ASN DIALYSIS ADVISORY GROUP

ASN DIALYSIS CURRICULUM

ASN LEADING THE FIGHT AGAINST KIDNEY DISEASE

FINANCIAL CONSIDERATIONS AND HOME DIALYSIS IN THE ERA OF THE BUNDLING: Part 2

John Burkart, MD
Professor of Medicine/Nephrology
Wake Forest University Medical Center
Chief Medical Officer
Health Systems Management

DISCLOSURES: current position (6/1/2014)

Professor of Medicine/Nephrology at Wake Forest University

CMO Health Systems Management

- Manages 19 outpatient dialysis units
  - 16 at Wake Forest University
  - 3 at Emory University

In Past, I had been medical director for 16 units

- Since CFC now medical director for 1 unit
  - Approved for 60 stations
  - Includes Home unit

Outline (Part 2)

Dialysis facility payments

CMS and “the bundle”

Dialysis Facility Payments

HISTORIC (Pre-Bundle) ESRD REIMBURSEMENT: *Providers*

Provider were historically paid as follows:

- **The composite rate, Plus**
- **Medicare allowable reimbursement/unit used and necessary waste,**
  - (Medicare reimbursement was typically more than what the medication cost --i.e. average wholesale plus 6%)
  - ESA, Vit D, Iron, etc
  - By 2007 Separately billable services (medications, labs, etc.) = 40% of cost for outpatient dialysis services.
- **Plus, Non ESRD related labs**

THE "FIRST" BUNDLED PAYMENT

HISTORY OF CMS PAYMENTS FOR RENAL REPLACEMENT THERAPIES

COMPOSITE RATE ISSUES

Implemented August 1, 1983

Composite rate was comprehensive in 1983

But, did not include separately injectable (billable) meds:

- ESA's, Vitamin D, Iron, etc.
- Currently reimbursed at ASP + 6%

By 2007 Separately billable services (medications, labs, etc.) = 40% of cost for outpatient dialysis services.

Source: Part II HHS CMS 42 CFR parts 410, 413, 415: 9/29/09

SEPARATELY BILLABLE MEDS (SBM's) or *"INJECTABLES"*

Dialysis historically were reimbursed by CMS per unit used.

(This is where default modality choice was driven.)

SBM Reimbursement = average wholesale plus 6 %

If you are a very large company and use many units you will likely purchase what you use from a pharmaceutical company for less than the average purchaser.

- **Historically SBM were a source for profit margin! i.e. meds were a PROFIT center.**

CMS / ESRD / REIMBURSEMENT

The “Bundle” or
The Prospective Payment System (PPS)

CMS STATED RATIONALE FOR ESRD PPS (Bundle)

- Eliminate incentive to overuse profitable SBM (p49924)
- Attempt to target greater payments to facilities with more costly patients to allow equitable access to services (p 49924)
- Promote operational efficiency (p 49924)
- Enhance quality of care (p 49924)
- Remove incentive to use separately billable meds as revenue (SBM) source which has potentially impeded greater use of PD. (p 49931)
- We want to encourage use of home dialysis…… PD is prevailing mode……..proposing a PPS that does not relay on separately billables for modality. (49967)

Source: Part II HHS CMS 42 CFR parts 410, 413, 415: 9/29/09

ORIGINAL FINANCIAL COMPONENTS OF FINAL CMS BUNDLE - *UNADJUSTED*

Composite Rate (from cost reports)	160.87	
ESA	60.80	
Vit D	11.15	
Iron	6.65	
Other Injectables	1.25	Medication
Labs	8.73	Add on
Durable Medical Equipment	0.49	
Other Supplies	1.11	
Part D oral meds with IV equivalent	0.51	
Total	$251.61 per treatment	

COMPONENTS OF FINAL CMS BUNDLE - *UNADJUSTED*

Composite Rate (from cost reports)	160.87
ESA	60.80
Vit D	11.15 --- HD IV vit D
Iron	6.65
Other Injectables	1.25
Labs	8.73
Durable Medical Equipment	0.49
Other Supplies	1.11
Part D oral meds with IV equivalent	0.51 -- PD oral vit D
Total	$251.61 per treatment

THE BUNDLE PAYMENT
Original calculation

Bundled payment / Rx = Total amount paid / year for all services divided by total number of treatments given in that year

- (Included PD and HD)
- Assumed 1 week of PD = 3 HD treatments

Bottom line: Since about 93% of patients were on CHD and 7% on PD --- The average reimbursement for CHD went down and for PD it went up

AVERAGE MEDICARE ALLOWABLE CHARGES: HD and PD

– *Proposed ruling FY 2004-2006*

	CHD	PD
Average / Rx Composite rate - Freestanding*	$135.00	$135.00
Average / Rx cost – Separately Billable Meds (SBM)	$87.20	$35.15
Average total Medicare allowable cost/Rx (Composite rate + SBM)	$222.20	$170.15

Data source – Medicare claims for 11 most commonly used separately billable drugs

And average Medicare allowable composite rate

Source: Federal Register: Vol. 74; # 187; Sept 29, 2009. Proposed Rules p 49967

EXAMPLE OF EFFECT BUNDLE WILL HAVE ON REIMBURSEMENT:

HD vs. PD – *FY 2004-2006; assumes 93% on HD 7 % on PD, 80% allowable*

	HD	Total Monthly Payment (PD + HD) assumes 100 Pts	PD
Average total / Rx cost (Composite + SBM)	$222.20		$170.15
	$2888.60		$2211.95
Total monthly Medicare allowable (for all Pts)	$268,639.00		$15,483.65
Total amount paid by Medicare for all patients		$284,123.45	
Monthly payment / patient in Bundle **	$2841.23		$2841.23
Projected Net loss () or increase / month by modality	($47.37)		$629.28

Federal Register: Vol. 74; # 187; Sept 29, 2009. Proposed Rules p 49967

LIKELY BOTTOM LINE FROM BUNDLE – Proposed Ruling Data

Based on 2006 data:

- For each HD patient - total monthly reimbursement will likely be about $47.37 less
- For each PD patient - total monthly reimbursement will likely be about $629.28 more

  (HHD may be more if > 3/week payment)

For every 100 patients:

- If you have 93 on CHD and 7 on PD total reimbursement should basically be the same but less will be from CHD and more from PD.
- If % on PD < 7% total pay to unit will likely be less.
- If % on PD> 7% total pay to unit will likely be more.

REIMBURSEMENT IN BUNDLE – advantage of PD/Home HD

Historically SBM costs for CHD higher Than PD due to differences in medication usage.

However Since implementation of Bundle (2011):

- **IN CHD:**
  - ESA use markedly reduced (lower targets and no lower QIP metric)
  - Costs of IV iron / VDRA's markedly less
- **PD Oral med costs are significant**
  - No doughnut hole (Was that cost included in initial calculation?)
  - Pharmacy costs for "dispensing" meds
  - Unit pays total cost, not just co-pay

Caveat – still less in labor and facility costs

BUNDLE - FINAL RULING
Key issues as of Jan 2011

Onset of dialysis add on for first 120 days is +51%!!!!!

- Timing starts 1st day of patients dialysis even if patient is not a Medicare participant at start
- Cannot bill onset multiplier and training at same time.
- Cannot bill onset multiplier and co-morbidity add on at same time
- If Medicare eligible (worked 40 quarters) but not a participant:
  - And you start on CHD must wait 90 days (3 months) to start billing
  - **If you do home dialysis you can bill from start of home training**

ONSET OF DIALYSIS AND PD

Medicare eligible but not current participants

KEY POINT --- if a patient is Medicare eligible but not a current participant and with no insurance:

- If you do home dialysis payment starts day 1
- If you do center HD payment starts day 90
- So during first 4 months of RRT in these patients:
  - Get paid for equivalent of 6 months if on PD (or home dialysis)
  - Get paid for only 1.5 months if started on CHD – difference $13,000!

BUNDLE - FINAL RULING

Key issues as of November 2013

	BASE PAYMENT
2011	$229.63
2012	$234.81
2013	$240.36
2014	$239.02
2015	

BUNDLE - FINAL RULING
Key issues as of November 2013

2011 Payment per treatment –

New Base rate was 229.63

ESRD related Drugs:

- Includes Separately billable ESRD injectables.
- If there is an IV equivalent ---
  - they *are* included (i.e Vit D, iron)
- Other Oral only drugs originally projected to be included in 2014 first *delayed* until 2016-- now 2024
  - (Cinacalcet, Phosphate binders)

BUNDLE 2014 - *Key issues*

Home Dialysis:

- **Initial \$33.44/day add on for training adjusted by wage index –**

- **This increased to \$50.16/day**
  - 25 days for HHD
  - 15 days for PD
    - If you only use a % for initial training, can use the rest if needed for “retrain” or change in equipment
    - Can use one of your training days if you “flush” catheter

THE BUNDLE
Quality Incentive Program (QIP)

The ESRD Quality Incentive Program (QIP) – potentially results in more cuts for providers

- **2% will be withheld (to pay for QIP payment)**
- **Pay for performance- means penalize for non-performance**
- **QIP adjustment (+0 to 2% of what would have been total)**

QIP PY 2014
(PERFORMANCE YEAR 2012)

There were three clinical measures –

- Anemia
- HD Adequacy now in terms of Kt/V
- Vascular Access Type (VAT)
  - AVF / Catheter

Three reporting measures –

- Dialysis event data to CDC – NHSN system
- Patients experience of care survey
- Monthly Mineral and Metabolism monitoring (Ca and PO4)
  - Reporting vs. hypercalcemia incidence

PY 2016 QIP Measures OVERVIEW

Metrics based on Unit performance in *2014*

Clinical Measures – 75% of Total Performance Score	
	Performance Standard
Anemia Management	
•Hemoglobin > 12	0%
Adequacy	
•KT/V e 1.2 (Adult hemodialysis)	93.6%
•KT/V e 1.7 (Adult Peritoneal Dialysis)	85.4%
•KT/V e 1.2 (Pediatric Hemodialysis)	92.5%
Vascular Access	
•AVF (using AVF with 2 needles last treatment of the month)	62.4%
•Catheter e 90 days	10.5%
NHSN Bloodstream Infection in Hemodialysis Patients (+ BC per 100 patient-months)	
Hypercalcemia (Proportion of qualifying patient-months with 3 month rolling average of total uncorrected Ca++ > 10.2)	2.3%
Reporting Measures – 25% of Total Performance Score	
ICH CAHPS Patient Satisfaction Survey (expanded)	
Mineral Metabolism – Serum Phosphorus (includes PD patients)	
Anemia Management Consenting (includes PD patients)	

PY 2016 QIP METRICS:

Achievement Thresholds, Benchmarks, and Performance Standards

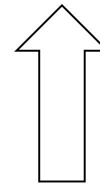
Measure	Achievement Threshold (15th percentile)	Benchmark (90th percentile)	Performance Standard (50th Percentile)
Anemia Management	1.2%	0%	0%
KT/V Dialysis Adequacy			
• Adult Hemodialysis	86%	97.4%	93.4%
• Adult Peritoneal	67.8%	94.8%	85.7%
• Pediatric Hemodialysis	83%	97.1%	93%
Vascular Access Type			
• AVF	49.9%	77.0%	62.3%
• Catheter	19.9%	2.8%	10.6%
NHSN Bloodstream Infections	See note	See note	See note
Hypercalcemia	5.4%	0%	1.7%

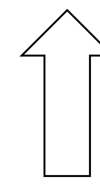
* The achievement threshold, benchmark, and performance standard for NHSN Bloodstream Infections measure will be set at the 15th, 90th and 50th percentile, respectively, of eligible facilities' performance in CY 2014.

IN QIP WE NEED TO BE CAREFUL AS WE INCLUDE PD

Hgb DATA (2010 metric year) CHD vs PD

Facility	%HD < 10	%PD < 10	%All < 10		%HD > 12	%PD > 12	%All > 12
State (NC/Ga)	2.9/3.5	6.9/10.0	2.8/3.5		10.7/11.1	16.7/13.7	10.8/11.0
Network	3.2	7.8	3.1		11.2	15.8	11.3
US	3.2	8.3	3.1		10.8	13.0	10.7





Note : PD patients are more likely to have a Hgb < 10 or >12 g/dl

But in U.S. only 7% of population, so minimal effect on overall %'s!

Source: CMS 2012 FACILITY PAYMENT

THE BUNDLE years 2014 and ON

Medicare will have reviewed cost reports and Medication usage and possibly adjusted baseline bundle payment as a result.

Will likely have QIP for

- Readmissions, hospitalizations, SMR

Calcimimetics and PO_4 binders may eventually be included in Bundle (But not till 2024?).

- What will that do for payment?
- How will clinical practice change?
- QIP will include some BMM related issues

Anticipated Changes in ESRD Related Reimbursement

Options:

1. Extension of Current Bundle to Cover Additional Services

- Possibly a monthly bundled payment/patient
- Additional Services in extended bundle may include things such as Vascular Access care, Physician Fees

2. ESCO (ESRD Seamless Care Organizations)

- **A dialysis specific ACO payment environment where participant owners share in savings with CMS.**
  - "Request for Application" have been re-issued three times for "ESCO" pilot-sites.
  - Many have elected to monitor progress, preparing for the future.
  - In an ESCO it is likely that even more Home Dialysis will be utilized (Less costly overall to do PD)

THE ESCO

ESRD Seamless Care Organization [Basically a dialysis ACO]

- Led by Dialysis Provider
- Must have equity partners and Nephrologists have to be one of the partners
- There will be a QIP but metrics not known
- Goal is to reduce overall coast and you share in the savings
  - Home dialysis (Especially PD) is less costly overall
- Most of savings will come from preventing hospitalizations

FINANCIAL ISSUES, RRT AND HOME DIALYSIS: *Summary*

CMS is well-intended. Unfortunately, there are often unintended consequences:

FOR MD:

- Some financial incentives to do Home Dialysis.

FOR Dialysis Unit:

- Bundle is here and will change as practice patterns react
- Dialysis units reacting to this mainly by adjusting use of SBMs.
- QIP piece an ever changing part of puzzle.
- Since bundle, the use of PD/HHD has increased.