Roll Out Qs & As
END STAGE RENAL DISEASE COMPOSITE PAYMENT RATE SYSTEM

Q1. CMS is sponsoring research to develop a bundled End Stage Renal Disease (ESRD) Prospective Payment System (PPS) that includes not only composite rate but also separately billable items and services. Because this research is ongoing, why is CMS revising the composite payment rates at this time?

A1. Section 623 of Public Law 108-173, the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 directed revision of the current composite rate payment system effective January 1, 2005. The statute requires:

- An increase of 1.6 percent to the current composite payment rates;
- An add-on for the difference between current payments for separately billable drugs and payments based on a revised drug pricing methodology using acquisition costs;
- Reinstatement of the ESRD exceptions process to pediatric facilities, effective October 1, 2002;
- A case mix adjustment to a provider's otherwise applicable composite payment rate based on a limited number of patient characteristics; and
- That aggregate payments under the revised case mix adjusted system be budget neutral.

Q2. What is the purpose of the drug add-on to the ESRD composite rates, given that separately billable drugs and biologicals will continue to be reimbursed separately pending the development of the bundled ESRD PPS?

A2. Because the composite payment rates have only been increased three times since their inception in 1983, composite rate payments to dialysis facilities generally are less than composite rate costs. However, payments for separately billable drugs exceed separately billable costs by an amount more than sufficient to make up the shortfall and provide an overall profit margin. We believe that Congress intended to reduce, if not eliminate outright, this cross subsidization between composite rate and separately billable ESRD drug payments by providing for the drug add-on to the composite payment rates. This adjustment accounts for the difference or spread between payment rates for separately billed drugs under the current system and acquisition costs, as determined by the Office of the Inspector General.

Q3. Section 623(d)(1) of the MMA gives the Secretary the discretionary authority to revise the current outdated wage indexes, and the urban/rural definitions used to develop them, currently reflected in the composite payment rates. Have the wage indexes been revised?

A3. The wage indexes currently reflected in the composite payment rates have not been revised. On June 6, 2003, the Office of Management and Budget (OMB) issued Bulletin 03-04, which announced new statistical areas based on the 2000 Census. The extent to which CMS recognizes the new OMB definitions will affect all of the various payment systems the Agency administers that have payment distinctions based on geographic location. Any wage index revisions would affect not only ESRD facilities but also hospitals, home health agencies, skilled nursing facilities, and rehabilitation providers. We are currently assessing the impact of policy proposals to revise the definitions used to develop the area wage indexes. We are proposing to take no action at this time to revise the current set of composite rate wage indexes, and the urban/rural definitions used to develop them, until those evaluations have been completed.

Q4. How were the case mix adjusters required under section 623(d) of the MMA developed?

A4. The detailed methodology is set forth in the final rule. The process involved the evaluation of 35 patient characteristics obtained from both the CMS 2728 and Medicare claims. The patient characteristics included weight, body mass index (BMI), body surface area (BSA), seven types of cancer, diabetes, chronic obstructive pulmonary disease, four types of heart disease, and race. Patient specific comorbidities, along with seven facility control variables, were used to predict ESRD facility composite rate costs obtained from the Medicare cost reports, based on standard least squares regression. Although we proposed the use of AIDS, peripheral vascular disease, and gender as case mix adjustment factors, we eliminated those variables in response to comments received and instead substituted BSA and a variable for low BMI. We also expanded the number of age categories from three to five. The result, after all necessary statistical adjustments, was a set of seven case mix adjustment factors based on age, BSA, and BMI. The appropriate factor, which will be automatically computed by the PRICER program based on submitted claims information, is simply multiplied by a facility's composite payment rate to yield a case mix adjustment for each patient.

Q5. Table 14 in the final notice reveals a similarity in the average estimated case mix adjustment factors for the ESRD facility classification groups shown. Are ESRD facilities that much alike when it comes to case mix?

A5. The case mix adjusters or multipliers shown in Table 14 are only averages. Some facilities, of course, would be expected to deviate substantially from these average values based on their specific patient mix. Nevertheless, the relative

similarity of the average case mix adjusters occurs because the proportion of patient treatments within each of the clinical classification groups generally are very similar, regardless of type of facility.

Q6. Some ESRD facilities currently have exceptions to their composite payment rates. Will implementation of the new case mix adjusted composite payment system result in those facilities losing their exceptions?

A6. No. Under the proposed rule, ESRD facilities currently with exceptions will be given the option of either retaining their exceptions or becoming subject to the new case mix adjusted PPS. An ESRD facility may notify its fiscal intermediary at any time if it wishes to withdraw its exception rate and become subject to the new case mix adjusted PPS.

Q7. The MMA requires that the case mix adjusted composite payment rates be effective January 1, 2005. However, CMS proposed an April 1, 2005 implementation date. Isn't the April 1, 2005 effective date in violation of the statute?

A7. Section 623(d)(1) of the MMA requires that the basic case mix adjusted composite payment rates be effective for services beginning January 1, 2005. Despite the law's specificity, we pointed out in the proposed rule that all of the systems, programming, and operational changes necessary to implement the new ESRD PPS cannot be completed in time for a prospective January 1, 2005 effective date. Although we considered an April 1, 2005 effective date, with bills reprocessed and adjusted to January 1, 2005, the likelihood of payment error, potential disruption of provider payments, cost, and complexity of this approach precluded further consideration of this option. Several commenters maintained that the proposed April 1, 2005 implementation date was overly ambitious and recommended a June 1, 2005 effective date instead. However, we believe that an April 1, 2005 effective date for the case mix adjustments is feasible and have decided not to revise that date. As we stated in the proposed rule, the 1.6 percent increase to the composite payment rates and drug add-on will be effective January 1, 2005.

Q8. The proposed rule did not include a specific case mix adjustment for pediatric ESRD patients. Although section 623(b) of Public Law 108-173 provided for an exceptions process for pediatric ESRD facilities, qualification is limited to those facilities where pediatric patients (those under age 18) comprise at least 50 percent of the caseload. Has CMS developed a case mix adjuster for pediatric ESRD patients?

A8. Using the same regression methodology described in the proposed and final rules, we attempted to develop a case mix adjuster for outpatient ESRD patients under age 18. However, the results were highly variable and statistically unstable because of the small numbers. Nevertheless, facilities not qualifying for

the pediatric exception provided in the law can still incur substantial costs for the treatment of pediatric ESRD patients. Accordingly, in the final rule we provide for an automatic percentage adjustment to a facility's otherwise applicable composite payment rate for outpatient ESRD pediatric treatments. The methodology used to develop the 62 percent add-on is described in the final rule.

Q9. How should the facilities enter weight and height for a person that has had their legs amputated?

A9. The height and weight should be calculated as the person presents. Their actual height and weight should be entered. No adjustments and no assumptions should be made about what their height and weight would have been without the amputation.