Medicare Bundling Reimbursement Transition Decision: Opt In or Phase In

Medicare reimbursement for outpatient dialysis is about to undergo the most massive and sweeping change since the inception of the program in 1972. Gone are the days of the incentive rate, target rate, & composite rate with no case mix adjusting. Gone will be the days of separately billable drugs and labs. Five years ago, case mix adjusted composite rates were ushered in starting with age, body surface area and body mass index. In the latest Medicare payment incarnation known as bundling, scheduled for implementation on January 1, 2011, the composite rate, all ESRD-related Part B drugs, any equivalent forms of part B drugs covered under Part D and non-routine ESRD-related laboratory services will become the payment norm for outpatient dialysis reimbursement. Case mix adjusting will remain but become more complex with the addition of 6 more case mix adjustors. Additional adjustors were added for the following situations:

- New patients in the first four months of dialysis (if they are age eligible).
- Low volume facilities defined as providing less than 4000 total treatments in each of the 3 years preceding the payment year and have not opened, closed, or received a new provider number due to a change in ownership during the 3 years prior to the payment year.
- Outlier payments for administered drugs that exceed specified limits.

In an effort to reduce the impact of such a massive change, CMS provided 2 transition options of either opting into Medicare bundling 100% on 1/1/2011 or phasing in over 3 years as follows:

- 2011: 25% of the opt in bundled rate/75% phase in bundled rate.
- 2012: 50% of the opt in bundled rate/50% phase in bundled rate.
- 2013: 75% of the opt in bundled rate/25% phase in bundled rate.
- 2014: 100% of the opt in bundled rate.

The challenge for all of us in this business is to decide which option financially benefits each outpatient dialysis facility and the total organization over the next 3 years. The decision must be made by November 1, 2010 or CMS will automatically select the phase in option. The purpose of this article is to present a decision making framework to navigate through the changes and select the best option for each of your facilities and your organization.

There will be 3 fundamental changes to the company's financial structure resulting from Medicare bundling reimbursement as follows:

- The reimbursement for outpatient dialysis will become all-inclusive for the treatment and administered drugs.
- Non-routine ESRD-related laboratory services currently billed by independent or wholly owned laboratories will be included in the bundle.
- Equivalent forms of Part B drugs covered under Part D that is currently included in the composite rate.

The key decision at this point is estimating the impact of the change in outpatient dialysis treatment reimbursement. The payment portions of non routine ESRD laboratory services and equivalent forms of part B drugs have been factored into the bundled base rate as follows:

- ESRD labs per treatment of $8.40.
- Oral part B drug equivalents per treatment of $.49.

The change to a facility's financial structure for these two additional reimbursement components is that the costs will become part of the expense base regardless of the transition option selected.

The question then is how does an outpatient facility owner estimate the impact of the change in outpatient dialysis treatment reimbursement? What is the financial impact of the new case mix adjustors, new patients starting dialysis, home training add-on or being a low volume facility? The remainder of this article will offer a multi step process to assist with making the transition decision and estimating the total financial impact of Medicare bundling.

STEP 1: Calculating the Current Medicare Reimbursement Rate per Treatment. Most outpatient dialysis facilities report revenues along service lines such as in-center hemo and home PD/ hemo treatments, EPO, iron, vitamin D and other billable services. Now facilities will need to look more closely at revenues by primary payor: Medicare, Medicaid and commercial insurance (PPO and HMO). This data can be gleaned from facility billing systems as seen in the example in the following table:

Average Payments Per Treatment

In-Center Hemo	**Payments**	**Treatments**	**Per Treatment**
Medicare	$2,750,858	11,557	$238.03
Medicaid	$68,428	294	$232.75
Commercial	$1,299,857	1,733	$750.06
Total In Center	$4,119,143	13,584	$303.23

Home PD & Hemo	**Payments**	**Treatments**	**Per Treatment**
Medicare	$882,170	4,683	$188.38
Medicaid	$31,621	156	$202.70
Commercial	$698,352	1,158	$603.07
Total Home	$1,612,143	5,997	$268.82

Total In-Center **& Home**	**Payments**	**Treatments**	**Per Treatment**
Medicare	$3,633,028	16,240	$223.71
Medicaid	$100,049	450	$222.33
Commercial	$1,998,209	2,891	$691.18
Totals	$5,731,286	19,581	$292.70

Note: The home treatments are hemo equivalents.

Fiscal Year Accrued Average Net Revenue per Treatment $291.38

The collections & revenue data in this table covers the most recent 12 month fiscal year. As you can see from the table, Medicare and Medicaid payments per treatment are very similar but there is a huge spread for the commercial primary payors. In order to validate the payments per treatment for the last 12 months, the total average payment rate per treatment was compared to the accrued average net revenue per treatment for the same time period. There was less than a .5% difference which validated the payment data, offered assurance that the annual accrued revenue estimates were accurate and that payments were close to 100% of the services provided and billed to the different payors.

Before moving to step 2, notice the $50.00 difference in Medicare in-center hemo and home PD/Hemo payments per treatment. This differential occurs primarily because of lower EPO utilization and minimal IV iron and vitamin D utilization. This payment differential will become a very powerful incentive to either increase home dialysis in existing programs or start new free standing home dialysis programs.

STEP 2: Calculate the Phase-In Bundled Rate Per Treatment: The second step is to calculate the base bundled rate that will be used if the facility elects the phase in option. The starting point is the 2010 national composite rate of $135.13 with the follow adjustments:

- 2.5% increase mandated in the MIPPA legislation.
- Pre bundling adjustment to the composite rate for the labor index (53% of $135.13) times the wage index used prior to bundling).
- Drug add on of 14.7%.
- Budget neutrality adjustment of .9116.

These adjustments will result in the composite rate that would be used for case mix adjusting of age, body surface area and body mass index. Once the case mix adjusted composite rate has been calculated, the following additional add on's and adjustments will be made to arrive at the 2011 bundled rate under the current outpatient dialysis Medicare reimbursement system that would be used for the phase in portion of the current Medicare reimbursement system:

- EPO utilization times ASP+6 rate.
- Iron and Vitamin D utilization times ASP+6 rates.
- ESRD related labs of $8.40 per treatment.
- Part D drugs of $.46 per treatment.
- Separately billable supplies of $1.78 per treatment.
- Network adjustment of $.50 per treatment.
- 3.1% transition adjustment.

These calculations yield a phase in bundled base rate of $234.27. This is a very complex calculation and the NRAA bundling spreadsheet described in the step 4 automatically calculates this rate.

STEP 3: Calculate the 100% Opt-In Bundled Rate Per Treatment: The next 2 steps are to estimate Medicare revenue under the bundled reimbursement system. This is actually a multi step process as follows:

- Start with the CMS bundled rate base of $229.63 per treatment.
- Adjust the labor portion of the bundled rate base rate.
- Case mix adjust the labor adjusted bundled rate.
- Add the home training adjustment of $33.38 per treatment.
- Deduct 3.1% for the transition adjustment.

The following data will be required to calculate the 100% opt in Medicare bundled rate and revenue:

- CBSA (core-based statistical area) labor index.
- Patient's birth date, height and weight, which is already being captured for billing.
- Patient's dialysis modality and date of first dialysis.
- Case mix adjustors for each Medicare primary patient for the last fiscal year.
- Average EPO, Iron and Vitamin D drug utilization per treatment.
- Home dialysis training treatments.

The following table illustrates the calculation for the labor adjustment to the CMS base bundled rate:

Base Bundled Rate	$229.63
Labor Percentage	41.7%
Labor Portion	$95.85
Wage Index Adjustment	114.08%
Wage Index Adjusted Base Rate	$109.34
Non Wage Base Rate	$133.78
Labor Adjusted Bundled Rate	$243.13
Current Medicare Rate	$223.71
Difference	$19.42

CMS specified that the labor related portion of the CMS base bundled rate was 41.7%. The CMS base bundled rate can be separated into a labor and non labor component as follows:

- Labor related portion $95.85.
- Non labor related portion $133.78

Given the differences in labor rates around the country, CMS developed wage indexes based on the average labor rates in metropolitan, suburban and rural areas of the US. Labor rate adjustments to dialysis payment rates are not new and have occurred since the composite rate system was established in 1983. However, CMS has updated the labor indexes and they are considerably lower than the last ones used when case mix adjusting was introduced under the MMA legislation in 2005. The national average wage rate index is pegged at 1.0 and wage indexes greater than the national average wage index mean the average labor rates in a facility's CBSA are higher than the national average. Conversely, wage indexes lower than the national average index mean the average labor rates in your CBSA are lower than the national average. In the example above, the CBSA labor index was 114.7, which means that labor rates in the community where this facility is located were 14.7%

higher than the national average. This resulted in a $13.50 adjustment to the base rate. It should also be noted that the wage adjusted rate of $243.13 is $19.42 higher than the most recent fiscal year Medicare payment rate.

STEP 4: Estimate Case Mix Adjustment For The 100% Opt-In Bundled Rate. The next step in the bundled rate calculation process is estimating the impact of the case mix adjustment. As previously noted, there are 6 new case mix adjustors, 3 chronic and 3 acute as follows:

- Chronic Case Mix Adjustors:
    - Hereditary hemolytic or sickle cell anemia
    - Myelodysplastic syndrome
    - Monoclonal gammopathy

- Acute Case Mix Adjustors:
    - Pericarditis
    - Bacterial pneumonia
    - Gastro-intestinal tract bleeding

In addition, patients who are in their first 4 months of dialysis and low volume facilities will also receive additional adjustments to the labor adjusted base rate. CMS ascribed weights to each of these variables to adjust the base rate. If a patient has more than one case mix adjustor or started dialysis in the last 4 months, only the highest weighted adjustor can be used to calculate the bundled payment rate.

All of this data must be abstracted from medical records and presents a potential hurdle to dialysis providers that don't use an electronic medical/clinical record keeping system. In addition to the facility medical records, facilities may also need to access hospital and physician records to capture all of the case mix data.

The next major challenge is calculating the bundled rate for each patient. The National Renal Administrator's Association (NRAA) developed an excel spreadsheet that calculates the case mix adjusted rates for each patient and it is available to anyone in the renal community regardless of membership in the organization. The spreadsheet can be found on the NRAA website (nraa.org) under the hot topic section on the right hand side of the front page. The previously described demographic and case mix data for each Medicare primary patient will need to be entered into the spreadsheet. The spreadsheet calculates a phase in bundled rate and 100% opt in bundled rate for each patient, adjusting for the 3.1% transition adjustment. There is a results tab that summarizes the phase in and 100% opt in bundled rates from 2011 to 2014. The results tab also includes Medicare revenue and expense data, an aggregated case mix adjustment index compared to national averages, and a more detailed analysis of the facility's case mix adjustors compared to national averages. The NRAA bundling spreadsheet produced the following data for the example facility:

- 2011 bundled base rate for the phase in calculation (step) 2: $234.27.
- 2011 bundled case mix adjusted rate after the 3.1% transition adjustment (step 4): $247.80.
- 2011 phase in rate: $237.65.

The final step in the bundled rate calculation process is to estimate the contribution from the home training treatment add on of $33.44 per treatment. The calculation is as follows:

- Fiscal year home training treatments: 133
- Home training add on: $33.44
- Additional Medicare reimbursement: $4,452
- Total Medicare treatments: 16,240
- Contribution to the bundled rate: $.27
- Bundled rate including home training $248.07

Clearly this facility should select the 100% opt in bundling option because there is a $13.80 difference between the case mix adjusted bundled rate calculated in step 4 ($248.07) and the 2011 unadjusted bundled base rate calculated in step 2 (234.27). In addition there is a $24.36 increase over the last fiscal year Medicare payment rate of $223.71. Outlier payments and Quality Incentive Program adjustments were not included in the transition analysis because they will apply regardless of the option selected.

The financial impact of the bundled rate calculation can be summarized as follows:

Labor Mix Adjustment	$19.42
Case Mix Adjustment	$12.64
Home Training Adjustment	$0.27
3.1% Transition Adjustment	-$7.69
Total Bundled Rate Adjustments	$24.64
Medicare Treatments	16,240
Additional Annual Medicare Reimbursement	$400,154

STEP 5: Non Routine Laboratory Expenses: The second financial impact resulting from the Medicare bundling reimbursement system is the addition of the non routine ESRD related laboratory test costs. Currently these lab tests are separately billable either by a private or wholly owned lab. As previously noted CMS estimated the average non routine lab revenue per treatment at $8.40 and added this to the bundled base rate. Outpatient dialysis facilities will now be responsible for the cost of these non routine labs. In the case of independent free standing facilities that use an outside lab, the facility will now pay the private lab directly for these non routine labs. For chain facilities that own a lab, the lab will no longer be able to bill Medicare for these lab tests. At the time this article was written the author has not seen any pricing data from private labs so the data in the example is based on the CMS data used to calculate the bundled base rate as follows:

Current lab cost/treatment ($3.50/patient/month)	$0.27
Bundled lab cost/treatment	$8.40
Additional lab costs/treatment	$8.13
Medicare treatments	16,240
Additional lab cost	$132,031

STEP 6: Expenses for Equivalent Forms of Part B Drugs Covered Under Part D: As previously noted, all ESRD related drugs that are separately billable under the current reimbursement system will be included in the bundled payment system regardless of the route of administration. This pertains primarily to home dialysis patients because most in center home patients receive IV or sub-cutaneous injections during treatment. Most home dialysis patients self administer EPO and occasionally receive injections of IV iron or vitamin D in the facility, which are presently separately billable. Under Medicare bundling, facilities will now be responsible for the expenses associated with home patients that self administer vitamin D or levocarnitine oral equivalents. For the example facility in this article, the only oral drug expense was for home patients taking vitamin D. The facility summarized the vitamin D prescriptions for its home patients and priced them out as follows:

Medication	Weekly Utilization	Annual Utilization	Cost/Pill	Annual Cost
Calcitriol .25 mcg	8	416	$0.62	$258
Calcitriol .5mcg	3	156	$1.29	$201
Hectoral 2.5 mcg	33	1716	$17.24	$29,584
Hectoral 5.0mcg	7	364	$4.96	$1,805
Zemplar 1 mcg	96	4992	$7.24	$36,142
Zemplar 2mcg	3	156	$14.48	$2,259
Total Drug Cost				$70,249

Summary: The total financial impact of the Medicare bundling reimbursement system can be summarized as follows:

Medicare Reimbursement Change	$400,154
Labs	-$132,031
Oral Drugs	-$70,249
Estimated Total Financial Impact of Medicare Bundling	$197,873

The Medicare bundled reimbursement system will have a favorable impact on the finances of the example facility. In the example facility's situation, the reason for the favorable impact is 3 fold:

1. Positive wage index adjustment of 14.7%.
2. High percentage of home dialysis patients (over 30% vs. national average of less than 10%) with an average bundled margin of approximately $60.00 per treatment compared to current rates.
3. Lower than average EPO utilization.

In other facility analyses performed by the author, the other three other factors that materially impacted the outcome of the bundling decision were:

1. Case mix adjustment index relative to national averages.
2. Small facility low volume adjustment.
3. Exception rate for atypical patient mix or isolated essential facility.

Conclusion: The transition decision to opt into Medicare bundling or phase in over 3 years requires considerable data gathering and analysis. Assembling the data for the analysis may be daunting for some facilities that do not have electronic medical records. Once the data has been gathered, the NRAA bundling spreadsheet is an excellent tool to calculate the bundled payment rates. The decision to opt in 100% vs. phase in over 3 years will be dependent on the impact and interactions of the following factors:

- Wage index.
- Case mix index.
- Home dialysis population.
- Current EPO, iron and vitamin D utilization relative to national averages in 2007.
- New patients in the first four months of dialysis that are age eligible for Medicare.
- Eligibility for the small facility adjustment.

The author has made the decision making spreadsheet available on his website as follows: www.dcgseattle.com.