

Related Change Request (CR) #: 3720

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Effective Date: April 1, 2005

Implementation Date: April 4, 2005

Medlearn Matters Number: MM3720

Revised

MMA - Full Replacement of CR 3572, New Case-Mix Adjusted End Stage Renal Disease (ESRD) Composite Payment Rates and New Composite Rate Exceptions Window for Pediatric ESRD Facilities. CR 3572 Is Rescinded.

Note: This article was revised on March 10, 2005 to correct two web addresses that were incorrect in the original article.

Provider Types Affected

Medicare Fiscal Intermediaries (FIs) for ESRD services

Provider Action Needed

This article contains information provided in Change Request (CR) 3720, which relates that the Centers for Medicare & Medicaid Services (CMS) is using a limited number of characteristics that explain variation in reported costs for composite rate services consistent with the legislative requirement. The current composite payment rates will be adjusted for individual patient characteristics and budget neutrality for services furnished on or after April 1, 2005.

Background

In accordance with the Social Security Act (Section 1881(b)(12)(A)), as added by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 623(d)(1)),

"The Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished (by providers of services and renal dialysis facilities in a year) to individuals in a facility and to individuals at home. The case-mix under the system would be for a limited number of patient characteristics."

The use of a case-mix measure permits the targeting of greater payments to facilities that treat more costly and resource-intensive patients. The methodology for applying patient characteristic adjusters (applicable to each treatment) will determine the case-mix adjustment (that will vary for each patient). Thus, an ESRD facility's average composite payment rate per treatment will depend on its unique (patients) case-mix.

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The patient characteristic variables that are utilized in determining an individual patient's case-mix adjusted composite payment rate include the following:

- Five age groups,
- Low Body Mass Index (BMI),
- Body surface area (BSA), and
- Patients under age 18.

Note: Pediatric ESRD patients (defined as those under the age of 18) receive a specific case-mix adjustment factor. As a result, none of the other case-mix adjustors (i.e., the five age groups, low BMI and BSA) is applicable to pediatric ESRD patients.

Each month, the ESRD Pricer Program uses each patient's height and weight (as reported on billing Form CMS-UB 92) to automatically calculate the low BMI and BSA case-mix adjustments to an ESRD facility's composite payment rate.

Budget neutrality is designed to ensure that the total aggregate payments each year from the Medicare Trust Fund do not increase or decrease as a result of changes in the payment methodology. Therefore, **the case-mix adjusted composite rate payments for 2004 must result in the same aggregate expenditures for 2005 (as if the adjustments are not made).**

While the magnitude of some of the patient specific case-mix adjustment factors appears to be significant, facility variation in the case-mix is limited. Regardless of the type of provider, the average case-mix adjustments for patient characteristics do not vary significantly. This is because of the overall similarity of the distribution of patients among the eight case-mix classification categories across facility classification groups.

Because ESRD facilities can maintain their current exception rates, they should compare their exception rate to the basic case-mix adjusted composite rate to determine the best payment rate for their facility.

Each dialysis facility has the option of being paid at:

- Its current exception rate, or
- The basic case-mix adjusted composite rate (including all of the MMA 623 payment adjustments).

If the facility retains its exception rate, it is not subject to any of the adjustments specified in Section 623 of the MMA.

Also, determinations as to whether an ESRD facility's exception rate per treatment will exceed its average case-mix adjusted composite rate per treatment are best left to the entities affected.

Each ESRD facility is required to notify its FI) in writing at any time if it wishes to:

- Give up or withdraw its exception rate, and
- Be subject to the basic case-mix adjusted composite payment rate methodology.

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The case-mix adjusted composite payment rates will begin 30 days after the FI's receipt of the facility's notification letter. ESRD facilities that elect to retain their exceptions do not need to notify their FIs.

Note: CMS is opening a new pediatric facility exception request window for pediatric facilities that **did not** have an approved exception rate as of October 1, 2002 (MMA, Section 623(b)(1)(D)).

The statute defines the term "**pediatric facility**" as a renal facility with at least 50 percent of patients under 18. If a pediatric ESRD facility projects (on the basis of prior years' cost and utilization trends) that it will have an allowable cost per treatment higher than its prospective rate, the facility may request that CMS:

- Approve an exception to that rate, and
- Set a higher prospective payment rate.

CMS will adjudicate these exception requests in accordance with the exception criteria contained in:

- The Code of Federal Regulation (CFR), Title 42, Chapter IV, Part 413, Section 180. See 42 CFR 413.180, which can be found at the following Government Printing Office (GPO) web site:
http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr413_04.html
- Publication 15, Medicare Provider Reimbursement Manual (PRM), Part I, Chapter 27, which can be found at the following CMS web site:
http://www.cms.hhs.gov/manuals/pub151/PUB_15_1.asp

If the facility fails to adequately justify its pediatric exception request (in accordance with regulations or program instructions), its exception request will be denied.

Implementation

The implementation date for this instruction is April 4, 2005.

Additional Information

For complete details, please see the official instruction issued to your FI regarding this change. That instruction may be viewed by going to:

http://www.cms.hhs.gov/manuals/pm_trans/R477CP.pdf

If you have any questions, please contact your FI at their toll-free number, which may be found at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>

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