End-Stage Renal Disease Prospective Payment System

PAYMENT SYSTEM FACT SHEET SERIES
This publication provides the following information about the End-Stage Renal Disease Prospective Payment System (ESRD PPS):

- **Background**;
- **Transition period**;
- **Payment rates for adult patients**;
- **Payment rates for pediatric patients**;
- **Outlier adjustments**;
- **Transition budget neutrality factor**;
- **Home dialysis**;
- **Laboratory services and drugs and biologicals**;
- **Patient deductible and coinsurance**;
- **End-Stage Renal Disease Quality Incentive Program (ESRD QIP)**; and
- **Resources**.

### Background

Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) requires the implementation of a bundled ESRD PPS effective for Medicare outpatient maintenance dialysis services furnished on or after January 1, 2011. The ESRD PPS combines payments for the composite rate and separately billable renal dialysis items and services into a single base rate.

### Transition Period

ESRD facilities that did not make an election to be paid 100 percent under the ESRD PPS on or before November 1, 2010, receive a blend of payments during the transition period. This blended payment is composed of the prior basic case-mix adjusted composite rate portion and the ESRD PPS. The percentages for the blend of payments are as follows:

<table>
<thead>
<tr>
<th>Transition Year</th>
<th>Composite Payment Rate Percent</th>
<th>ESRD PPS Percent</th>
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</thead>
<tbody>
<tr>
<td><strong>Year one</strong></td>
<td>75 25</td>
<td></td>
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<tr>
<td>January 1, 2011 –</td>
<td></td>
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<tr>
<td>December 31, 2011</td>
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<tr>
<td><strong>Year two</strong></td>
<td>50 50</td>
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<td>January 1, 2012 –</td>
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<td>December 31, 2012</td>
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<td><strong>Year three</strong></td>
<td>25 75</td>
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<td>January 1, 2013 –</td>
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<td>December 31, 2013</td>
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<tr>
<td><strong>Year four</strong></td>
<td>N/A 100</td>
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<td>January 1, 2014 –</td>
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<td>December 31, 2014</td>
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For calendar year (CY) 2011 and each year thereafter, ESRD facilities that elected to be reimbursed 100 percent based on the ESRD PPS will continue to be reimbursed 100 percent based on the ESRD PPS payment amount.
Payment Rates for Adult Patients

For CY 2013, the base rate for adult patients is $240.36, which is determined by:

- Updating the CY 2012 ESRD PPS base rate of $234.81 by the ESRD bundled market basket minus a productivity adjustment ($234.81 x 1.023 = $240.21); and
- Applying the 1.000613 wage index budget neutrality adjustment factor to the updated base rate of $240.21 ($240.21 x 1.000613 = $240.36), resulting in an increase of 2.3 percent.

To determine the payment rate for an adult patient’s dialysis treatment, the following adjustments and applications are made to the base rate:

- Patient-level adjustments for case-mix;
- Facility-level adjustments;
- A training add-on (if applicable);
- An outlier adjustment (discussed on pages 4 and 5); and
- A budget neutrality adjustment during the transition period through 2013 (discussed on page 5).

Patient-Level Adjustments for Case-Mix

The patient-level adjustments are patient-specific case-mix adjusters developed from a two-equation regression analysis that encompasses the composite rate and separately billable items and services. The following are included in the patient-level adjustments:

- The variables used in the basic case-mix adjusted composite rate portion – Patient age, body surface area, and low body mass index;
- A single adjustment, with the highest co-morbidity adjustment applied if there is more than one co-morbidity condition:
  - Chronic comorbid conditions – Hereditary hemolytic and sickle cell anemia, monoclonal gammopathy (in the absence of multiple myeloma), and myelodysplastic syndrome; and
  - Acute comorbid conditions – Bacterial pneumonia, gastrointestinal bleeding, and pericarditis. This adjustment will be applied for no more than four consecutive months for any reported acute comorbid condition, unless there is a recurrence of the condition; and
- An onset of dialysis adjustment for the patient’s first 120 Medicare eligible days after the start of renal dialysis. When this adjustment is being applied, the chronic and acute comorbid adjustments and the training adjustment will not be applied with the onset adjustment.

Facility-Level Adjustments

The facility-level adjustments include the following:

- An adjustment that reflects urban and rural differences in area wage levels using an area wage index developed from Core-Based Statistical Areas; and
- An adjustment for facilities that furnish a low-volume of dialysis treatments. To receive the low-volume adjustment, the ESRD facility must submit an attestation to the Medicare Claims Administration Contractor no later than the November 1 prior to the CY in which the adjustment would be effective.

For Medicare Contractor contact information, visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Provider-Compliance-Interactive-Map on the Centers for Medicare & Medicaid Services (CMS) website.
Training Add-On

Facilities certified to furnish training services receive a training add-on payment amount of $33.44, which is adjusted by the geographic area wage index to account for an hour of nursing time for each training treatment that is furnished. This adjustment applies to both peritoneal dialysis and hemodialysis training treatments.

Payment Rates for Pediatric Patients

For CY 2013, the ESRD PPS base rate for services furnished to pediatric patients is $240.36. Pediatric patients include those individuals who are under the age of 18.

Adjustments for Pediatric Patients

To determine the payment amount for a pediatric patient's dialysis treatment, the following adjustments and applications are made to the base rate (as discussed in the Payment Rates for Adult Patients section on pages 3 and 4):

- Pediatric patient-level adjustments for case-mix;
- Facility-level adjustments;
- A training add-on (if applicable);
- An outlier adjustment (if applicable); and
- A budget neutrality adjustment during the transition period through 2013.

Pediatric Patient-Level Adjustments for Case-Mix

The pediatric model incorporates separate adjusters based on two age groups (<13, 13 – 17) and dialysis modality (hemodialysis, peritoneal dialysis). The per-treatment base rate as it applies to pediatric patients is the same base rate that applies for adult patients, which is also adjusted by the area wage index.

Treatments furnished to pediatric patients can qualify for a training add-on payment (when applicable) and are eligible for an outlier adjustment.

Note: Pediatric dialysis treatments are not eligible for the low-volume adjustment.

Outlier Adjustments

Outlier adjustments will be made for facilities that treat patients with unusually high resource requirements as measured through their utilization of identified services beyond a specified threshold. These adjustments are an additional payment beyond the otherwise applicable case-mix adjusted PPS amount and include the following items and services:

- ESRD-related drugs and biologicals that were or would have been separately billable under Medicare Part B prior to January 1, 2011;
- ESRD-related laboratory tests that were or would have been separately billable under Medicare Part B prior to January 1, 2011;
- ESRD-related medical/surgical supplies, including syringes, that were or would have been separately billable under Medicare Part B prior to January 1, 2011; and
- ESRD-related drugs that were or would have been covered under Medicare Part D prior to January 1, 2011, notwithstanding the delayed implementation of ESRD-related oral-only drugs effective January 1, 2014.

Effective January 1, 2012, the laboratory tests that comprise the Automated Multi-Channel Chemistry panel are excluded from the definition of outlier services.
Note: Services not included in the PPS that remain separately payable (e.g., blood and blood processing, preventive vaccines, and telehealth services) are not considered outlier services.

Transition Budget Neutrality Factor

For CY 2013, a 0.1 percent transition budget neutrality factor is applied.

Home Dialysis

Effective January 1, 2011, home dialysis items and services previously reimbursed under Method II, regardless of home treatment modality, are included in the ESRD PPS payment rate. All home dialysis claims with dates of service on or after January 1, 2011, must be submitted by the ESRD facility and will be processed as Method I claims.

Laboratory Services and Drugs and Biologicals

Effective January 1, 2011, ESRD-related laboratory services and drugs and biologicals previously separately billable under Medicare Part B are included in the ESRD PPS. Drugs and biologicals that are used as a substitute for any of these items, or are used to accomplish the same effect, are also included in the ESRD PPS. Please refer to the list of some of the items and services that are “always ESRD-related” and, therefore, are not separately payable to facilities located at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRD payment/Downloads/Items-Services-Consolidated-Billing-for-ESRDPPS-Effective10-1-2012CR7858.pdf on the CMS website. Please note that this is not an all-inclusive list.

Laboratories, other suppliers, and physicians who furnish services otherwise included in the payment bundle that are not related to the patient’s ESRD may bill separately for these services using the AY modifier. The AY modifier should not be used to bill for services that are included in the ESRD PPS.

Patient Deductible and Coinsurance

The patient is responsible for any unmet deductible and coinsurance amounts. Effective January 1, 2011, the patient’s deductible and coinsurance amounts depend on how the ESRD facility elects to be reimbursed:

- If the facility will receive the blend of payments composed of the basic case-mix adjusted composite rate portion and the ESRD PPS, the patient’s coinsurance is based on the final blended payment amount; or
- If the facility will be reimbursed 100 percent under the ESRD PPS, the patient’s coinsurance is based on the ESRD PPS base rate and all applicable adjustments.

End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

The ESRD QIP, which was mandated by Section 153(c) of the MIPPA, adjusts Medicare payments to renal dialysis facilities based on how well they meet or exceed performance standards for quality measures. For more information about the ESRD QIP, visit http://www.cms.gov/Medicare/End-Stage-Renal-Disease/ESRDQualityImproveInit on the CMS website.
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<th>For More Information About…</th>
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<td>End-Stage Renal Disease Services</td>
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<td>Medicare Learning Network® (MLN) publication titled “Composite Rate Portion of the End-Stage Renal Disease Prospective Payment System” located at <strong><a href="http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ESRDpaymtfctsh.pdf">http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ESRDpaymtfctsh.pdf</a></strong> on the CMS website</td>
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<td>Chapter 8 of the “Medicare Claims Processing Manual” (Publication 100-04) located at <strong><a href="http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf">http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf</a></strong> on the CMS website</td>
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<td>“Medicare Learning Network® Catalog of Products” located at <strong><a href="http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf">http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf</a></strong> on the CMS website or scan the Quick Response (QR) code on the right.</td>
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