

Centers for Medicare & Medicaid Services  
End Stage Renal Disease Open Door Forum  
Tuesday, December 10, 2024  
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*Webinar Recording:*

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**Jill Darling:** Wonderful, thank you. Good morning and good afternoon, everyone. My name is Jill Darling, and I'm in the CMS Office of Communications, and welcome to today's first End Stage Renal Disease (ESRD) Open Door Forum (ODF). It has been quite some time since we have engaged with this Open Door Forum, so we welcome it back. And so, before we get into today's agenda, I do have a few announcements. For those who need closed captioning, a link was provided in the chat, and I will provide it again for you. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum transcript web page, and that link was on the agenda, and I will share it in the chat. If you are a member of the press, please refrain from asking questions during the webinar. If you do have any questions, please email [press@cms.hhs.gov](mailto:press@cms.hhs.gov). All participants are muted upon entry. And for today's webinar, I will—I have the agenda slide up for you. So, this is the only slide for today.

We will be taking questions at the end of the agenda today. We note that we will be presenting and answering questions on the topic listed on the agenda. We ask that any live questions relate to the topic—topics—presented during today's call. If you have any questions unrelated to the agenda items, we may not have the appropriate person on the call to answer your question. As such, we ask that you send any of your unrelated questions to the appropriate policy component or send your email to the ODF resource mailbox that I will provide, and that was also on the agenda that was sent out, and we'll get your question to the appropriate component for a response. You may use the raise hand feature at the bottom of your screen, and we'll call on you when it's time for Q&A. Please introduce yourself with your organization or business you're calling from. And when the moderator says your name, please unmute yourself from your end to ask your question and one follow-up question, and we'll do our best to get to all your questions today. And so now, I will turn the call over to Abigail Ryan.

**Abigail Ryan:** Hi, good afternoon, and thank you everyone for joining our first ESRD Open Door Forum in a long time. As Jill mentioned, we're very, very pleased to be able to do this and continue this and hope that all the stakeholders will choose to engage with us, send us questions, ask questions, and this is an opportunity for input from you into how we can make our payment system better and how we can better align our payment with resource use through the years. We are always in the process of continuing improvement. And with that, we will go ahead and have all of our staff subject matter experts presenting today on the various topics.

But before we kick that off, I want to go ahead and just give a real high overview of the ESRD PPS (Prospective Payment System) system. It began in calendar year 2011, and it was a semi rocky start. We weren't sure we were going to do oral-only drugs, and it kept getting postponed,

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but the sum and substance of it is generally it has remained the same—what I call the same skeleton. And that is the base rate is composed of a wage portion, labor portion, and a non-labor portion. And we look at that for the labor portion of a wage index, and Russell is going to speak about this in the final rule for calendar year 2025 and how we used it and use the Bureau of Labor Statistics (BLS) for the wage index and how we calculate it. And once we have those two, then we go ahead and we adjust the base rate for different geographic factors, and we also adjust it for various other—what I call adjustment PPS adjustment factors. And those are patient characteristics and facility characteristics. Now for our patient characteristics as an overview, we do age body mass index, body surface area, onset of dialysis, and various comorbidities. And for the facility characteristics, we look at the rural volume—the low volume and the rural adjustment. And once we have all that pulled in, then we move over to high-cost outliers if the beneficiary is costly. And we see, is the beneficiary getting home dialysis or self-dialysis services. And then to all of that, we add what's called—is new ESRD related items, which are the transitional add-on payment adjustment for drugs, we call that TDAPA (Transitional Drug Add-on Payment Adjustment). And the add-on payment for equipment and supplies, we call that TPNIES (Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies). And last year, we included an adjustment for three years for pediatric because we knew that they were more expensive, and more resources are being used to provide renal dialysis services to that population. And from all of that, we get a payment. Now the payment this year for the calendar year 2025 rule is \$273.82. And what I'm going to do is turn this over right now to Russell Bailey, and he's going to go through the payment rates for the ESRD PPS and for the AKI (acute kidney injury). Go ahead, Russell.

**Russell Bailey:** Thank you, Abby. Yes, as Abby said, the CY 2025 ESRD PPS base rate is \$273.82. This number is then adjusted by a variety of adjustment factors based on either the individual patient's characteristics or the ESRD facility's characteristics. And then, after that figure is adjusted, we then apply any add-on payment adjustments, like the TDAPA or the TPNIES for new drugs or new and innovative equipments and supplies, respectively. This CY 2025 ESD PPS base rate represents an increase of 2.2% according to a market basket increase from last year's base rate and is applied for all ESRD patients. For 2025, AKI patients also received the ESRD PPS base rate of \$273.82, and for AKI patients, their payment rate is also adjusted by the wage index, but AKI patients are not eligible for the other adjustment factors under the ESRD PPS.

On to the second area I'll be discussing today, which is our new wage index methodology for 2025. As Abby briefly gave an overview for the ESRD PPS payment rate, we break it up into a labor-related share and a non-labor related share. And for every ESRD and AKI patient, the labor-related share of the base rate is adjusted by a wage index according to the geographic location of the ESRD facility in which the treatment took place. Prior to 2025, this ESRD—the ESRD PPS used the wage index value based on the Inpatient Prospective Payment System, IPPS, wage index, which was based on inpatient acute care hospital data. However, over several years, we have heard from stakeholders that the IPPS wage index was not the most appropriate for ESRD facilities because it is by definition “hospital-based.” It is entirely from hospital data. And although there are some ESRD facilities, of course, that operate in hospitals, most of the data for the IPPS was coming from non-ESRD related health care fields, and any and all freestanding ESRD facilities were not included in the IPPS wage index data.

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So, to try and improve the payment accuracy under the ESRD PPS, we proposed and subsequently finalized a new wage index methodology that utilizes data from the Bureau of Labor Statistics, occupational employment, and wages statistics. Essentially, this new data, instead of being derived from hospital cost reports, comes from survey data of all—well, the survey itself is for all employer types, but for the actual statistics that we are using in our payment calculation, it's from all health care employers who employ certain occupations that are relevant to furnishing renal dialysis services. For example, registered nurses or equipment technicians for dialysis technicians. And so what we do is we take the wages for a variety of health care occupations across all of the geographic areas surveyed, and then we weight those wages according to an occupational mix, which is derived from freestanding ESRD facility cost reports to determine, for example, if nurses are, say, 20% of ESRD facility employees, then there would be 20% of the weight in the wage index. Just as an example, that's not the exact number. And then we use that BLS data weighted according to the occupational mix, and we have developed this new wage index, which we believe better targets the actual costs faced by ESRD facilities because it is using the data that actually incorporates ESRD facilities' employees and more similar workers in other health care areas as well as weights those occupations according to what ESRD facilities actually employ.

And I would note that for CY 2025 and going forward, we are continuing to apply the 5% cap on wage index decreases, which was finalized in 2023. That—what that says is that if your wage index value for your ESRD facility decreases more than 5% in a given year, you would instead get 95% of your last year's wage index, and that can go on for multiple years depending on the changes from year to year. Additionally, we apply a wage index floor of 0.6, so any wage index values that fall below that 0.6 floor are instead replaced by 0.6. And so that is a quick overview of the wage index policy that we finalized for 2025. And now I'm going to pass it on to Abby to discuss the inclusion of oral-only drugs in the ESRD PPS.

**Abigail Ryan:** Thank you, Russell. Insofar as the inclusion of oral-only drugs into the ESRD PPS bundled payment, the genesis of this was actually from the Social Security Act from 1881(b)(14), and that requires the Secretary to implement an ESRD payment system under which we make a single payment. It's going to be made for the provision of renal dialysis services in a renal dialysis facility. And this has to be done in lieu of any other payment. And I think this is a very important point to make because a number of folks come in and want us to be—to be—paid separately for different things, but we are required by statute to make one payment.

When the ESRD PPS was first implemented in 2011, and I mentioned this at the beginning of the call, we excluded—CMS excluded—oral-only drugs from the bundle payment until 2014, and then through—we didn't have pricing or we didn't have utilization date at that time. And so, we—it became several laws then delayed incorporation of oral-only drugs a number of times until ultimately it was going to be decided that it would be put in January 1, 2025. So, in 2016, as a matter of fact, CMS finalized this policy and to include oral-only dialysis drugs in the bundle and we at the time had a mechanism for collecting the utilization and price information for these drugs. And if those familiar with the current 42 CFR (Code of Federal Regulations) at 413.17, payment to an ESRD facility for oral-only renal dialysis drugs and biological products is included in the ESRD PPS bundle payment and it's going to be effective January 1, 2025. We

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have provided information in the—in the—ESRD PPS proposed rule that came out earlier about how we were operationalized the inclusion of oral-only drugs and biological products into the ESRD PPS and we also had budgetary estimates as far—insofar as the effect of the inclusion for public awareness.

As in that proposed rule for 2025, we discussed potentially increasing the TDAPA amount for phosphate binders. We received many, many, many comments in response to this. And so, as a result of looking at all those comments, we finalized a policy to pay TDAPA for phosphate binders based on 100% of average sales price (ASP). And we would increase—we will increase—that amount by a fixed amount of \$36.41 for recognition of incremental costs such as dispensing and storage fees at phosphate binders. And this will be added to any monthly claim for which there is a TDAPA payment for phosphate binders. It's our expectation that incorporating orally drugs and biological products into the ESRD PPS will increase access to those drugs. We have firm data that shows that a significant percentage of ESRD PPS beneficiaries do not have access to Part D, and we've previously seen that incorporating the Medicare Part D drugs into the ESRD PPS had a significant positive effect on expanding access, but we want to make sure that everyone has access to everything and therefore will be incorporated into Part B January 1, 2025. And that—with that, I will go ahead and pass on to our next subject, which is the Low-Volume Payment Adjustment (LVPA) to our subject matter expert, Leone Kisler. Go ahead, Leone.

**Leone Kisler:** Thank you, Abby. I'd like to start with a little bit of background on the Low-Volume Payment Adjustment, or LVPA, which has been monumental for increasing access to ESRD services. In 2011, an amendment to the Social Security Act allowed Medicare to provide a payment adjustment that reflects the extent to which low-volume facilities exceed the costs incurred by other facilities. Now, eligibility for the LVPA is currently based on the cost reports from the three years preceding the payment year. As of this year, a facility may close and reopen or exceed the 4,000 treatment threshold in response to an emergency without being disqualified from the LVPA. This is just one step towards our goal of using the LVPA to advance health equity and protect access to dialysis services, particularly for vulnerable beneficiaries in underserved communities and especially those that are rural and isolated. A common criticism of the LVPA in recent years was the cliff effect created by the 4,000 treatment threshold where many worry that maintaining the single threshold would incentivize facilities to restrict their patient caseload in order to remain eligible for the LVPA.

Last year, we issued a request for information in which we discussed potential modifications to the LVPA, and after careful consideration of comments and analysis of ESRD cost report data, our team formulated a two-tier alternative structure for the LVPA, which we finalized within the calendar year 2025 ESRD PPS final rule published on November 12. The new two-tier structure includes one tier for facilities furnishing less than 3,000 treatments and a second tier for facilities furnishing between 3,000 and 3,999 treatments, which would receive 28.9 and 18.3% payment adjustments, respectively. The two-tiered approach provides the highest payments of the facilities, furnishing the lowest treatment counts, which we hope will prove beneficial to rural providers. And we believe the two-tiered approach strikes a balance between simplicity for ESRD facilities, sufficiently large tiers to allow for treatment volume variation from one year to the next, and of course payment adequacy for current low-volume facilities, particularly those

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with the lowest volumes. Alongside the two-tier structure and in an effort to address the payment list that would still exist under a two-tier structure, we also finalized methodology that will determine an ESRD facility's LVPA tier based on the median treatment count volume of the last three cost reporting years rather than using a single year treatment count. We believe this methodology will increase stability and predictability in payments to low volume facilities, especially for facilities whose treatment counts are on the margins of a tier, and we are extremely excited about this change. We hope that this methodology will allow small facilities to grow without fear of losing the financial support that they are dependent on and help avoid closures in rural areas by providing a grace for facilities that are on track to outgrow the LVPA criteria. That concludes the updates to the LVPA, and I will now pass the microphone to Lisa Rees.

**Lisa Rees:** Thank you, Leone. I'm going to speak about the new home payment for AKI dialysis. The AKI dialysis payment rate for calendar year 2025 will be \$273.82, which is equal to the ESRD PPS base rate. We are going to pay for the \$95.60 training adjustment. This does have to be budget neutralized because AKI payment is made under a different Social Security rule. It's paid under 1834(r) of the Act, and anything above the base rate has to be budget neutralized. So, we have calculated a budget neutrality factor for this—for 2025, and that budget neutrality factor is zero. So, facilities will get the \$95.60 for each training treatment. The daily rate based on hemo-equivalent treatments will apply for CAPD (Continuous Ambulatory Peritoneal Dialysis) and CCPD (Continuous Cycling Peritoneal Dialysis) for claims for beneficiaries that have AKI when they're dialyzing in the home setting. The labor-related share related to the wage index is 55.2% for AKI. The AKI payment rate is not reduced for the QIP (Quality Initiative Program) and TDAPA, post TDAPA, TPNIES, and TPEAPA (Transitional Pediatric ESRD Add-on Payment Adjustment) do not apply on AKI claims. Beneficiaries with AKI will still be able to receive their phosphate binders through Part D because TDAPA does not apply to beneficiaries with AKI. And that's all I have, and I'll pass the microphone to Nick Brock for discussion of the outliers.

**Nicolas Brock:** Actually, Lauren Blum has one update.

**Lauren Blum:** Hi, yes, I am here to say that we finalized our proposals without modification to make conforming changes to the ESRD facility conditions for coverage. Specifically, we adjusted language so AKI patients can receive home dialysis services. Doing so aligned with the expanded payment coverage for home dialysis services for AKI patients included in this rule. All right, off to you Nick.

**Nicolas Brock:** Thanks, Lauren. So, I'll talk a little bit about the outlier policies in this final rule. For those who are unfamiliar with the outlier policy under the ESRD PPS, we—we—pay an outlier adjustment for those cases that are exceptionally costly. And the way that we calculate the—currently under 2024, the way that we calculate that outlier payment is only for those items and services that were previously billable, separately billable, before the implementation of the ESRD PPS, or those that would've been separately billable. So, the reason that we constructed the outlier policy in that way was because those formerly separately billable items were seen as the drivers of cost for those exceptionally costly cases. But when you look at the data, what we found is that, in fact, there are some drugs in the composite rate, which is sort of the bundle before the bundle was implemented in 2011, there are drugs that were previously paid under—

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under—that system which are still renal dialysis services but haven't received outlier consideration. Some of those are, in fact, drivers of cost, particularly for patients in—pediatric patients and patients in the hospital-based ESRD facility setting.

And so, what we proposed and finalized for 2025 is that not only formerly separately billable renal dialysis drugs, but, in fact, renal dialysis drugs that were either included in the composite rate—considered to be composite rate drugs or separately billable. So, expanding the—the—scope of drugs that receive consideration under the outlier adjustment to include those composite rate drugs. And so, we finalized that proposal for 2025. And so that has an impact on some of the—the—thresholds that we use to set the outlier payments. We establish each year a MAP (Medicare allowable payment) amount, which is the average payment amount and then the fixed dollar loss (FDL) amount. And so those amounts determine the point at which a—a—claim is going to receive outlier payments, and we set those so that outlier payments equal 1% of the total PPS payments. And so, the incorporation of those additional composite rate drugs into the outlier policy does—increases the fixed dollar amount for pediatric patients. But the impact of this is that while fewer cases were going to receive an outlier payment under this policy, the size of each of those outlier payments will be higher. So, this really focuses the impact of those outlier payments on—on—patients whose care is particularly costly.

Also, you know, every year—so that's the main policy change for the outlier policy. We also, you know, we set the MAP and FDL amounts every year, which is something I mentioned. So, we finalized MAP and FDL amounts for calendar year 2025 again to target that 1% of total payments. Those are all the baked, you know, baked into the claims processing systems and those calculations should happen. But I think the main thing to know for—for—ESRD facilities is that composite rate drugs do receive outlier consideration. And this is not a new policy, but since 2016 you should be including composite rate drugs on your claims. And so, with, I believe with that, that wraps up the agenda that we had presented. And I think we'll take questions now. I'm not sure how we do that.

**Jill Darling:** Yeah, thanks, Nick. I appreciate it. So, before we get into the Q&A portion, I just want to mention we are in the process of getting the ESRD Open Door Forum web page available. And for those who are new to Open Door Forums, we—since this is recorded, we have the webinar recording, we will get a transcript and then the questions asked on today's call will also be together with the transcript. So, I'll put a Q&A document together and the transcript, so that will all be on that transcript web page that I had posted in the chat and I can put that again for you in case anyone did have questions for those logistics. So now we can open up for Q&A. Reminder to please use the hand raise feature at the bottom of the screen if you have a question, and then we'll call on you, and please unmute from your end.

**Isaac Fisher:** OK, Jill, we have Dawn Edwards.

**Jill Darling:** Thanks, Isaac.

**Dawn Edwards:** Good afternoon. My name is Dawn Edwards, and I am a 35-year kidney patient. I represent the National Forum of ESRD Networks. I'm the Co-Chairperson of that patient organization within the forum. And I first want to begin by thanking you all for

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everything that you do for kidney patients. And I had a comment/question in reference to the phosphate binders going into the bundle on January 1. As a 35-year kidney patient, I've been taking phosphate binders for most of those 35 years except for the six years that I—I—had a kidney transplant. My concern with the transplant, with the bundle—with the bundle—payment for the binders is that in some facilities, yes it will increase access for patients, and it'll probably increase access for all patients. However, in some of our smaller facilities, dispensing those phosphate binders may become a burden for the facility. And in addition to that, I am afraid as a patient that there may be some unintended circumstances behind the binders going into the bundle.

For example, there are some patients that take two different types of binders to control their phosphorus levels. And I see it happening already that binders are being switched from two binders to one and if they're going into the cheaper binders, for example, calcium acetate, which is one of the cheapest ones. And we know that studies show that large levels of calcium is harmful to kidney patients. So, I'm concerned about the long-term effects of these calcium acetate binders being used because they're the cheapest and the unintended harm that may take place as a result of those. And I was wondering if CMS is concerned about that. Are we going to study that, and are we going to study what the effects of patients long term with all of this calcium in our system is going to be? Thank you.

**Abigail Ryan:** Hi Dawn, this is Abby Ryan, Deputy Director for the ESRD PPS, and I'll address both of your questions, and thank you very much for bringing them up because we've received several questions about this. The first has to do with dispensing may become a burden for smaller facilities. Now keep in mind that this has been on the books that we were going to do this since 2016 and what we have told, and we've sent out guidance on this, and it also included this in the final rule, that these smaller facilities, they can either provide themselves if they choose to, or they can do it under arrangement. And so, with that, we feel, and we've investigated this, that there's an ample opportunity for the patients to obtain the phosphate binders, and it really shouldn't be any different than them obtaining it before, when they had it through Part D. The advantage being, is now about 20% of the people have access to it that didn't have it before. And I appreciate you very much bringing that up because that, to me, is a huge plus for the folks that didn't have it before.

And the second one that you mentioned has to do with the unintended consequences about the two different types. We have provided guidance about how to go ahead and have the ESRD facilities put the—if patients are taking two different types of binders, putting that on the claim that they will be reimbursed. Now keep in mind that the—what the patient is prescribed and what their plan of care is, is between their nephrologist and the patient. CMS by law is not allowed to practice medicine. And so if there is a problem, what we are going to do is we have an abundant amount of information that we have been collecting for years and years and years about phosphate binders and the outcomes that we see in patients, whether it's, you know, has to do with cardiac or bone and mineral metabolism, breaks, MACE (major adverse cardiovascular event) events, all of those. We have all of that information as it stands now and in past years. We will be closely monitoring it and looking at the different populations and subpopulations of payment—patients who receive different phosphate binders. And if there's a change, we're going to be looking at that also and monitoring that. And if we see that, we are certainly going to send

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that information to the appropriate divisions and components so it can be more thoroughly investigated. And I hope that answers your question, Dawn.

**Dawn Edwards:** Thank you so much. And I just have one quick follow-up. Will there be a quality measure on phosphorus levels in patients?

**Abigail Ryan:** I'm going to leave that to CCSQ (Center for Clinical Standards and Quality). Is there—Lauren, can you address that?

**Nicolas Brock:** I don't think we have the right folks on that.

**Abigail Ryan:** We may not have it. We'll have to get back to you if we—and to find out. But I know that we have talked about it, and—but when it will happen, I don't know.

**Dawn Edwards:** OK, thank you.

**Isaac Fisher:** Jill, we have Jackson Williams.

**Jackson Williams:** Good afternoon. This is Jackson Williams from Dialysis Patient Citizens. Can—can—you hear me?

**Abigail Ryan:** I can.

**Jackson Williams:** Our recent comment letter went through the litany of new drugs for which TDAPA has failed to provide meaningful access to patients. In the preamble to the rule, you acknowledge unintended consequences of bundling new drugs, but you say you are counting on physicians to prescribe those drugs even though practically speaking, the cost of the new drugs comes out of the physician's pockets. I just want to say that I regularly receive announcements from CMS assuring beneficiaries will get access to new Part B and Part D drugs for diseases like sickle cell or even obesity. But I've never seen a press release trumpeting a TDAPA drug. And I'm assuming the reason for that is that you know that dialysis patients are unlikely to get these drugs. In three decades of working on public policy, I've never seen a worse case of groupthink than the enthusiasm for rigid bundling and the denial that there are trade-offs, and the trade-off is the possibility that any patient who differs from the average patient who needs an expensive treatment is not going to get it. My question is, has your group briefed the CMS administrators on the trade-offs inherent in the dialysis bundle and offered them either the last two, any options other than this current policy that is not delivering these drugs to patients?

**Abigail Ryan:** All right, I'll take that one too. Thank you for your comment, Jackson. And yes, and answer to your question, yes, we brief the administrators. We—we—have routinely expressed our desire to match payment with resource use, and part of the reason for having the bundle to begin with is because there was an abuse in anemia management drugs. So, we wanted to go ahead and provide these functional categories for different—for nephrologists to have this armamentarium of drugs to use for patients. Not every patient needs every drug in every functional category. So, we wanted to provide flexibility, and in doing so, in addition to which we had to do that within the framework of what section 1881(b)(14) allows us to do, and that is

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we have to have a single payment. Now we have discussed many opportunities of perhaps looking at different aspects of our payment system including, you know, rebasing. And so, my suggestion would be to you, but we can't do that. CMS is not allowed to dictate policy. Congress—we don't tell Congress what to do. Congress tells us what to do. And so, it would seem that an ability to rebase, because we haven't done it in a very, very long time, would help many problems with not only drugs, but with TDAPA and TPNIES and other various aspects of this. We have to go ahead and do what Congress tells us to do in a budget neutral fashion. And so that's why we have the system set up the—the—system set up the way that we do. And if anybody else on the team wants to add any more to that, please feel free to jump in. Nick?

**Nicolas Brock:** Yeah, I just thought, well, I wanted to address that. So, Jackson, thanks for your—for your—comment. I definitely think I may have a follow-up question back to you but shouldn't—you should not infer that we don't expect patients are going to receive TDAPA drugs. We absolutely expect that we should receive TDAPA drugs when it's appropriate. And I'm not really certain whether you're talking about any of the drugs that have recently received, you know, TDAPA. If it was any of the new drugs or if you're talking about TDAPA for phosphate binders, but it just in principle, the payment policy for TDAPA is based on average sales price. So—so—your—your—other comment about the cost of drugs for TDAPA coming out of the—the—the—don't remember if you said it was a dialysis facility's pocket or a physician's pocket. I'm not really sure that I follow that, and I just want to make sure that—that—you're—you're—aware that the TDAPA policy is—there is an add-on payment under the TDAPA, which is based on average sales price, which will—OK.

**Jackson Williams:** I certainly understand that. I mean the problem is that the doctors are in joint ventures with the dialysis clinic. So, they are—it's almost a form of capitation in the sense that the money is spread across all patients rather than following the individual patient with special needs. And I just wish that there could be a little bit more creativity on the agency's part to figure out how to get these drugs to patients. Because getting Congress to do anything, as you know, is very difficult, and there's a score involved, and it would just be a lot easier if CMS could resolve this problem for patients. Thank you.

**Nicolas Brock:** So, I think I want to—I think that we're—are you talking about the post TDAPA we talk about? So TDAPA is—is—paid on a, like, a utilization basis, so the claims billed and TDAPA is paid for the claim that includes but—

**Jackson Williams:** Yeah. Yes. But the doctors are anticipating a post-TDAPA period that's not going to have an adequate payment. So, they're anticipating that they're not going to deliver the drug in the first place because then they have to withdraw it.

**Nicolas Brock:** Thank you. That makes sense. That clarifies the comment. I think what I would encourage, ongoing dialogue. This is kind a good dovetail into sort of what I want to say later about the future of these Open Door Forums, just ongoing dialogue about ideas that the community has for—for—making revisions in the payment system. I think we've—we've—the CMS has solicited comments as readers of the rule will know about making revisions to the case-mix adjustments and collecting the types of data that would be necessary to understand the drivers of—better understand the drivers of cost and make those kinds of revisions. So, in

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addition to, as I mentioned earlier, the outlier adjustment, which recognizes costlier patients and—and—makes an adjustment for those patients whose treatment is costlier, we would strongly encourage dialogue from the community here on how we might recognize those—those—types of things and potential revisions in the future. Thank you for clarifying your question, Jackson.

**Jackson Williams:** Thank you.

**Isaac Fisher:** Next we have Tina Martinez.

**Tina Martinez:** Hi, everyone. Thank you for taking my question. I have three, actually, if you can bear with me. The first is regarding the new wage index table. I just want to make sure as I'm reading this to load into my billing system that it is read left to right including the 24 and the 25 columns. Is that correct?

**Nicolas Brock:** I can go ahead and jump on this. Yeah, that's correct. So, the—the—I think you're talking about the crosswalk that's on the website.

**Tina Martinez:** Yeah.

**Nicolas Brock:** The far left column is—is—FIPS (Federal Information Processing Series) state and county codes.

**Tina Martinez:** Yes.

**Nicolas Brock:** So, what that tells you is for a given FIPS state and county code, it was in CBSA (Core-Based Statistical Areas) or state code whatever in 2024. And in 2025 because the delineations have changed—

**Tina Martinez:** Correct.

**Nicolas Brock:** It is a different CBSA or state code.

**Tina Martinez:** OK. I just wanted to make sure because one of mine so far in my list has been changed. Second, for the composite rate items that are moving to outlier, the first communication had a hundred pages of NDCs (National Drug Codes) and drugs that will be moving to outlier. Does that also include the composite rate injectables that we've been given—that we've been—that've we've been giving to our patients such as heparin, mannitol, glucose, that whole list that we've seen before. Does the outlier now include both the orals and the injectables or just the orals that were included in the outlier communication?

**Nicolas Brock:** The outlier includes both the orals and the injectables that are composite rate drugs. The—the—change request I think you're referring to—I think the document you're referring to is coming from the transmittal. That includes the oral NDCs and HCPCS (Healthcare Common Procedure Coding System) ASP pricing will be available later this year—later this month. It typically comes at the last couple weeks of the quarter. And once that's made

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available—once the ASP file is made available, then those—those—prices will be available. But just generally, I think your question was general. Yeah.

**Tina Martinez:** Just yeah. Will that—will heparin, mannitol, glucose, and everything else that is on that list, those will be included in outlier going forward?

**Nicolas Brock:** Yeah, if you want to send the—our mailbox is the ESRD—we can send you the—the—mailbox, but if you want to send a specific list of HCPCS codes, we can—we can verify, and Jill has just put that in the chat.

**Tina Martinez:** Yeah, I'm very familiar with that. I've been using it a lot this year.

**Nicolas Brock:** OK.

**Tina Martinez:** Then my final question was regarding the LVPA, the two-tiered system. Will we be notified which tier each clinic falls in with our attestation approvals, or is this something that we're going to have to make our determinations ourselves—ourselves?

**Nicolas Brock:** I'm not sure. So, like, there's instructions in the—the criteria for which tier the—the—facility falls in are—I think are clearly laid out in the change request. So, I'm not—I'm not—sure that I understand the question. CMS is not dictating which tier the facilities fall in. That's going to be determined based on the attestation process with the—

**Tina Martinez:** Which answers my question that if it's—if it's—in the attestation approval, once we receive that back, then that's my answer.

**Nicolas Brock:** OK. Thank you for helping me understand your question.

**Tina Martinez:** Thank you.

**Isaac Fisher:** Next we have Corrine Simpson.

**Nicolas Brock:** Corrine, I think you can go off mute. If you're—if you're—speaking, you're still muted.

**Isaac Fisher:** Corrine just lowered a hand. We have Deanna Jones Harwood next. Deanna Jones Harwood—Harewood.

**Nicolas Brock:** Deanna, I can see you're off mute, but I can't hear you.

**Jill Darling:** I would suggest if they're having audio issues, you can just send the—your question or comment into the ESRD payment email that I had posted.

**Nicolas Brock:** Yes, and for anyone—it's in the chat, but it's esrdpayment—all one word, no space— at cms dot hhs dot gov.

**Jill Darling:** OK. At this time, I don't see any more hands, so we can close it out, Nick.

**Nicolas Brock:** All right. Well, thank you all for joining us this afternoon. As Jill and Abby mentioned, this is our first ESRD Open Door Forum in quite some time, and I really appreciate all the active engagement. I speak for the whole team, I think. I look forward to holding these more frequently, I think ideally a couple of times throughout the year. And we will try to bring relevant updates to you that involve updates related to, you know, the policies that we're proposing or finalized. We would love to hear from you if you have the email, the ESRD payment mailbox in the chat, and I mentioned it earlier. If there are any topics that you would like to hear from us about that we can, you know, bring the information that is important to you, we would love to hear about that. So please do go ahead and—and—reach out. So again, thank you so much for joining us, and have a great afternoon.

**Jill Darling:** And this is Jill. I just put in the chat again the web page for the transcripts. And also, if you did not receive the agenda firsthand, you received it secondhand, I just put up a link to sign up to receive agendas, blurb announcements, anything coming regarding Open Door Forums, so you have a choice to pick this particular Open Door Forum or any of our other Open Door Forums. So, we thank you for joining us. This—we will talk with you next year. Happy holidays. And this concludes today's webinar. Thank you.