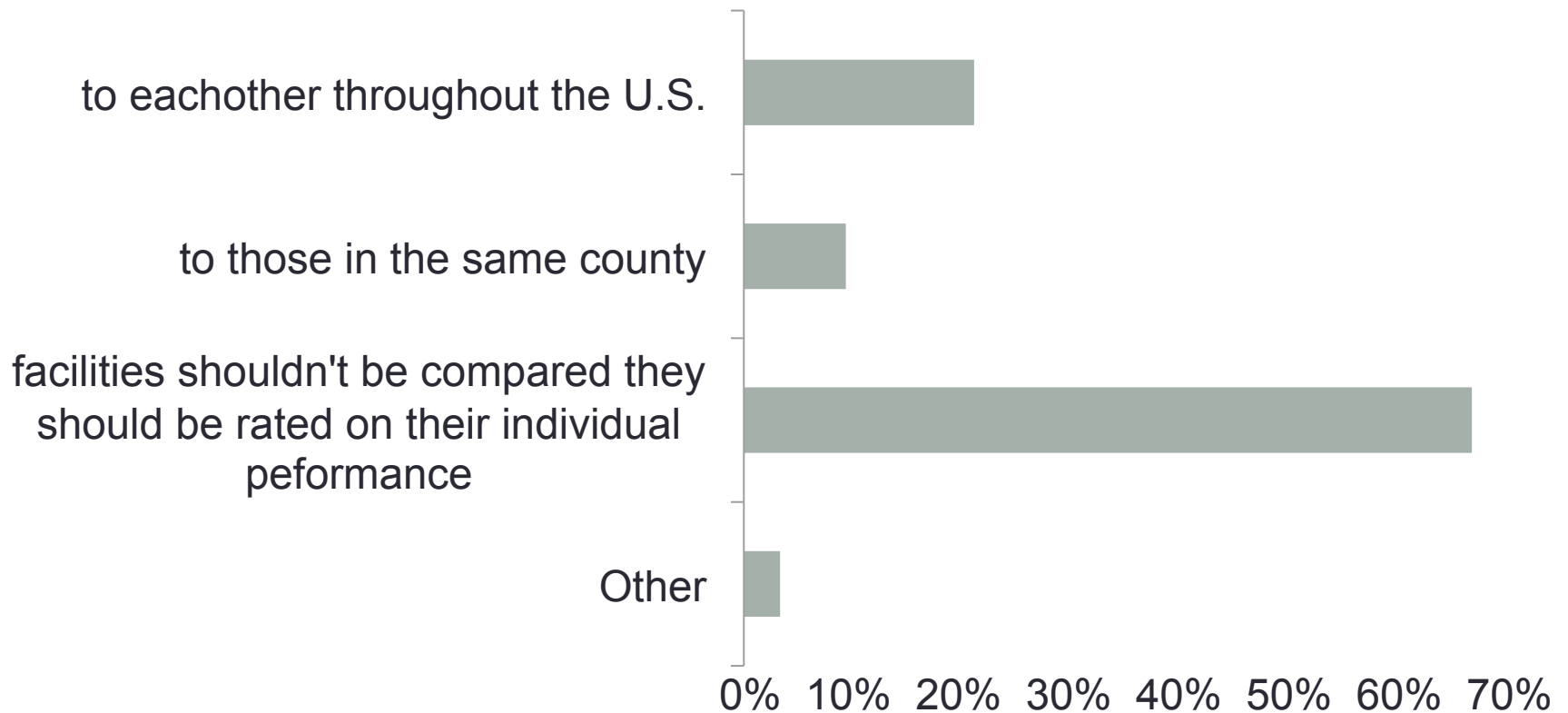
# Patients May Appreciate a Star Rating System if it is Based on Information They Care About

**How do you think Medicare should communicate the quality of care provided in the dialysis facility?**



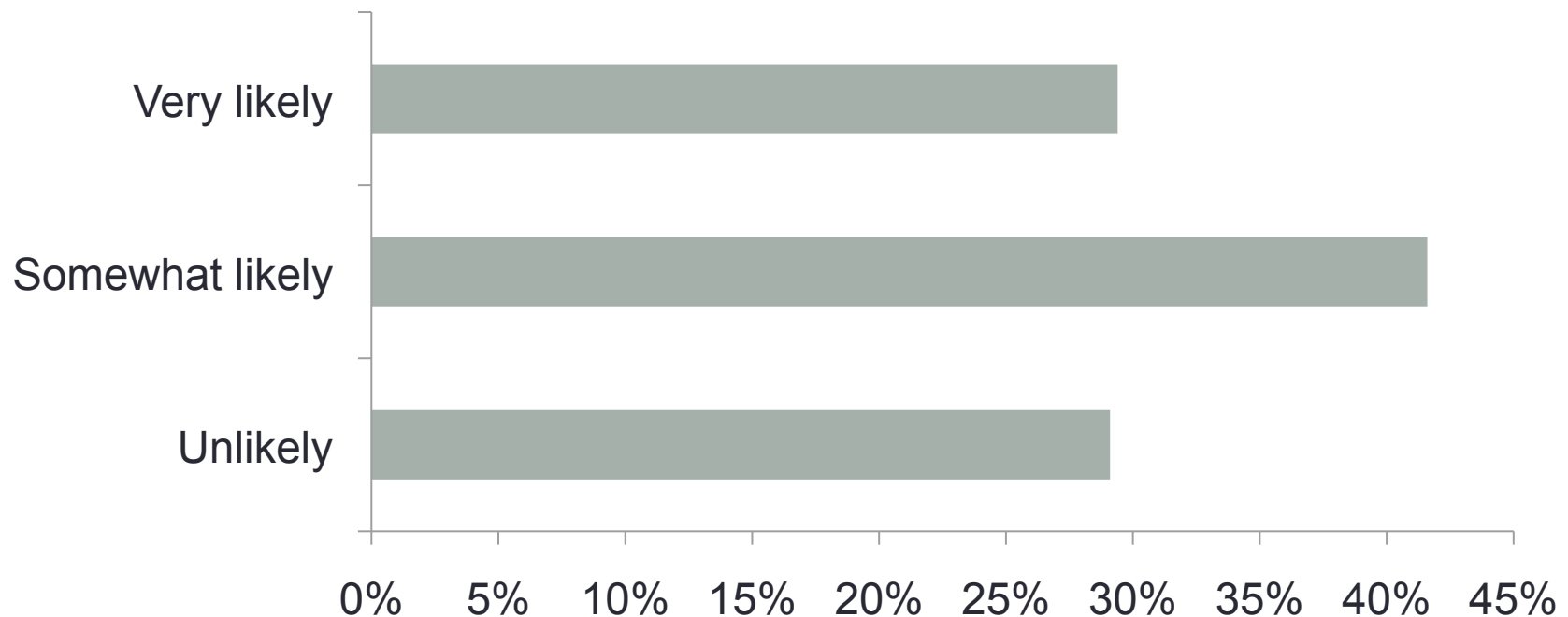
# Maybe CMS Should Rename Dialysis Facility Compare?

**Should Medicare rate quality by comparing facilities**



# Patients May Not Act on a Low Quality Rating

**How likely would you be to change dialysis facilities if your facility received a low quality rating by Medicare?**



# A Rating System Should Include

- measures of quality that are important to patients
- a way for patients to directly contribute their experience with the quality of care delivered in the facility (i.e. Yelp, Rotten Tomatoes)



# FUTURE LANDSCAPE

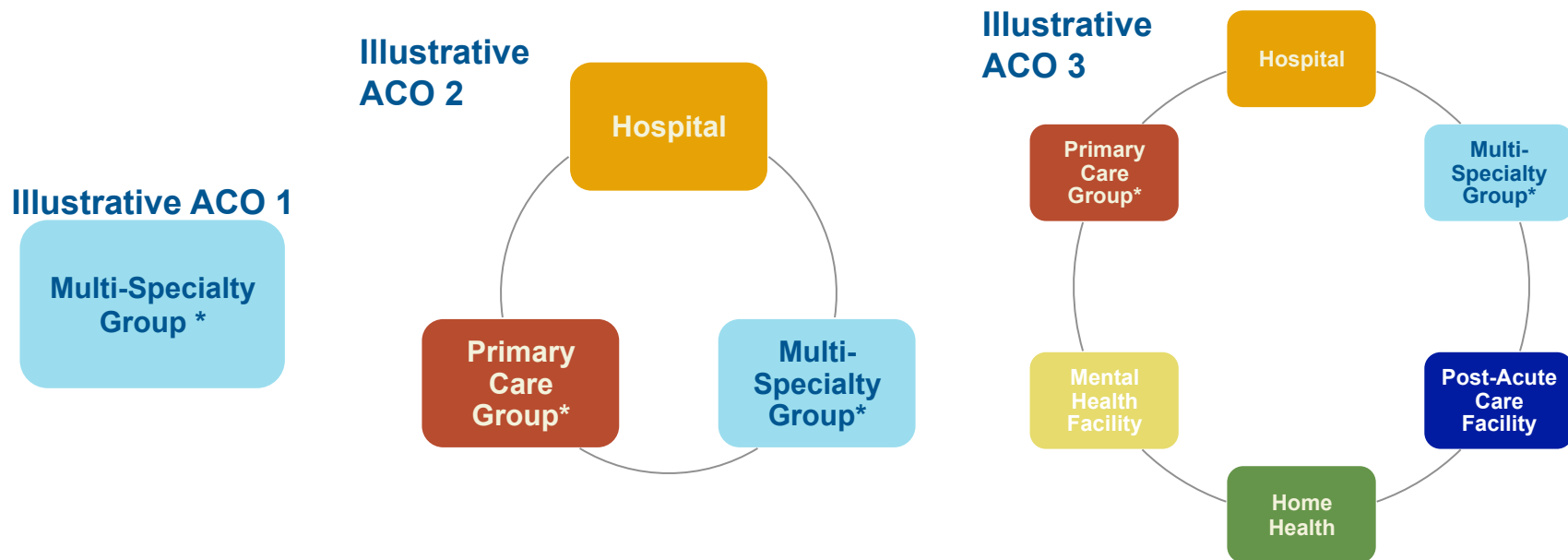
---

# Accountable/Coordinated Care

- Centers for Medicare and Medicaid Innovation (CMMI)
  - Accountable Care Organizations (ACO) – Medicare shared savings
  - Comprehensive ESRD Care/ESRD Seamless Care Organizations (ESCOs)
  - Award Cycles
    - *Using Telemedicine in peritoneal dialysis to improve patient adherence and outcomes while reducing overall costs*  
George Washington University  
Geographic Reach: District of Columbia, Maryland, Virginia  
Funding Amount: \$1,939,127  
Estimated 3-Year Savings: \$1.7 million
    - *Healthy Transitions in Late Stage Kidney Disease*  
NORTH SHORE LIJ HEALTH SYSTEM, INC  
Geographic Reach: New York  
Estimated Funding Amount: \$2,453,742

# Future Delivery Models for Dialysis Care May Include Shared Savings Models

- In addition to health insurance exchanges and Medicaid expansion, the Affordable Care Act (ACA) established multiple initiatives to promote new payment and delivery systems
  - The Medicare Shared Savings Program (MSSP) and Pioneer ACO programs took effect in 2012

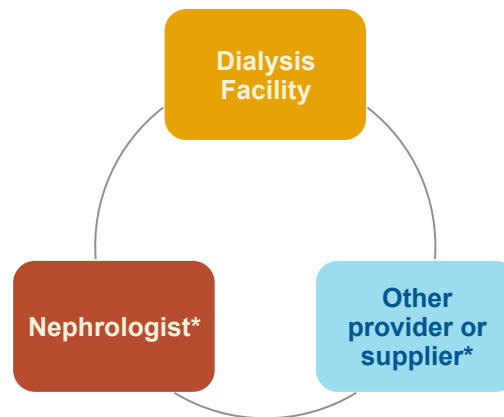


- The law also called for the creation of a new office within CMS to test different payment and delivery systems within the Medicare population, known as the Centers for Medicare & Medicaid Innovation (CMMI)

# CMMI Will Test a Dialysis-Specific ACO

- On February 4, 2012 CMMI announced the Comprehensive ESRD Care (CEC) model, which will provide incentives through shared savings for dialysis facilities and nephrologists to collaborate with other health care providers and supplier organizations to manage and coordinate care for ESRD beneficiaries through an ESRD Seamless Care Organization (ESCO)

**Illustrative  
ESCO**



- CMMI expects to select 10-15 applicants to form ESCOs, and the demonstration will last a minimum of 3 years with the possible extension for an additional 2 years
- Dialysis facilities will continue to be reimbursed according to the ESRD PPS and other providers will still be reimbursed according to fee-for-service

**Dialysis providers are seeking new ways to expand their role in the care of patients with chronic kidney disease. As opportunities to participate in ACOs emerge, dialysis providers will have a more influential role over patients' treatment options.**

# Addressing Barriers through Policy and Legislation

- 2012 Congress passes legislation to cut Medicare dialysis payment
- 2014 Congress passes legislation that offsets Medicare dialysis payment cuts
- Legislation benefits to home
  - Telehealth and remote monitoring
  - CKD education expansion
  - Physician payment differential for hospitalized home patients vs. in-center patients

# Key Takeaways

- Outlook for PD Reimbursement looks bright (if the shortage is solved)
  - Cost savings to facilities
  - Reduced hospitalizations
- Outlook for HHD remains in question
  - Patient churning
  - Takes time to recoup costs
- Challenges on the Physician payment side remain
  - Face to face visits
  - Need greater uptake of pre-dialysis education
- Questions remain
  - What do patients want?



# THANK YOU

---

Tonya Saffer

[tonya.saffer@kidney.org](mailto:tonya.saffer@kidney.org)

202.244.7900 ext 26