

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

Public Law 110-275

Presentation to The Renal Network

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Overview of MIPPA

- Renal provisions are only one element of many Medicare reforms under MIPPA
- MIPPA contains the most significant payment reforms to the ESRD program since 1983.
- The law changes dialysis reimbursement from a partial prospective payment system (composite rate; drug add-on; separately billable medications; separately billable lab test) to a fully bundled prospective payment for dialysis services, beginning in 2011.

Payment Increase

- Prior to the bundle there will be a **1% increase to the dialysis treatment component** of the current composite rate beginning **January 1, 2009**
- There will be another **1% increase to the dialysis treatment component** of the current composite rate beginning **January 1, 2010**

Renal Dialysis Services in Bundle

- Items and services included in the **Composite Rate** for renal dialysis services as of 12/31/10.
- **ESR agents** and any oral form of such agents that are furnished to individuals for the treatment of ESRD
- **Other drugs and biologicals** that are furnished to individuals for the treatment of ESRD and for which payment was (before the application of this paragraph) made separately under this title and any oral equivalent form of such drug or biological.
- Does not include vaccines
- **Diagnostic laboratory tests** and other items and services not described in clause (i) that are furnished to individuals for the treatment of ESRD

Payment Reduction of 2%

- The estimated total amount of Medicare payments for dialysis services for the bundle payment in 2011 (composite rate; drug add-on; separately billable drug revenue; separately billable lab revenue) will reflect a 2% reduction from the estimated total amount of payments for such services that would have been made without this change in the law
- In making this estimate, the Secretary will use per patient utilization data from 2007, 2008, or 2009 - whichever has the lowest per-patient utilization.

Bundling

Phase-In

- Facilities have ability to have a **one-time opt out** of the phase-in (i.e. full bundle in 2011).
- There is a four-year phase-in:
 - 25% bundled rate; 75% old payment amount;
 - 50-50;
 - 75-25
 - **Full phase-in by 2014**
- The 98% payment rate applies to all payments in 2011, including transition facilities.
- Eliminates the \$4.00 treatment differential for hospital-based providers in 2009

Unit of Payment

- The bundled payment may provide payment for services furnished during a week or a month
“ or other appropriate unit as specified by the Secretary of HHS”, i.e.

A per treatment payment would be at the discretion of the Secretary of HHS

Case-Mix Adjusters

The bundled payment system will be case-mix adjusted for variables that may include:

- Weight
- body mass index
- co-morbidities
- length of time on dialysis
- age
- race (difficult for Medicare to determine; discrepancies in databases)
- Ethnicity (same)
- other appropriate factors

Example 1—Relatively healthy ESRD patient with no co morbidities

John Smith, a 45 year old male, is 187.96 cm. (1.8796 m.) in height and weighs 95 kg. He has chronic glomerulonephritis and hypertension, underwent the creation of an AV fistula in 2000, and was diagnosed with ESRD in 2001. The patient also has secondary hyperparathyroidism.

Patient Multiplier = 1.1332

1.1332 x \$243.88 = \$276.36

Example 2—ESRD Patient with multiple co morbidities

Mary Livingston, a 66 year old female, is 167.64 cm. in height and weighs 105 kg. She has diabetes mellitus, a history of chronic Hepatitis B, parathyroidism, and liver cirrhosis. She was diagnosed with ESRD in 1995, esophageal varices in 2006, and had a diagnosis of upper gastrointestinal (GI) bleeding the previous month.

Patient Multiplier = 1.5676

1.5676 x \$243.88 = \$382.31

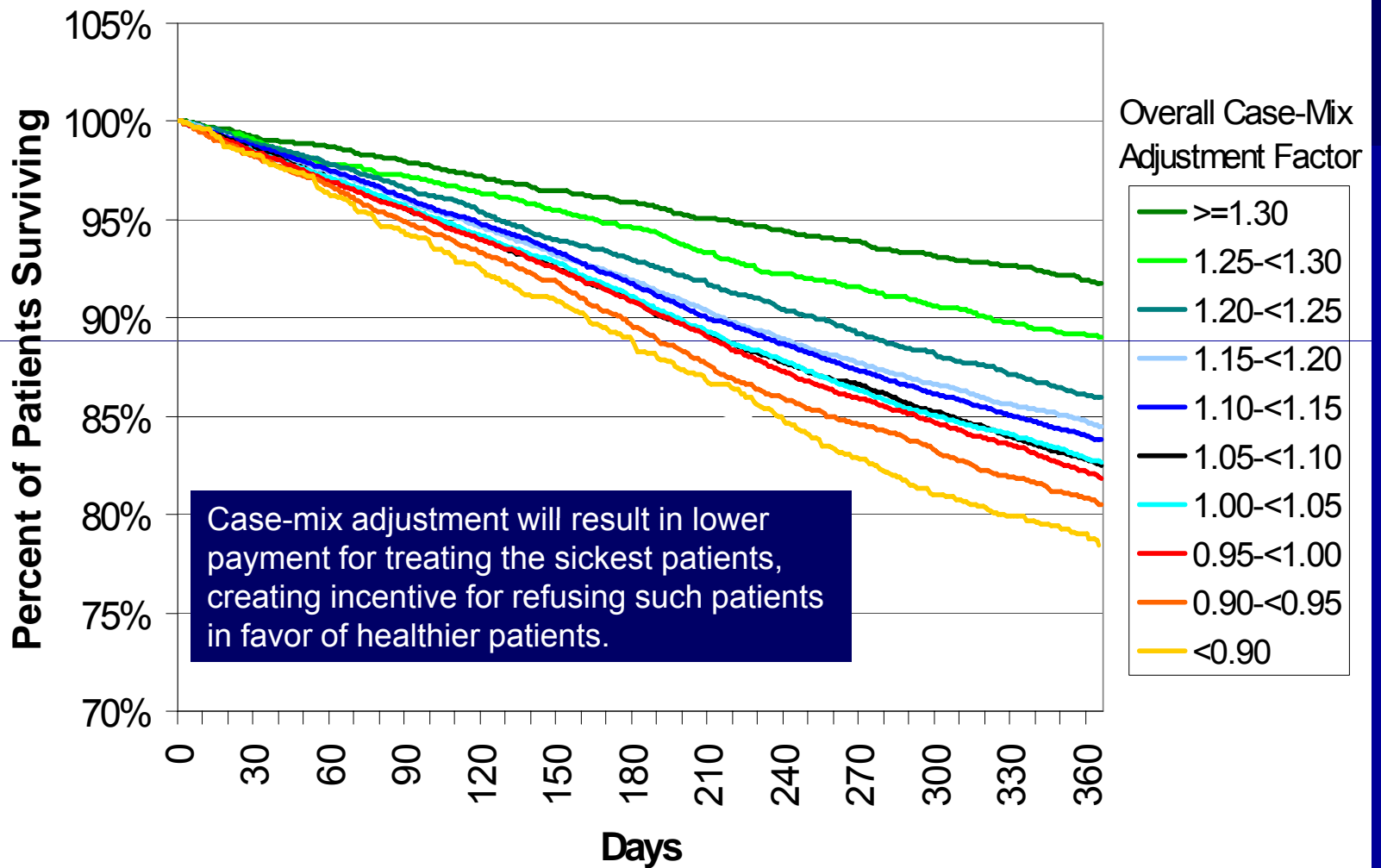
Example 3—Aged ESRD patient with low BMI (< 18.5kg/m²) and history of hospitalization

Agnes Jones, an 82 year old female, is 160.02 cm. (1.6002 m.) in height and weighs 45.36 kg. She has longstanding type II diabetes mellitus and was diagnosed with ESRD in 2002. The patient has coronary artery disease and peripheral vascular disease. In January 2006 Ms. Jones began dialyzing with an upper arm AV fistula, which had been created in 2002. In March 2006, after an unsuccessful attempt to declot the AV fistula during hospitalization, Ms. Jones experienced additional bleeding complications, and has been dialyzed using a catheter ever since. Last month, the patient was again admitted to the hospital after suffering an observed cardiac arrest during outpatient dialysis. She was diagnosed with myocardial infarction, and underwent coronary artery angioplasty and coronary artery stent placement during that hospitalization. Ms. Jones was again admitted to the hospital on the 14th of the current month for congestive heart failure.

Patient Multiplier = 1.128

1.128 x \$243.88 = \$275.09

Survival vs. Overall Case Mix Adjustment Factor



FMCNA Data November 2004

Annual Updates

- Starting in 2012 there will be an annual increase to the bundled payment amount by an ESRD market-basket percentage minus 1.0 percentage point.

Mandatory Payment Adjusters

- There will be a payment adjustment for **high cost outliers** due to unusual variations in the type or amount of medically necessary care, including the amount of ESAs necessary for anemia management
- There will be a payment adjustment for **low-volume facilities** that reflects the extent to which costs incurred by low-volume facilities - which will be defined by the Secretary - exceed the costs incurred by other facilities.

Discretionary Payment Adjusters

To be determined at the discretion of the Secretary of HHS - there may be other payment adjustments for:

- (1) pediatric providers/facilities;
- (2) a geographic index such as that used today;
- (3) for providers/facilities in rural areas

Quality Incentives Program

- Beginning January 1, 2012 there will be a 2% payment reduction for providers/facilities not meeting the requirements for a specific year, with reduction specific only to the year involved.
- Mandatory measures include:
 - anemia management (that reflects FDA labeling)
 - dialysis adequacy
 - patient satisfaction (to the extent feasible)

Quality Incentives Program

Discretionary measures... "other measures the Secretary may specify" such as:

- iron management,
- bone mineral metabolism,
- vascular access (including bonus for maximizing placement of AV fistula)

Quality Incentives Program

- The Secretary will develop a methodology for assessing the total performance of each provider/facility based on performance standards.
- The total performance score will be calculated in a manner that weights the individual measures scores to reflect priorities for quality improvement.
- The individual measures scores will reflect levels of both achievement and improvement

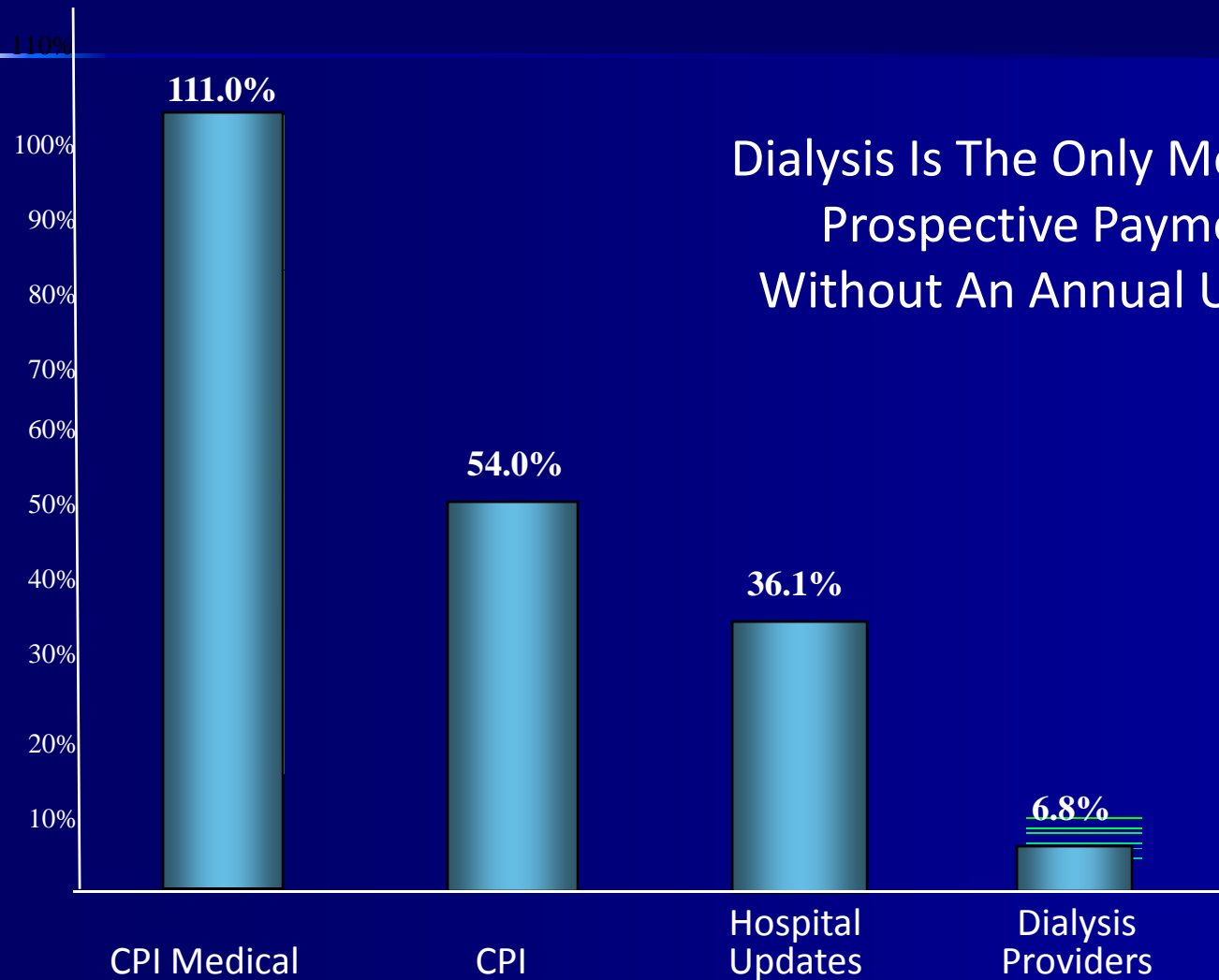
Government Accountability Office (GAO) Report on Bundling System and Quality Initiative

- Due March 1, 2013
- To include:
 - Changes in utilization of ESAs
 - Mode of administration of ESAs
 - Analysis of payment adjustment for low volume providers, including rural
 - Changes in utilization rates of drugs & biologicals & any oral equivalents or substitutes, or of new ones following implementation

Why support the Bundle?

- Payment for dialysis is the only Medicare payment that does not have an annual inflation mechanism in the law. Reimbursement updates require Congressional action.
- Dialysis providers are largely dependent on public payers:
 - 93 percent of patients have Medicare
 - 40 percent of patients are dually eligible for Medicare and Medicaid
- Payment for dialysis services has been increased only \$10 since 1983 – over 20 years ago!
 - Average treatment rate 1983 - \$123
 - Average treatment rate 2006 - \$133
- Providers have experienced increases in all labor costs – nurses, dieticians, and other health care professionals. Medical Director contract rates have also increased over time.
- The costs for updating equipment and facilities are not reflected in dialysis payments to providers.
- Providers sustained a loss of over \$700 per Medicare beneficiary in 2005 based on an industry study of Medicare dialysis treatment costs and reimbursements (*2006 Moran Study*).

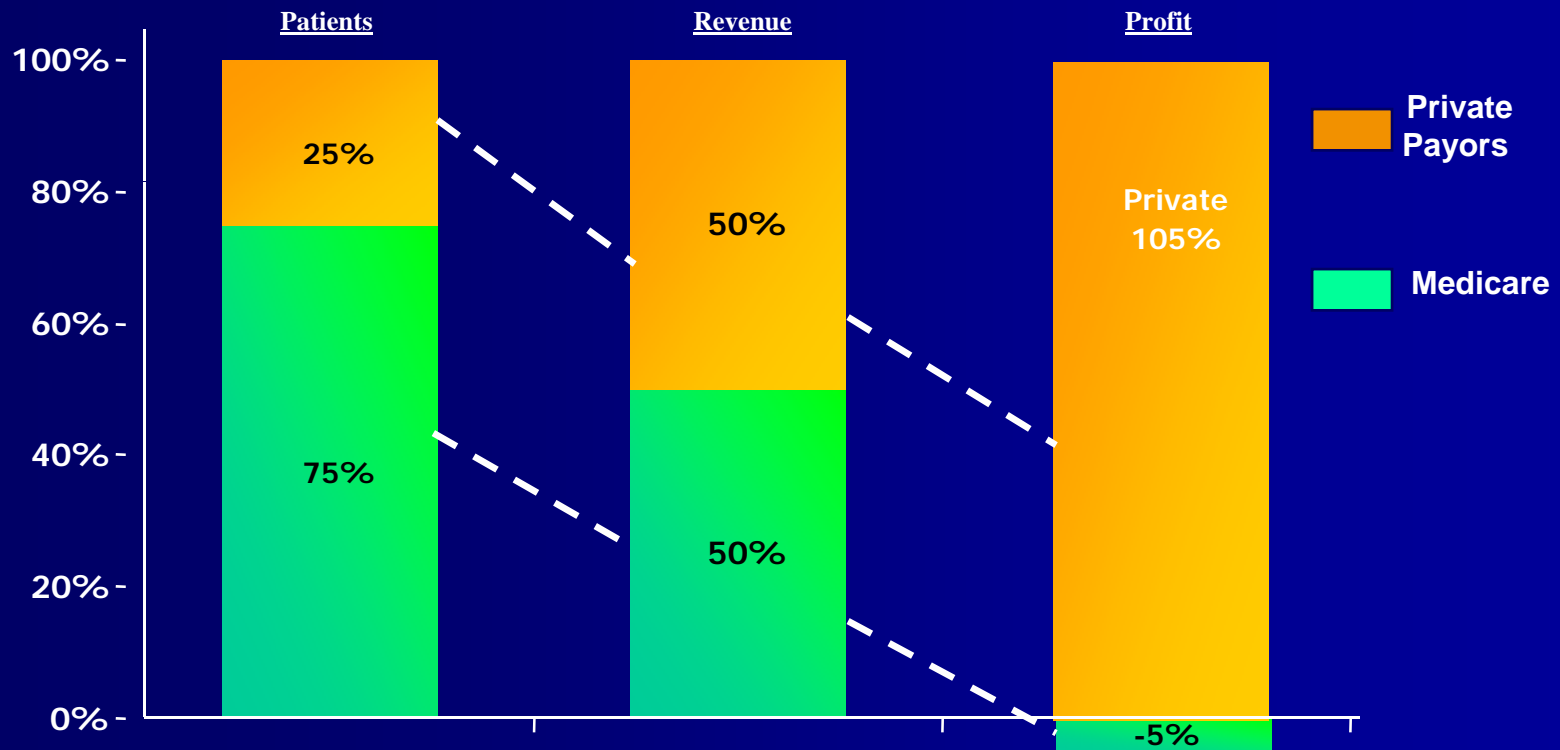
Cumulative Percentage Increases 1990-2006



Dialysis Is The Only Medicare
Prospective Payment
Without An Annual Update

Medicare Role In Provider Economics

Private Payors Furnished 100% of the Dialysis Provider Margin



Medicare Percentage in Green

Implementation Issues

- Capturing all appropriate current lab and drug utilization and all related costs
- Case mix adjusters
 - Cost-relevance
 - Readily identifiable by facility
- Establishing appropriate outlier withhold
- Unit of payment – per treatment, per week or per month
- Secondary coverage
- Market basket definition
- Quality measure development
- Risk that compounded adjustments and penalties threaten facility viability

Operational Issues

- Resource utilization efficiency
 - Home therapies
 - Drug and lab utilization
- Key to understand efficiency opportunities before opt-in election
- Achievement of clinical quality measures
- Adoption of best practices:
 - Clinical decision support
 - Protocols
 - Formulary standardization

SEC. 399R. CHRONIC KIDNEY DISEASE INITIATIVES

Establish pilot projects to—

- (1) increase public and medical community awareness (particularly of those who treat patients with diabetes and hypertension) regarding chronic kidney disease, focusing on prevention;
- (2) increase screening for chronic kidney disease, focusing on Medicare beneficiaries at risk of chronic kidney disease; and
- (3) enhance surveillance systems to better assess the prevalence and incidence of chronic kidney disease.

SCOPE—at least 3 States in which to conduct pilot projects under this section.

DURATION— for a period that is not longer than 5 years and shall begin on January 1, 2009.

CKD Education Benefit

- MIPPA creates a new Medicare benefit - coverage of kidney disease patient education services beginning in January, 2010
- Six education sessions furnished to diagnosed Stage IV individuals who are referred by a nephrologist for education about:
 - Management of comorbidities
 - Prevention of uremic complications
 - Education about renal replacement therapy and vascular access options to ensure individual's participation in choice of therapy tailored to meet their specific needs

CKD Education Benefit

- Education can be provided by:
 - physicians and non-physician providers (nurse practitioners, clinical nurse specialists, physician assistants)
 - hospital-based dialysis providers IN RURAL AREAS ONLY
 - Out patient dialysis facilities may not provide this service
- Payment will be made under physician fee schedule

CKD Education Benefit

Standards for content of CKD education to be determined by CMS after consulting with

- MDs & other health professionals, health educators, professional organizations and accrediting bodies, kidney patient organizations, dialysis facilities & transplant centers, network organizations & other knowledgeable persons....
- who have not received industry funding from a drug or biological manufacturer or dialysis facility, to the extent possible.