Finances of Home Dialysis: Facility and Physician Payments

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Outline/Summary

• Dialysis facility payments
  – Infrastructure
  – Revenue and expenses
  – Medicare
  – Bundling
• Physician payments
  – Hospital
  – Office
  – Medical directorship
Dialysis Facility Payments
Key Components to a Successful Home Program

Life Plan

Stage 4 options education

Integrated treatment strategy

Unit organization

Standardized processes of care

Quality measurement tools

Staff education and development

* Staffing types, patient:nurse ratios, services linked to patient numbers, medical certification, reimbursement
† Standardized protocols, flow charts
‡ Key quality characteristics for improvement, collect sufficient data points

(courtesy of Marty Schrieber)
Home Dialysis Infrastructure

**Administrative**
- Advantages/disadvantages of LDO affiliation
- Staffing
- Care delivery
- Secretarial support
- Space
- Supplies
- Pharmacy
- Billing

**Care delivery**
- Primary care nursing
- Physicians
- Back-up dialysis
- Surgical support
- Radiology
- Clinic structure
- Technicians
- Dietary
- Social service
Conceptual Model for PD Services Based on Program Census

> 50 patients: comprehensive services
25-50 patients: most services
10-25 pts.: medium level services
<10 pts.: fewest services
To have this infrastructure requires the revenue to support it
Facility economics.

Managing margins
1. Decrease operating costs
2. Increase service volumes (e.g. 4th shift)
3. New services
4. Re-value current services (convince payer to accept your price raise)
5. Share in generated savings (capitation)
6. Earn incentive payments
Facility economics.

In 2004 almost the entire operating margin came from injectable drugs, from 2004 to 2010 this was still somewhat the case, but on 1/1/11 all changes as "bundling" begins.
Dialysis Facility Payment Composite Rate

- Separate from physician payments or hospital payments
- From 1983 to 2011 it is a per treatment fixed rate that includes labor, disposables, routine labs, routine surveillance
  - Excluded injectables such as antibiotics, epo, iron Vit D, carnitine
  - Excluded non-routine labs
- In 2011 this changes to “bundling” a prospective payment system (PPS)
Medicare History and Terms

- 1972 Amendment to Social Security Act established ESRD as the only health condition covered under Medicare in the absence of age 65 or disability
- Made ESRD pts entitled to not just dialysis, but all Medicare services
- Medicare pays 80% of “usual and customary” fees.
- Either a co-insurance or the beneficiary pays the remainder of the total charge
- Must attempt to collect this difference
  - To not attempt a collection can be construed as an incentive for a Medicare beneficiary to seek your services
  - May eventually be written off as “bad debt.”
Medicare Budget

- Funds come from specific Medicare taxes and social security trust fund
- Yearly budgeted
- Expenditures cannot exceed budget
  - If they do, payments are stopped (2007)
- Not budgeted per beneficiary
- Zero sum game, budget neutrality, splitting of a fixed pie
USRDS 2009 ADR

ESRD projections to 2020

Projected sources of incident & prevalent ESRD patients through 2020 (Welcome Text, Figure 1.2)

Counts projected using a Poisson model. See the complete ADR — at www.usrds.org — for detailed analytical methods.
The target of bundling

Total Medicare dollars spent on ESRD, by type of service (Volume Two, Figure II-5)
See the complete ADR — at www.usrds.org — for detailed analytical methods.
Almost all of these costs are included in the new bundle.
A Look at the Overall CMS Cost of Care

Milliman and Robertson 1994 YAR data
Lewin Group for RPA/ASN 1996 YAR data

- Other
- MD Fees
- Epogen / Medications
- Hospitalizations
- Dialysis treatment
A Look at the Overall CMS Cost of Care

Milliman and Robertson 1994 YAR data


Lewin Group for RPA/ASN 1996 YAR data

- Milliman and Robertson 1994 YAR data: $52,716
- Lewin Group for RPA/ASN 1996 YAR data: $48,351

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- Other
- MD Fees
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- Other
- MD Fees
- Epogen / Medications
- Hospitalizations
- Dialysis treatment
Growing Modality Payment Disparity
(HD vs PD PPPY)

Unadjusted

USRDS Annual Data Report 2007. Data tables k.8 & k.7
Money Must be Found

- US Government overcommitted
- State governments in crisis
- Private payers under duress
Changes in Payments: Bundling

- Medicare Improvements for Patients and Providers Act (MIPPA) passed in 2008 directed CMS to develop a prospective payment system (PPS) which would bundle dialysis facility services into one fixed payment.
- Proposals were made, openly commented upon by the community and a final rule made in July 2010.
- First phase of implementation January 1, 2011.
Bundled Payments for 2011

- Although there will be some regional variation due to costs differing by region and low volume facility adjustments, essentially there is a fixed payment per dialysis treatment (in one hemodialysis equivalent, 3 per week unless medical justification for >3)
- National average will be a base payment of $229.63
- Bundle covers all associated services including dialysis related drugs with injectable equivalents, lab tests, equipment, supplies and staff labor
- ESA and Vit D are to be paid for within this bundle
- Drugs with no injectable equivalent such as phosphate binders are excluded until 2014
# Lab tests Included In Bundled Base Payment

<table>
<thead>
<tr>
<th>Test</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alb (mg/dl)</td>
<td>blood culture</td>
</tr>
<tr>
<td>BUN (mg/dl)</td>
<td>blood culture</td>
</tr>
<tr>
<td>Creatinine</td>
<td>blood culture</td>
</tr>
<tr>
<td>Electrolytes</td>
<td>automated electrolyte test</td>
</tr>
<tr>
<td>Glucose</td>
<td>automated glucose test</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>automated hemoglobin test</td>
</tr>
<tr>
<td>Sodium</td>
<td>automated sodium test</td>
</tr>
<tr>
<td>Total Protein</td>
<td>automated total protein test</td>
</tr>
<tr>
<td>WBC (cells/cu mm)</td>
<td>automated WBC test</td>
</tr>
<tr>
<td>CBC</td>
<td>automated CBC test</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
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Lab tests Included In Bundled Base Payment

<table>
<thead>
<tr>
<th>Test</th>
<th>Method</th>
<th>Cost Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albunin</td>
<td>Proteinuria</td>
<td>SPC or Diff</td>
</tr>
<tr>
<td>Albumin</td>
<td>Proteinuria</td>
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</tr>
<tr>
<td>LDH</td>
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<tr>
<td>Lactate Dehydrogenase</td>
<td>Test protein</td>
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PD effluent and exit site cultures included
## Adjustments To the Base Payment

<table>
<thead>
<tr>
<th>“Bundle” Case Mix Adjusters</th>
<th>Multiplier</th>
</tr>
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<tbody>
<tr>
<td>Age (Sliding Scale by Age Cohorts)</td>
<td>1.000-1.171</td>
</tr>
<tr>
<td>Body Mass Index (Low)</td>
<td>1.025</td>
</tr>
<tr>
<td>Body Surface Area (Small) per 0.1 m²</td>
<td>1.020</td>
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<td>1.183</td>
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<td>1.072</td>
</tr>
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Adjustments To the Base Payment By Adult Age Categories

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<th>Variable</th>
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<tbody>
<tr>
<td>Ages 18-44</td>
<td>1.171</td>
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<tr>
<td>Ages 45-59</td>
<td>1.013</td>
</tr>
<tr>
<td>Ages 60-69</td>
<td>1.000</td>
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<tr>
<td>Ages 70-79</td>
<td>1.011</td>
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<tr>
<td>Ages 80+</td>
<td>1.016</td>
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<td>Incident Patient Adjuster (≥ 120 days)</td>
<td>1.510</td>
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</table>
New Patient Adjustment For Incident Patients At Onset of Dialysis

• 1.510 adjustment for in-center initiates
• Same for home dialysis initiates
• Applicable for the initial 4 months
• If home training occurs in the first 4 months, this adjuster pays for home training
• If home training occurs after 4 months there is an add on of $33.38 to the base
Calculating facility Payments For Peritoneal Dialysis

- 3 single hemodialysis equivalents equals 7 daily peritoneal dialysis treatments
- Incident patient adjustment
- First 4 months facility payment per day of PD is:
  - 3 X ($229.63 X 1.51) / 7 = $148.60
- After first 4 months, the 1.51 adjuster is gone but the training period is supplemented
  - $33.38 X 3/week / 7 days/week = $14.31 per day* so (3 X $229.63)/7 + $14.31 = $112.72 per day
- After 4 months on dialysis and after training daily PD facility payment is
  - (3 X $229.63)/7 = $98.41

* 15 days of home training allowed for peritoneal dialysis
**Key Issue:**
Reimbursement changes make the office look more profitable

*Internal Amgen Study, 2003, International Nephrology Networks*
Physician Payments Related To Dialysis Care

• Hospitalization (In-patient)
• Office visits, unrelated to ESRD
• Monthly capitated payment (MCP) for out-patient ESRD services
• Home training fees
• Medical Director fees
In-Patient Billing

• Can bill for a dialysis procedure (90935, 90937, 90945, 90947) procedure on the same days as:
  – Admission
  – Discharge, or
  – Consultation
• Dialysis can be charged daily
Physician Payments Related To Dialysis Care

• Hospitalization
• Office visits, unrelated to ESRD
• Monthly capitated payment (MCP) for out-patient ESRD services
• Home training fees
• Medical Director fees
Non-ESRD Office Visits

• Must be clearly **not** related to ESRD
  – URI, conjunctivitis (not related to mineral metabolism), other infections
• Paid like any other office visit
• Want to detail this more than usual, since it may get audited
• Do not list ESRD as the major diagnosis for the visit: ESRD is incidental
• If visit is related to ESRD, count it as an MCP visit
Physician Payments Related To Dialysis Care

• Hospitalization
• Office visits, unrelated to ESRD
• Monthly capitated payment (MCP) for out-patient ESRD services
• Home training fees
• Medical Director fees
MCP Changes 2004

• CMS created codes which pay based on physician frequency of visit for hemo
• MCP for home therapy is not based on frequency
  – Specifically, CMS recommends, but does not require, a monthly visit to bill the MCP for Home Patients
CMS Fee Schedule Changes Regarding Old MCP

• Per month payment scheme based on visit frequency
  – 1
  – 2 or 3
  – 4 or more
• Should document what is clinically relevant in a shared medical record
<table>
<thead>
<tr>
<th>Visits Frequency</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 or more visits/mo</td>
<td>$303</td>
</tr>
<tr>
<td>2-3 visits/mo</td>
<td>$252</td>
</tr>
<tr>
<td>1 visit/mo</td>
<td>$201</td>
</tr>
<tr>
<td>0</td>
<td>$0</td>
</tr>
</tbody>
</table>

- Home dialysis payment
- Not tied to visit frequency
- Cannot bill combinations

Respects amount of non-visit work such as care plans and care coordination
## 2005-8 Monthly Capitated Payment

<table>
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</tr>
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<tbody>
<tr>
<td><strong>In- Center Dialysis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Visit</td>
<td>Old G0319 90962</td>
<td>$207</td>
<td>$207</td>
<td>$186</td>
<td>$175</td>
</tr>
<tr>
<td>2-3 Visits</td>
<td>Old G0318 90961</td>
<td>$260</td>
<td>$259</td>
<td>$236</td>
<td>$225</td>
</tr>
<tr>
<td>4 Visits</td>
<td>Old G0317 90960</td>
<td>$312</td>
<td>$311</td>
<td>$287</td>
<td>$274</td>
</tr>
<tr>
<td><strong>Home Dialysis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Month</td>
<td>Old G0323 90966</td>
<td>$260</td>
<td>$259</td>
<td>$230</td>
<td>$214</td>
</tr>
</tbody>
</table>

*Calculated From: http://www.cms.hhs.gov/PhysicianFeeSched/01_Overview.asp
*Courtesy of Gary Inglese*
### 2008-11 Monthly Capitated Payment

<table>
<thead>
<tr>
<th>Dialysis Services</th>
<th>HCPCS Code</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In- Center Dialysis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Visit</td>
<td>Old G0319 90962</td>
<td>$175</td>
<td>$164</td>
<td>$170</td>
<td>$175</td>
</tr>
<tr>
<td>2-3 Visits</td>
<td>Old G0318 90961</td>
<td>$225</td>
<td>$227</td>
<td>$236</td>
<td>$235</td>
</tr>
<tr>
<td>4 Visits</td>
<td>Old G0317 90960</td>
<td>$274</td>
<td>$282</td>
<td>$294</td>
<td>$286</td>
</tr>
<tr>
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<td>Full Month</td>
<td>Old G0323 90966</td>
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*Courtesy of Gary Inglese and Greg Abbott*
**Physician Payments Related To Dialysis Care**

- Hospitalization
- Office visits, unrelated to ESRD
- Monthly capitated payment (MCP) for out-patient ESRD services
- Home training fees
- Medical Director fees
Why Would CMS Offer Incentives for Home Therapy?

- The Social Security Act requires Medicare "…to promote home dialysis more effectively."
- Where the Home Training Fees came from (90989, 90991). RVU=0; Allowable= $500
- Why the home MCP Codes do not require a visit to bill.
- The 2011 bundling continues to pay for home training to both facility and physician

RVU= Relative Value Units This is how MD allowables are set.

Basic take-away on this slide is to show that CMS has good reasons to incentivize home therapy.

Also, remember that CMS is spending over $14k per patient per year MORE if a patient is on hemo. They have to reduce costs in the system. Getting more patients at home does this.
### Maximize Revenue with Homecare Opportunities

<table>
<thead>
<tr>
<th>Program</th>
<th>PD or Home HD</th>
<th>Center HD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Training Fees</strong></td>
<td>Up to $500 for each new home patient trained, plus retraining $</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Dialysis Center Training Fees</strong></td>
<td>Center may bill up to <strong>15 sessions</strong> of training per new patient. Modified in 2011 bundling Billing Rate per Session - CAPD: - CCPD or Home HD:</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Waiver of Three Month Coverage Waiting Period</strong></td>
<td>Up to <strong>90 days</strong> of increased reimbursement as Medicare coverage begins on the first month that training is begun</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Physician MCP</strong></td>
<td>Monthly visit and complex documentation not required in order to bill for equivalent of 2-3 visit code for in-center hemodialysis. CMS states the intent is to incent home therapy.</td>
<td>MCP rules</td>
</tr>
</tbody>
</table>

See PD Today - Economic brochure, page 7.
Physician Payments Related To Dialysis Care

• Hospitalization
• Office visits, unrelated to ESRD
• Monthly capitated payment (MCP) for out-patient ESRD services
• Home training fees
• Medical Director fees
Medical Director Activity

• See module “Medical Directorship of a Home Dialysis Unit”
• Qualifications, duties, compensation discussed
Question #1

• For hospitalized patients a dialysis billing code can be utilized on the same day as which of the following services?
  – A. Admission history and physical exam (admission note)
  – B. Discharge
  – C. Initial consultation
  – D. All of the above
  – E. None of A, B, or C
Question #1: Answer

- The correct answer is D. All of the above
Question #2

- A nephrologist’s payment for the care of home dialysis patients has advantages over the payments for in-center dialysis patient for what reason(s)?
  - A. Pays more than a one visit per month in-center visit payment
  - B. The home training fee is a one-time only payment
  - C. Requires less frequent visits per month to receive a monthly payment
  - D. All of the above
  - E. None of A, B, or C
Question #2: Answer

• The correct answer is A. Pays more than a one visit per month in-center visit payment
Question #3

• The size (numbers of patients) of a home dialysis program is important for which reason(s)?
  – A. It will lead to higher expenditures on personnel/staff
  – B. More patients mean more complications and less time for training new patients and growth
  – C. Economies of scale allow for a broader provision of services
  – D. All of the above
  – E. None of A, B, or C
Question #3: Answer

• The correct answer is C. Economies of scale allow for a broader provision of services