



Overview: Brief History of Medicare End-Stage Renal Disease (ESRD) Reimbursement

When Medicare was first established in 1965, it did not provide coverage for individuals with ESRD. At that time, kidney failure was a fatal disease, as treatment was not available outside of a limited number of clinical study centers. Once it was clear that dialysis could be performed as a chronic therapy, lack of insurance coverage became a barrier to treatment. This led to the passage of the Medicare ESRD program. The following provides a brief history of some of the major changes in reimbursement for the Medicare ESRD program since its enactment in 1972.

Social Security Amendments of 1972 (P.L. 92-603)

In October 1972, Congress passed the *Social Security Amendments of 1972*. Under this Act, Congress changed the Medicare law to extend coverage to individuals who were under 65 years of age, had ESRD, and had (or were the spouse or dependent of someone who) worked long enough to qualify for Social Security. Such coverage became effective July 1, 1973.

Medicare's payment policy for outpatient dialysis from 1973 to 1983 limited reimbursement by a payment ceiling of \$138 per treatment. Like other Medicare Part B benefits, Medicare pays 80 percent of the allowable rate.

ESRD Program Amendments of 1978 (P.L. 95-292)

The *ESRD Program Amendments of 1978* included several new provisions for the ESRD Program to encourage home dialysis and eliminate some of the existing financial disincentives to transplantation. These changes provided for immediate Medicare entitlement (without a 3-month waiting period) for people who choose self-dialysis or transplantation as their initial ESRD treatment modality. The law also provided for the implementation of a prospective reimbursement method for dialysis payment and extended Medicare transplant benefits from 12 to 36 months post-transplant.

Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35)

The ESRD provisions of the *Omnibus Budget Reconciliation Act of 1981* again called for the establishment of a prospective payment system for outpatient dialysis to include a single rate to cover all supplies and services associated with a routine dialysis treatment. Other provisions modified rules to make Medicare the secondary payer to employer group health insurance for the first 12 months of Medicare entitlement.

Pursuant to this law, the prospective "composite rate" payment system was implemented. It established a per-treatment payment rate, adjusted for geographic wage differences. This averaged \$123 per treatment, down from the prior \$138 rate, with a slightly different rate for hospital-based programs. For the first time, home and in-center dialysis treatments were paid at a single base composite rate, which was intended to be an incentive to promote home dialysis.

Medicare Modernization Act (MMA) of 2003 (P.L. 108-173)

The MMA contained the most far-reaching changes to the ESRD program since its creation. There were no changes to reimbursement in 2004, but in 2005, the composite rate was increased by 1.5%. The MMA changed the way the Medicare program reimbursed facilities for the cost of separately billable dialysis-related drugs and biologics, basing payment on the Average Sales Price (ASP) plus 6%. To prevent a major reduction in reimbursement related to this change in drug payment, in 2005 Medicare began augmenting the composite rate payments with a drug spread “add-on” – the historical difference between Medicare payment and provider acquisition cost, which was to be adjusted annually beginning in 2006. MMA case-mix adjusted the composite rate for beneficiary age, body surface area, and low body mass index.

The MMA also called for a report by the Secretary of Health and Human Services on a fully bundled dialysis prospective payment system (PPS) to incorporate all the formerly separately billable items and services into the dialysis payment.

Medicare Improvements for Patients and Providers Act (MIPPA) 2008 (P.L. 110-275)

MIPPA required Medicare to establish a full PPS for ESRD services to include the composite rate components, plus injectable drugs and biologics and their oral equivalents, laboratory tests previously paid for separately, and renal-related oral medications. MIPPA also eliminated the differential payment between independent and hospital-based dialysis programs. The law called for an annual update to the PPS payment rate; this update was 1% for both 2009 and 2010. Beginning in 2012, the PPS base rate is to be increased annually by an ESRD market basket percentage increase factor, minus 1%.

The PPS “bundle” was implemented in 2011, reducing payment by 2% at the outset, in anticipation of efficiency gains by providers under the PPS system. The base rate was \$229.63 before wage adjustment. Some adjusters were included at the patient level and the facility level as well as a home training add-on payment.

MIPPA also required ESRD providers to meet certain quality metrics, to be defined annually. This Quality Incentive Program (QIP) went into effect in 2012 and was the first pay-for-performance program in the history of Medicare. The purpose of the QIP was to incentivize providers to continue to provide high quality care and protect patients from potential cuts to quality of care, which might occur with the changes in the reimbursement system. Facilities which fail to meet the minimum scores on the defined metrics may lose as much as 2% of their total Medicare reimbursement for a payment year. The initial QIP included three clinical measures related to dialysis adequacy and anemia management. Clinical and reporting measures are published annually through notice and comment rulemaking for the following year.

The American Taxpayer Relief Act of 2012 (ATRA) (P.L. 112-240)

Under ATRA, Medicare is required to recalculate the dialysis bundled payment rate for 2014 to account for changes in use of drugs and biologics as a result of the PPS. This law delayed inclusion of oral drugs into the ESRD PPS and required providers to report monitoring of bone and mineral metabolism to CMS. The Protecting Access to Medicare Act of 2014 (PAMA) amended ATRA to delay payment for ESRD-related oral-only drugs until January 1, 2024.