

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

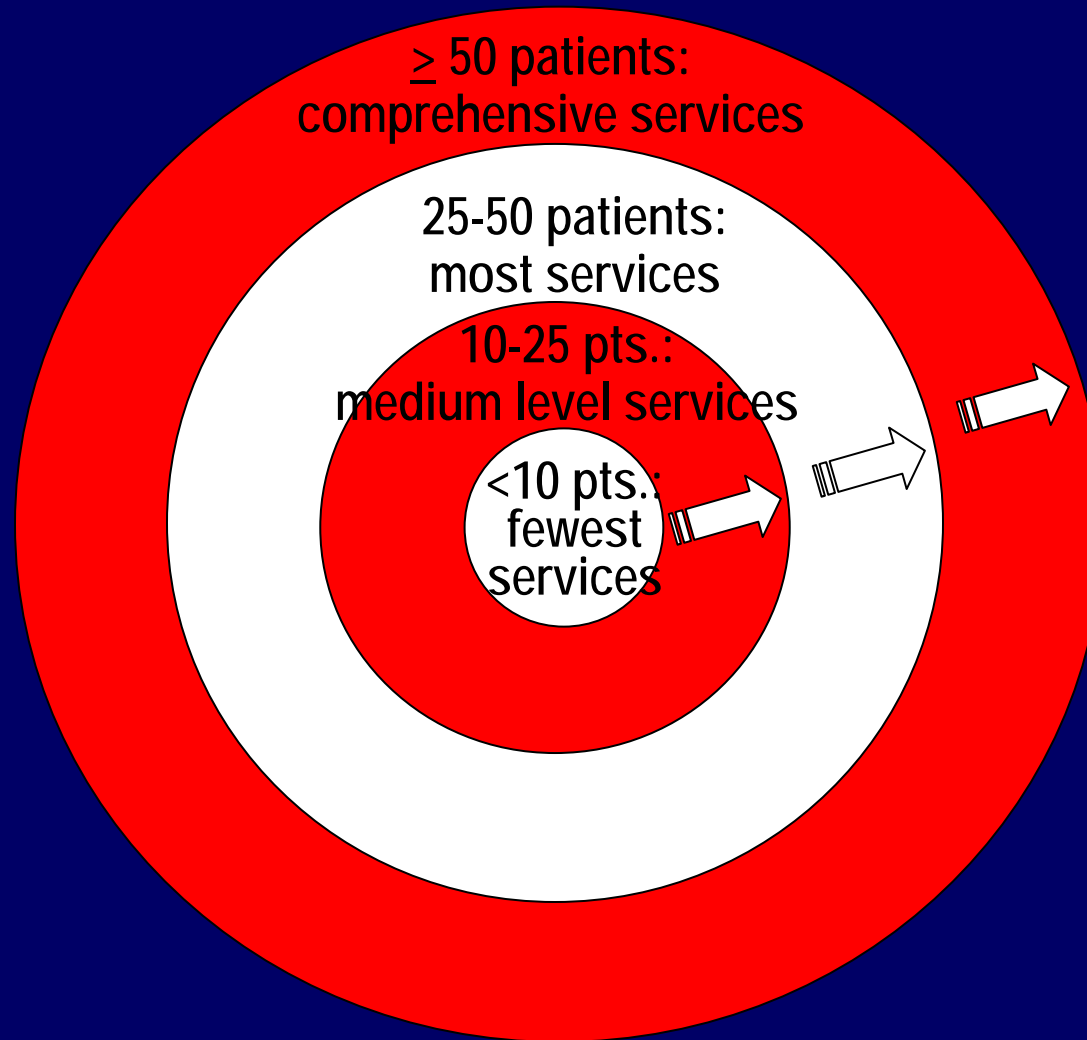
Administrative

- 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



**To have this infrastructure
requires the revenue to support it**

Dialysis Facility Economics

$$\text{Revenue} - \text{Expenses} = \text{Net Income or margin}$$

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

Dialysis Facility Economics

Revenue

–

Expenses

=

Net Income
or margin

- ✓ Maximize Reimbursement
- ✓ Manage Modality Mix
- ✓ Improve Accounts Receivable
- ✓ Payer Mix
- ✓ Increase Patient/Referral Base
- ✓ Acute Contracts
- ✓ Non-Dialysis Services (lab, access, etc)

- ✓ Manage Labor Expense & Staff Retention
- ✓ Manage Inventory
- Manage Administrative costs & Overhead Effectively
- ✓ Limit Capital Outlay

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

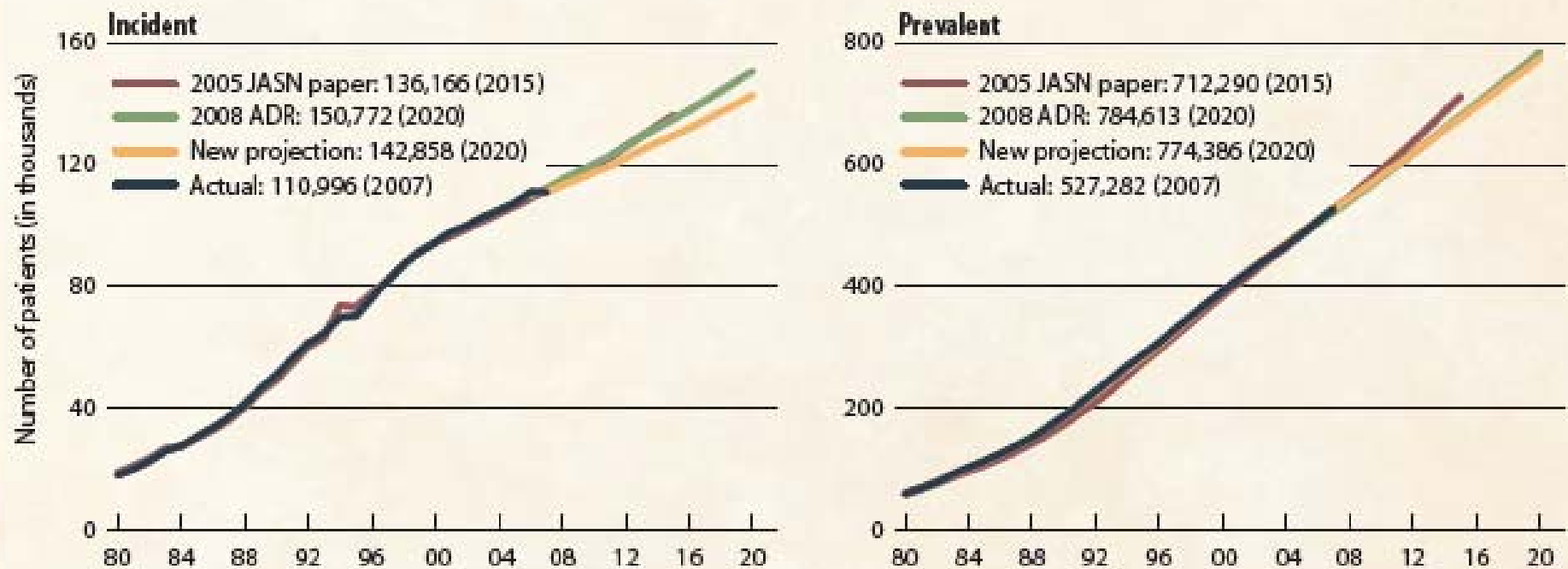
- 1972 Amendment to Social Security Act established ESRD as the only health condition covered under Medicare in the absence of age 65 or disability
- Made ESRD pts entitled to not just dialysis, but all Medicare services
- Medicare pays 80% of “usual and customary” fees.
- Either a co-insurance or the 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

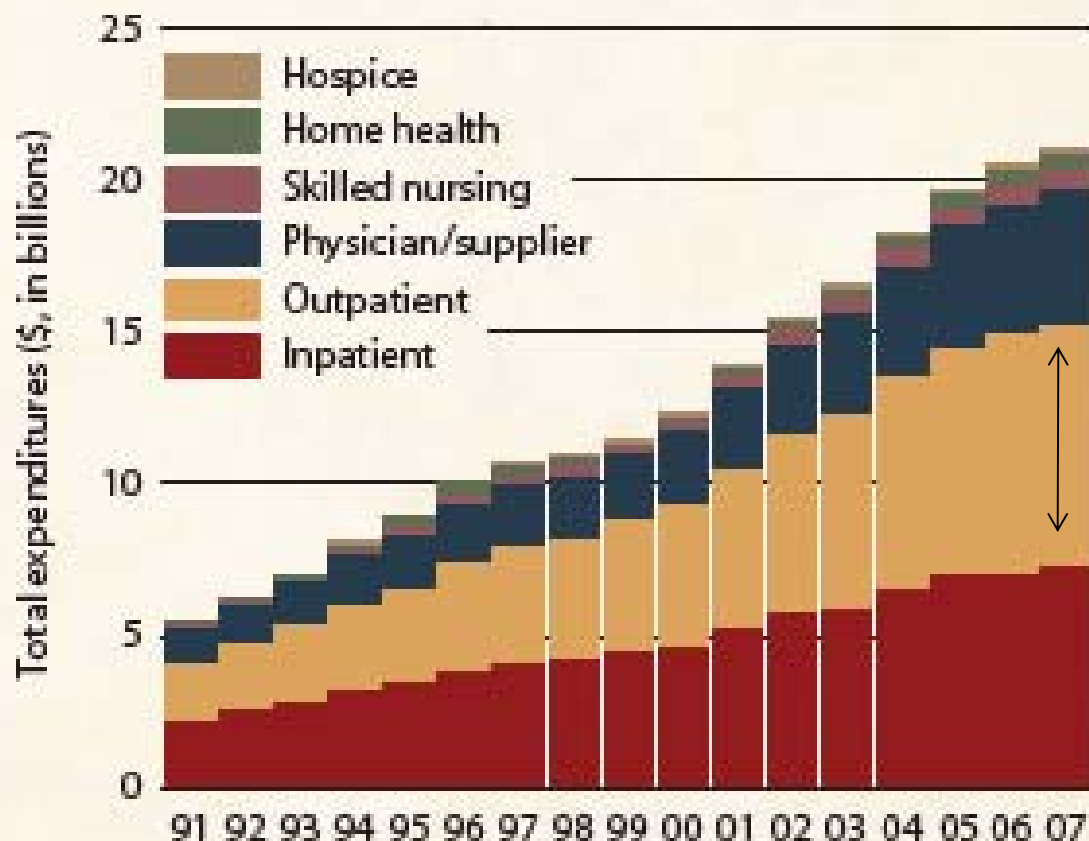


Projected counts of incident & prevalent ESRD patients through 2020 (Volume Two, Figure 2.1)

Counts projected using a Markov model. See the complete ADR — at www.usrds.org — for detailed analytical methods.

Costs of ESRD

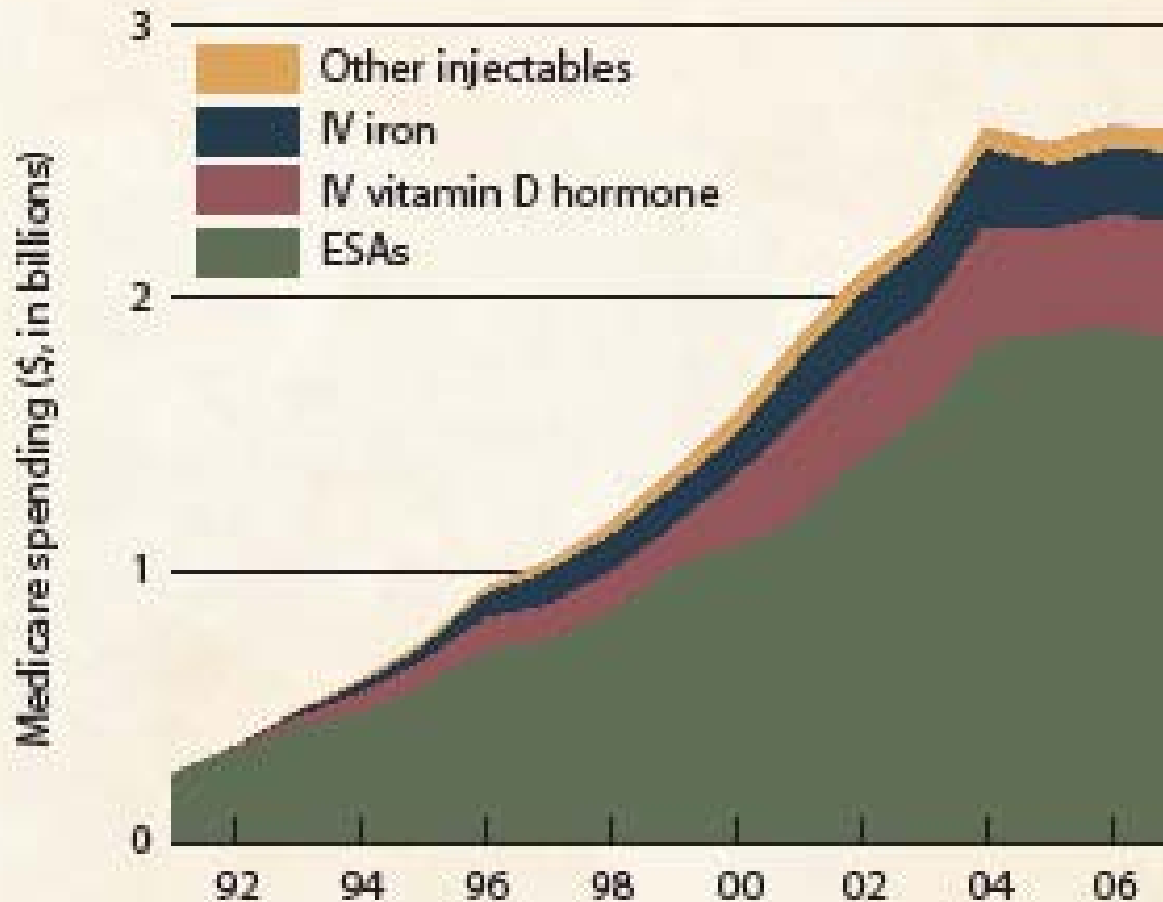
USRDS 2009 ADR



Total Medicare dollars spent on ESRD,
by type of service (Volume Two, Figure 11.5)
See the complete ADR — at www.usrds.org — for detailed analytical methods.

The
target of
bundling

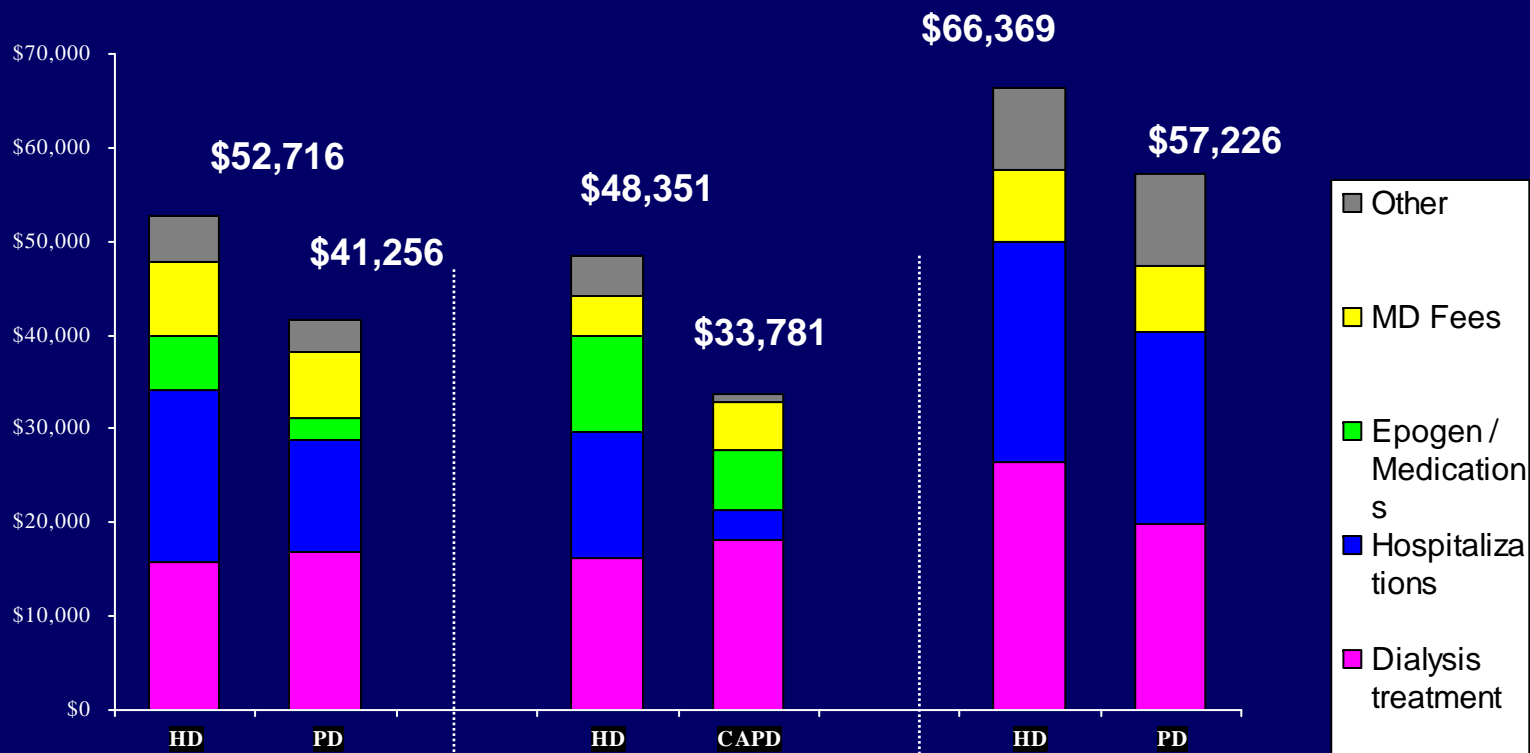
USRDS 2009 ADR



Total Medicare spending on injectables (Volume Two, Figure 11.13)
Period prevalent dialysis patients.

Almost all of these costs are included in the new bundle

A Look at the Overall CMS Cost of Care

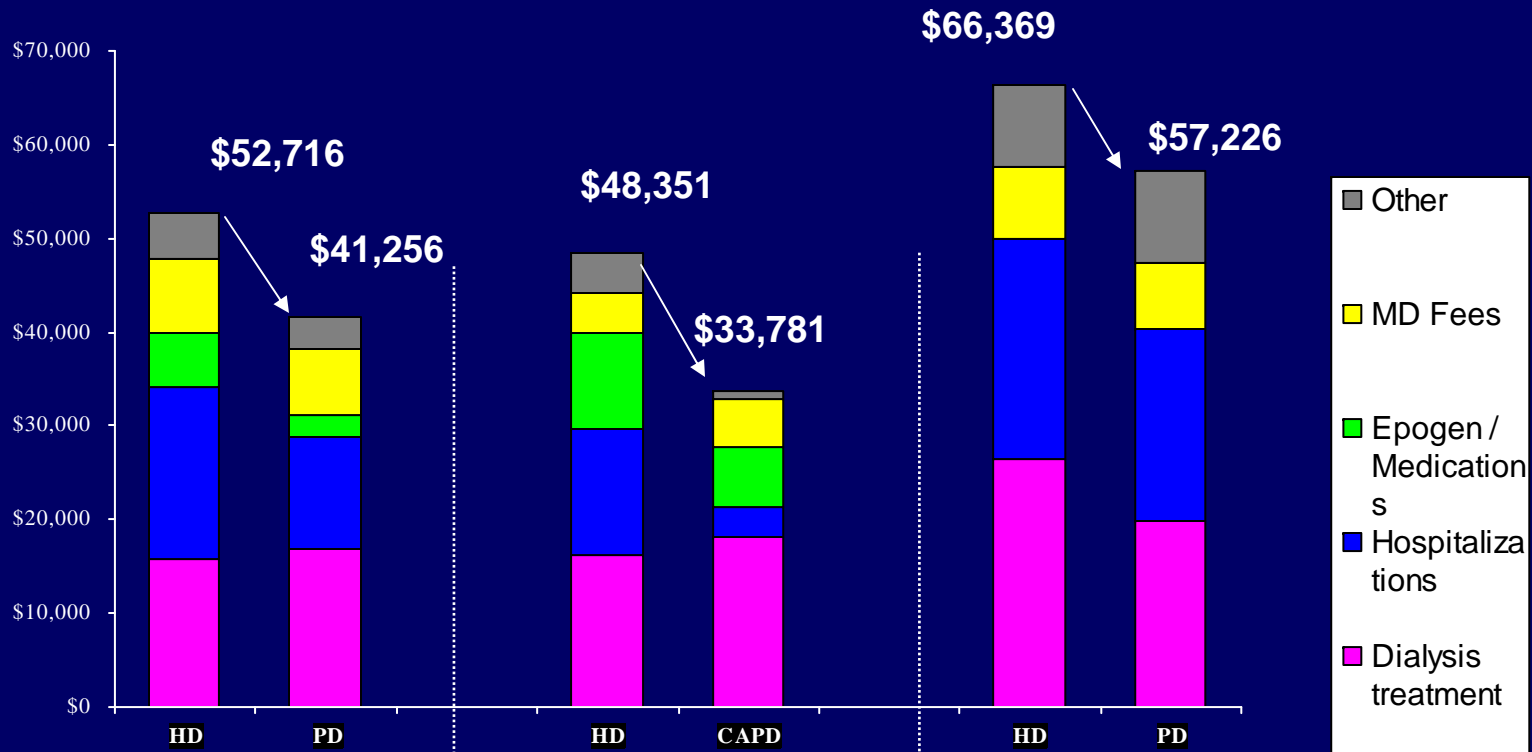


**Milliman and
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1994 YAR data**

**McMurray,
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AJKD 30:542
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**Lewin Group
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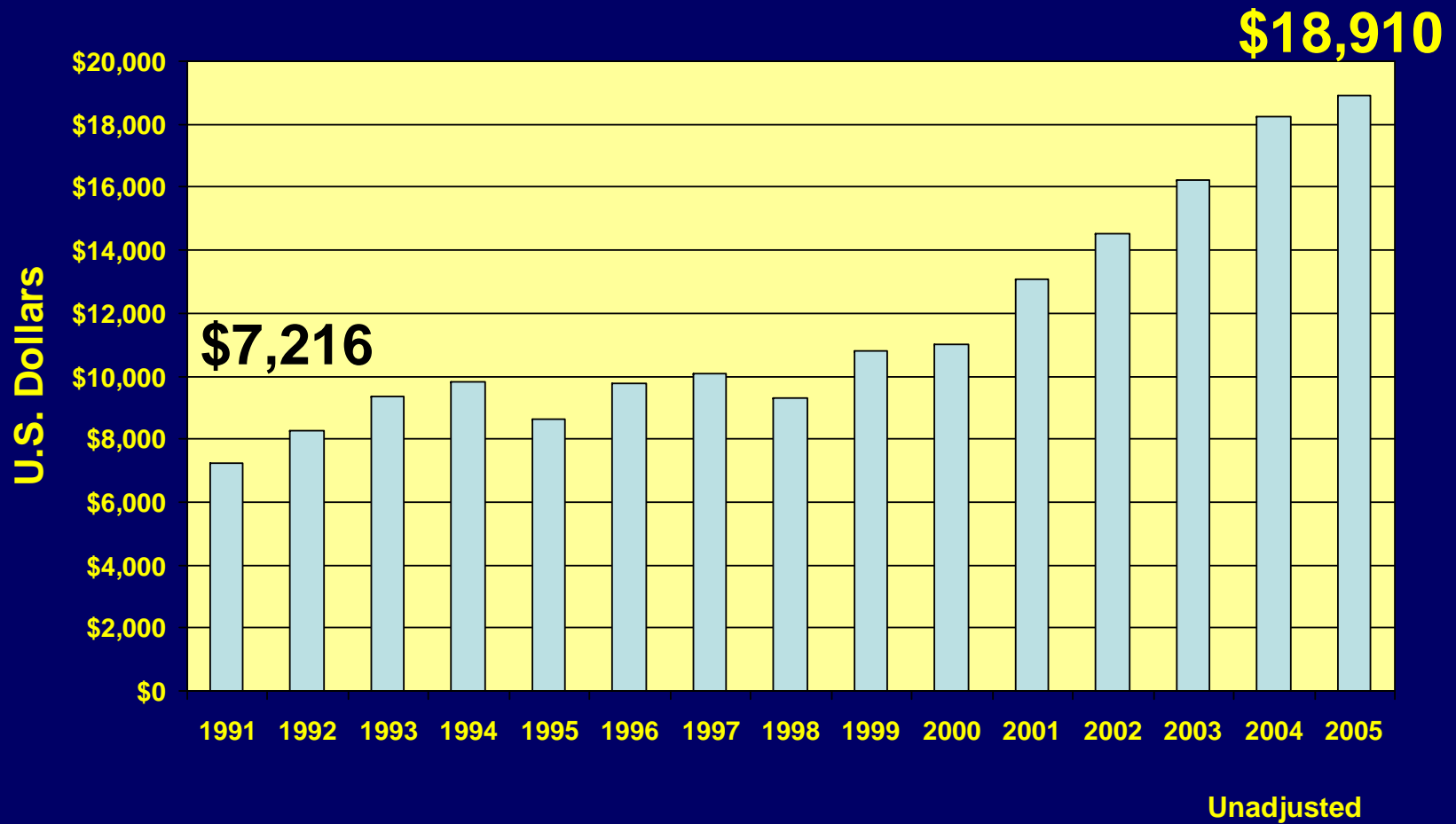


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Growing Modality Payment Disparity (HD vs PD PPPY)



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

Bundled Laboratory Tests

Albumin	B12	Potassium	CBC w/ Diff	Culture, bacterial aerobic – access related
Aluminum	1,25 (OH) ₂ D ₃	Prealbumin	RBC	Culture bact. anaerobic – access related
25 (OH)D ₃	Erythropoietin	Total protein	Reticulocyte, Manual	Culture bacteria not blood - access related
Calcium	Ferritin	Sodium	Reticulocyte, Automated	Culture anaerobic - access related
Ionized Calcium	Folic acid	Transferrin	Reticulocyte/Hgb Concentration	Culture screen - access related
Carbon Dioxide	Iron	Urea nitrogen	Automated WBC	HbsAg
Carnitine	Iron binding cap.	Urine urea nitrogen	HBcAb	CBC /diff wbc w/o platelet
Chloride	Magnesium	Urine urea nit. clearance	HBcAb, IgM	CBC without platelet
Creatinine	PTH	Hct	HBsAb	
Urine Creatinine	Alkaline phosphatase	Hgb	Blood Culture for bacteria	
CrCl	Phosphorus	CBC	Culture, Bacterial other	

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CrCl	Phosphorus	CBC	Culture, Bacterial other	

PD effluent and exit site cultures included

Adjustments To the Base Payment

“Bundle” Case Mix Adjusters	Multiplier
Age (Sliding Scale by Age Cohorts)	1.000-1.171
Body Mass Index (Low)	1.025
Body Surface Area (Small) per 0.1 m ²	1.020
Pericarditis (Acute)	1.114
Bacterial Pneumonia (Acute)	1.135
Gastrointestinal Tract Bleeding with Hemorrhage (Acute)	1.183
Hemolytic Anemia with Sickle Cell Anemia (Chronic)	1.072
Myelodysplastic Syndrome (Chronic)	1.099
Monoclonal Gammopathy (Chronic)	1.024
Incident Patient Adjuster (< 120 days)	1.510

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Adjustments To the Base Payment By Adult Age Categories

Variable	Multiplier
Ages 18-44	1.171
Ages 45-59	1.013
Ages 60-69	1.000
Ages 70-79	1.011
Ages 80+	1.016

Adjustments To the Base Payment

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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

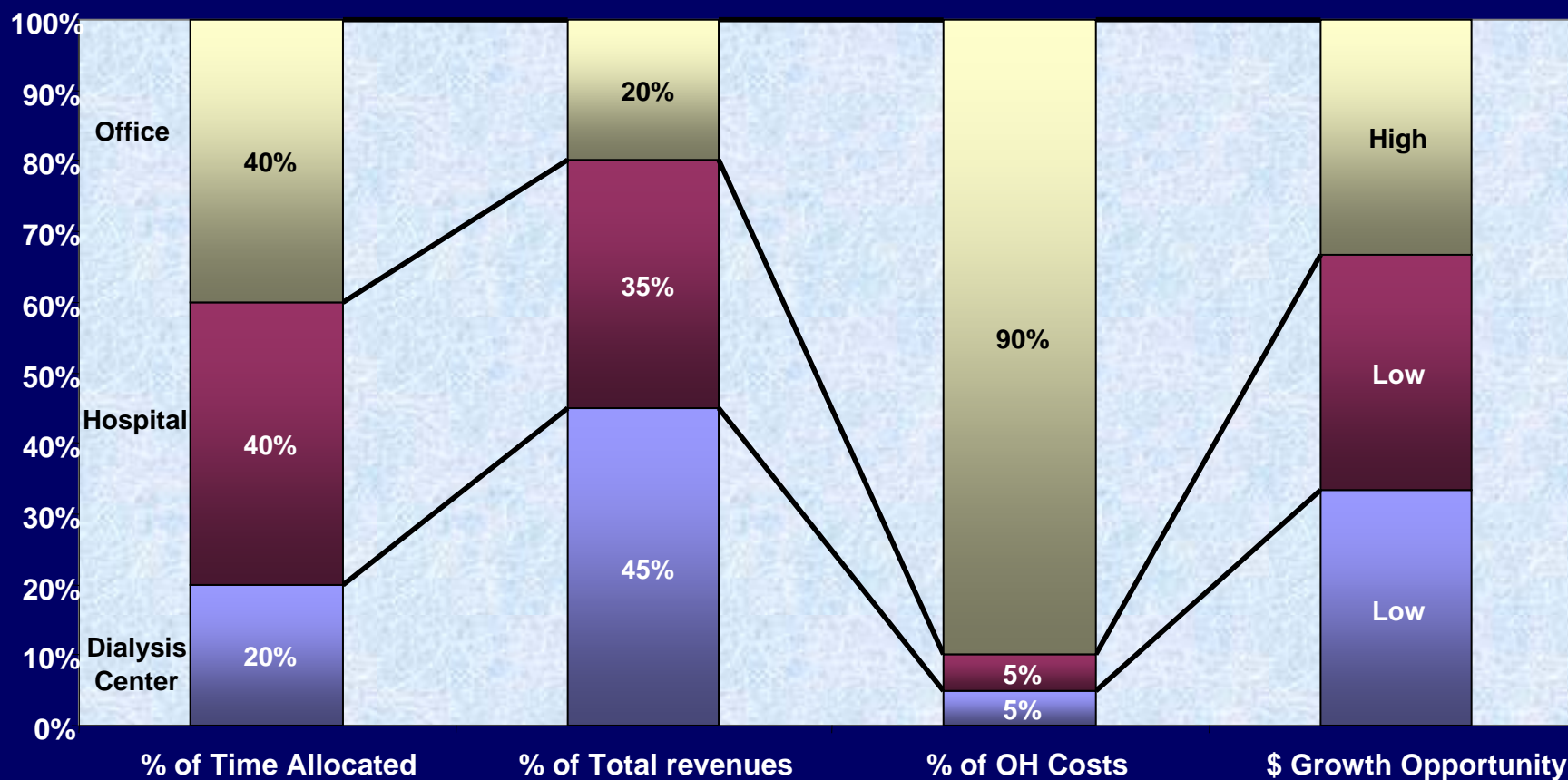
Calculating facility Payments For Peritoneal Dialysis

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

* 15 days of home training allowed for peritoneal dialysis

Physician Payments

Nephrology Revenue Streams



Key Issue:

Reimbursement changes make the office look more profitable

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
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- Monthly capitated payment (MCP) for out-patient ESRD services
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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
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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

CMS Fee Schedule (Medians) Old (Pre 2004) MCP (\$262.28)

4 or more visits/mo	\$303	←	Home dialysis payment
2-3 visits/mo	\$252		Not tied to visit frequency
1 visit/mo	\$201		Cannot bill combinations
0	\$ 0		

Respects amount of non-visit work such as care plans and care coordination

2005-8 Monthly Capitated Payment

Dialysis Services	HCPCS Code	2005	2006	2007	2008
<i>In- Center Dialysis</i>					
1 Visit	Old G0319 90962	\$207	\$207	\$186	\$175
2-3 Visits	Old G0318 90961	\$260	\$259	\$236	\$225
4 Visits	Old G0317 90960	\$312	\$311	\$287	\$274
<i>Home Dialysis</i>					
Full Month	Old G0323 90966	\$260	\$259	\$230	\$214

- Calculated From:http://www.cms.hhs.gov/PhysicianFeeSched/01_Overview.asp
- Courtesy of Gary Inglese

2008-11 Monthly Capitated Payment

Dialysis Services	HCPCS Code	2008	2009	2010	2011
<i>In- Center Dialysis</i>					
1 Visit	Old G0319 90962	\$175	\$164	\$170	\$175
2-3 Visits	Old G0318 90961	\$225	\$227	\$236	\$235
4 Visits	Old G0317 90960	\$274	\$282	\$294	\$286
<i>Home Dialysis</i>					
Full Month	Old G0323 90966	\$214	\$225	\$235	\$234

- Calculated From:http://www.cms.hhs.gov/PhysicianFeeSched/01_Overview.asp
- 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

Maximize Revenue with Homecare Opportunities

Program	PD or Home HD	Center HD
Physician Training Fees	Up to <u>\$500</u> for each new home patient trained, plus retraining \$	\$0
Dialysis Center Training Fees	Center may bill up to <u>15 sessions</u> of training per new patient. Modified in 2011 bundling Billing Rate per Session - CAPD: - CCPD or Home HD:	\$0
Waiver of Three Month Coverage Waiting Period	Up to <u>90 days</u> of increased reimbursement as Medicare coverage begins on the first month that training is begun	\$0
Physician MCP	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.	MCP rules

Physician Payments Related To Dialysis Care

- Hospitalization
- Office visits, unrelated to ESRD
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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