2005 Updates

Composite Rate Adjustments and Changes in Pricing of Separately Billable Drugs and Biologicals

Objective

The objective of the 2005 Updates chapter is to provide information to FIs and ESRD facilities that will help them understand the changes to take effect in 2005.

Participants will learn about the following information in the course of this chapter:

- Updated composite rate payments
- Reimbursement for separately billable drugs
- Case-Mix Variables
- Pediatric Adjustment
- Budget Neutrality

January 1, 2005 Changes

Changes to ESRD payment will be made in two stages in 2005. The first stage is effective January 1, 2005.

- The wage adjusted composite payment rates in effect December 31, 2004 will increase by 1.6 percent
- A drug add-on adjustment of 8.7 percent will be added
- Payment for separately billed drugs and biologicals will be paid based on the average acquisition price (AAP) or average sales price (ASP) plus 6 percent
- The cost for supplies to administer Epogen (EPO) may now be separately billed
- Reporting of two new value codes:

    - A8 – patient weight in kilograms (after dialysis)
    - A9 – patient height in centimeters (as patient presents)

1.6 Percent Increase

The 1.6 percent increase updates hospital-based and independent facility composite rates adjusted by the current wage index. The updated rates do not include any of the basic case-mix adjustments required under section 623 of the MMA.

This change increased the composite rate for independent facilities from $126.33 by $2.02 to $128.35. The composite rate for hospital-based facilities increased from $130.32 by $2.09 to $132.41.

	Composite Rate Prior to January 1, 2005	1.6 Percent Increase Amount	2005 Updated Composite Payment Rate
Independent	$126.33	$2.02	$128.35
Hospital-based	$130.32	$2.09	$132.41

Since the composite rate payment for hospital-based facilities is higher than the composite rate for independent facilities, the adjustment results in a higher payment rate for hospital-based facilities. The hospital-based facilities' rate is higher by $4.06. Section 1881(b)(7) of the Social Security Act requires that the payment methods differentiate between hospital-based facilities and others.

8.7 Percent Drug Add-On Adjustment

In addition to the 1.6 percent increase, the MMA requires an add-on adjustment of 8.7 percent to the composite rate to account for the drug spread. The drug spread is the difference between the payments prior to January 1, 2005 for separately billable drugs and payments based on the revised drug pricing methodology.

The drug add-on adjustment is based on average acquisition costs for the top 10 ESRD drugs updated to 2005 and ASP plus 6 percent for the remaining separately billable ESRD drugs. Since this is an add-on to the composite rate, these payments are also geographically adjusted.

Because ESRD facilities receive composite rate payments for their Method I home patients, the drug add-on would apply to composite rate payments for all patients regardless of the type of dialysis received. Method II home patients are not affected since payment for these patients is made based on reasonable charges as opposed to the composite rate.

Regulations require that ESRD facilities provide appropriate care to each patient based on a plan of care that would include the administration of medically necessary drugs as prescribed by the patient's dialysis physician.

QUICK FACT

Method II patients are not affected by the 2005 payment updates.

2005 Base Composite Rates

The following table shows the effect of the 8.7 percent add-on to the composite rate for independent and hospital-based facilities:

	2005 Base Composite Rate	8.7 percent Add-On (2005)	2005 Composite Rate With Add-On
Independent Facilities	$128.35	$11.17	$139.52
Hospital-Based Facilities	$132.41	$11.52	$143.93

2005 Payment for the Top 10 Most Frequently Used ESRD Drugs

For 2005, the top 10 most frequently used ESRD drugs, including EPO, will be paid at acquisition cost updated by the Producer Price Index (PPI).

Payment for the top 10 most frequently used ESRD drugs

Drug	2005 Average Acquisition Payment Amounts
Epogen	$9.76
Calcitriol	$0.96
Doxercalciferol	$2.60
Iron dextran	$10.94
Iron sucrose	$0.37
Levocarnitine	$13.63
Paricalcitol	$4.00
Sodium ferric gluconate	$4.95
Alteplase, Recombinant	$31.74
Vancomycin	$2.98

Separate Payment for Supplies to Administer EPO

Effective January 1, 2005, providers may bill separately for an administration supply (syringe) when administering EPO.

To bill for the administration supply (syringe), report the following:

- Revenue code 270
- HCPCS A4657

Although a provider may use more than one syringe per administration, the provider should only bill for one syringe per EPO administration.

2005 Payment for Other Drugs

ESRD drugs not included in the top 10 most frequently used are paid at the ASP plus 6 percent.

* NOTE: Hospital-based ESRD facilities will continue to be paid cost for all separately billable drugs with the exception of EPO which will be paid at the AAP as described above. All other drug pricing changes only apply to independent ESRD facilities.

April 1, 2005 Changes

The second phase of 2005 changes are effective April 1, 2005. These changes include the following:

- Implementation of case-mix variables
- Separate pediatric adjustment
- Budget neutrality

Patient Characteristic Adjustments

The ESRD composite payment rates prior to April 1, 2005 were not adjusted for variation in patient characteristics or case-mix. Section 623(d)(1) of the MMA added section 1881(b)(12)(A) of the Act to require that the outpatient dialysis services included in the composite rate be case-mix adjusted. Specifically, the statute requires the establishment of a basic case-mix adjusted prospective payment system for dialysis services for a limited number of patient characteristics.

Case-Mix Adjustments

The case-mix adjustments are based on the following variables:

- Age
- Body mass index (BMI)
- Body surface area (BSA)

There will be a separate case-mix adjustment for pediatric patients.

While co-morbid conditions are not currently part of the basic case-mix system, all facilities are encouraged to more thoroughly report and code co-morbid conditions on their claims. This will enable appropriate refinements to the basic case-mix adjustments and development of a database of case-mix measures for a bundled payment system.

New Value Codes

The National Uniform Billing Committee approved the use of two new value codes for reporting weight and height (A8—weight in kilograms, A9—height in centimeters) on the billing forms effective March 7, 2005. More information on these two new codes will be discussed in the next section since the reporting of the codes affect payments after April 1, 2005.

Continuing Research to Develop a More Fully Bundled Case-Mix System

The research activities for the fully bundled system have focused on updating the database. Research efforts since the passage of MMA have focused on

supporting the Congressional mandate for the development of a limited number of case-mix variables. The MMA requires the establishment of the full case-mix adjusted demonstration, which will bundle into the payments both separately billable drugs and biologicals and clinical labs. Both the Report to the Congress and the demonstration will be supported by continuing research.

Age Groupings for the Case-Mix Adjustment

There are five age groupings for the case mix adjustment:
18–44
45–59
60–69
70–79
80+

Patients under 18 are discussed in the Case-Mix Adjustment for Pediatric Patients section.

Payment for the age adjustment will be made based on the following chart:

Age	Multiplier
18-44	1.223
45-59	1.055
60-69	1.000
70-79	1.094
80+	1.174

The multiplier for the 60-69 age group is 1.000 because that age group was used as the reference group for the purpose of calculating the multiplier that is applicable to the other four age categories. This is a standard statistical technique used to develop case-mix adjusters.

For a month when the patient has a birthday that puts him or her into another age category, the first of the month is the effective date of the patient's new age category.

EXAMPLE

Mr. Smith turns 45 on July 16, 2005. For services provided on or after July 1, 2005 the age multiplier used for Mr. Smith is 1.055 since the age multiplier is effective the first day of the month of his birthday.

BMI and BSA

Below is a discussion of the case-mix adjustments related to a patient's size. Both the BMI and BSA will be calculated by the PRICER based on the two new value codes.

ESRD facilities are required to report height and weight using the new value codes, so that payment can be based on the case-mix adjusted composite rate payment system on April 1, 2005. For the implementation of the basic case-mix payments, an adjustment for low BMI is being provided. A low BMI is any patient with a BMI less than 18.5 kg/m^2. This variable was included because the regression analysis indicated that those patients who are underweight and malnourished consume more resources than other patients. The measure of low BMI that is consistent with the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) definition for malnourishment was chosen.

BSA

Case-mix adjustments based on BSA are being provided. The research into this body measurement indicated that BSA ($meters^2$) is a good predictor of composite rate resource consumption. All of the formulas for BSA were examined. While very little differences between the formulas in predictive power were found, the Dubois and Dubois formula[1] for BSA was adopted since the literature search revealed that this particular formula was the most widely known and accepted. This formula is: $BSA=W^{0.425} * H^{0.725} * 0.007184$. W represents weight in kilograms and H represents height in centimeters in the formula. In addition, a number of options for setting the reference values for the BSA were explored. The distributions for both the midpoint of the BSA and the count of dialysis patients by age, body surface and low BMI were examined. Based on this analysis, the reference point was set for a BSA of 1.84 (the average BSA among dialysis patients in 2002). By setting the reference point at the average BSA, the adjusters reflect the relationship of a specific patient's BSA to the average BSA of all patients. Therefore, some adjusters will be greater than 1.0 and some will be less than 1.0. In this way, the magnitude of the budget neutrality offset to the composite payment rate is minimized. The BSA multiplier is applied per $0.1\Delta BSA$ of 1.84 and is used in the following calculation: $1.037^{((BSA-1.84)/0.1)}$.

[1]DuBois D. and DuBois, EF. "A Formula to Estimate the Approximate Surface Area if Height and Weight be Known": Arch. Int. Med. 1916 17:863– 71.

An example of the method for calculating patient level multipliers that were derived from the coefficients resulting from the regression model that includes control variables, expanded age groups, BSA, and an indicator for low BMI (<18.5 kg/ m^2) (excluding small facilities and outliers) is:

Case-mix adjuster = Age factor * low BMI factor * BSA factor

An increment of 0.1 provides an appropriate degree of precision of the calculation of the exponent used to compute the BSA case-mix adjustment.

Value Codes Reporting Weight and Height

The National Uniform Billing Committee has approved the use of two new value codes for reporting weight and height on billing forms effective March 7, 2005:

- A8 - weight in kilograms
- A9 - height in centimeters

Both A8 and A9 can be reported with up to two decimal places on the CMS 1450 claim form or its electronic equivalent.

The mandatory reporting of height and weight permits the development of case-mix measures that reflect both variables, such as BMI and BSA, each of which are superior to weight alone as predictors of resource use. Given the impending availability of height and weight data on outpatient dialysis bills, the predictive power of weight, BMI, and BSA in lieu of gender based on data (reported on Form 2728 from 2000 through 2002) was examined. It was determined that both BMI and BSA are superior predictors to weight alone and that BSA, coupled with a variable for low BMI, is the best predictor of facility differences in composite rate costs. Height and weight should be reported for all ESRD patients including Method II and pediatric patients.

The weight reported on the claim should be the "dry" weight, which is the actual weight of the patient after they receive their last dialysis treatment for the month. For home dialysis patients use the dry weight that is recorded at the latest clinic visit for all home dialysis patients. The height should be reported as the actual height, as the patient presents.

EXAMPLE

To convert pounds to kilograms, 1 pound = 0.453 592 37 kg. For a 150-pound person multiply 150 pounds by 0.45359237 kilograms.

150 lbs
X 0.45359237 kg
68.0388555 kg

To convert inches to centimeters, there are 2.54 centimeters in 1 inch. A person who is 5 feet, 5 inches tall is 65 inches. Multiply 65 inches by 2.54 centimeters.

65 in
X 2.54 cm
165.1 cm

Case-Mix Adjustment for Pediatric Patients

Qualification for a pediatric exception is limited to those facilities where pediatric patients comprise at least 50 percent of the caseload. A pediatric patient is under age 18.

ESRD pediatric patients are unusually resource intensive and costly and are widely scattered among facilities, and most of these facilities would not qualify as pediatric facilities under the definition set forth in the statute.

Pending the development of more refined case-mix adjustments that are more sensitive to individual variation in treatment costs under a fully bundled ESRD PPS, a single adjustment to a facility's otherwise applicable composite payment rate is being developed and implemented based on the methodology for outpatient ESRD pediatric treatments. The pediatric adjustment factor resulting from this methodology is intended to be a temporary measure, which will apply until an adjuster under the bundled ESRD PPS can be developed that is more similar to the case-mix adjustments that would apply to non-pediatric ESRD patients.

For pediatric patients, a case-mix factor of 1.62 will be applied to the composite rate.

This includes both in-facility and home dialysis. Applying the adjuster multiplicatively in this manner recognizes the wage index variation in labor costs among urban and rural areas built into the composite rates.

Budget Neutrality for Case-Mix Adjustment

Section 1881(b)(12)(E)(i) of the Act, as added by section 623(d)(1) of the MMA, requires that the basic case-mix adjusted composite rate system be designed to result in the same aggregate amount of expenditure for such services, as estimated by the Secretary, as would have been expended for 2005 if that paragraph did not apply. Therefore, the patient characteristics case-mix adjustment required by section 623(d)(1) of the MMA must result in the same aggregate expenditures for 2005 as if these adjustments were not made. Payment for each ESRD provider was simulated by applying a facility-specific case-mix multiplier to the composite rate applicable for that facility. Since the pediatric case-mix adjustment was developed outside the regression model, payments were simulated separately for those treatments. The results of these two computations were then combined to arrive at the total case-mix adjusted payment. Payment was also simulated for each provider as if they did not receive any case-mix adjustments. Then the total simulated payments with case-mix adjustment to total simulated payments was compared without case-mix adjustment. The resulting budget neutrality adjustment to the composite rate is 0.9116.

New Exception Window

Section 623(b) of the MMA reinstated exceptions for qualifying pediatric facilities, which are defined as facilities with at least 50 percent of their patients under 18 years of age. The current exception window for pediatric facilities closed on September 27, 2004. At this time, future exception windows will be open only for pediatric facilities. The exceptions process is opened each time there is a legislative change in the composite payment rate or when the exception window is opened. The FI will notify the ESRD pediatric facilities when a new exception window opens. Effective April 1, 2005, a new exception window will open for pediatric ESRD facilities.

QUICK FACT

Facilities currently receiving an exception rate must notify their FI if they prefer to receive the new composite rate payment.

FIs must notify ESRD providers on or before March 1, 2005, of the opening of a new 180-day window for pediatric facilities to file exception requests. Pediatric facilities have 180 days from April 1, 2005 to September 27, 2005, to submit a valid exception request to its FI. Pediatric composite rate exception requests received by fiscal intermediaries after their close of business on September 27, 2005, will be considered untimely and must be denied. In addition, FIs cannot accept exception applications from any pediatric facility with a current exception rate approved prior to October 1, 2002.

FIs must verify that a pediatric facility applying for an exception meets the revised definition of a pediatric facility, which is a renal facility with at least 50 percent of whose patients are individuals under 18 years of age.

FIs must inform ESRD facilities that the facility may at any time give up their exception rate by providing written notification to their FI. FIs must notify CMS when an ESRD facility requests a withdrawal of a previously granted exception and inform the facility that their basic case-mix adjusted composite payment will begin 30 days after receipt of the notification letter.

EXAMPLE

The case-mix adjuster for a 47-year old person who is underweight (BMI<18.5 kg/m^2) and has a body surface area of 2.0 m^2 is calculated by using the 1.84 BSA reference point:

Age Factor = 1.055
Low BMI Factor = 1.112
BSA Factor = 1.037 ((2.0-1.84)/0.1) = $1.037^{(1.6)}$ = 1.060
Case-Mix Adjuster = 1.055 * 1.112 * 1.06 = 1.244

The resulting case-mix adjustment factor of 1.244 for this patient is applied to the facility's composite payment rate that is adjusted for area wage index, drug add-on, and budget neutrality.