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CMS Proposes ESRD PPS for 2013, and Bad Debt Reductions for All

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CMS has released the 2013 proposed regulation for the End Stage Renal Dialysis Prospective Payment System [PDF] (ESRD PPS). In that rule CMS proposed a payment rate increase in the per treatment reimbursement, a 35% reduction in allowable ESRD bad debt amounts to be implemented over 3 years, and an update to the ESRD Quality Improvement Program (ESRD QIP). The proposed rule also implements reductions in bad debt reimbursements for all other health care providers, suppliers and other cost-reporting entities required by the Middle Class Tax Extension and Job Creation Act of 2012 [PDF]. Comment on the proposed regulations will be accepted through **August 31, 2012**.

ESRD Provisions

CMS estimated that the proposed 2013 payment rates will increase ESRD facility reimbursement by $300 million nationwide, or approximately a 3.0% increase over 2012. CMS also anticipated that the ESRD QIP, which reduces reimbursements to ESRD facilities that do not provide quality improvement data, will reduce reimbursements by $8.5 million in 2013.

ESRD reimbursement remains in transition and 2013 will mark the third year of a four year transition to the ESRD PPS. In November of 2010 ESRD facilities had the option of entering the ESRD PPS in 2011 or choosing reimbursement under an ESRD PPS blended payment system. The ESRD PPS blended payment system includes three components—the ESRD PPS, ESRD composite rate and the drug add-on. Accordingly, the proposed rule includes an update to each of these components.

The proposed ESRD PPS will increase the per treatment ESRD PPS Base Rate from $234.81 to $240.88 in 2013. This rate includes a 3.2% market basket update to reflect the changes in the services and goods (and the prices of those services) that make up ESRD services; a -0.7% productivity adjustment based on an economy-wide productivity adjustment; and a small adjustment for a wage index budget neutrality factor. The ESRD PPS reimbursement includes the cost of services, laboratory, drugs and biologicals for ESRD-related services. The proposed base rate is applicable to both the ESRD PPS portion of the blended payment under the transition and payments under the full PPS.

For those facilities that selected the ESRD PPS blended payment system in 2010, that payment will be equal to 75% of the ESRD PPS Base Rate and 25% of the basic case mix adjusted composite rate. The composite rate for 2013 will be $145.49. The new rate is a 2.5% increase from last year's composite rate of $141.94. Facilities that are paid under the blended payment system also receive a drug add-on payment. The drug add-on per treatment rate for 2013 will remain unchanged at $20.33.

The proposed rule also includes a change in Medicare's payments to ESRD facilities of allowable bad debt from patient co-pays and deductibles. Currently an ESRD facility receive 100% of allowable bad debt amounts from Medicare, subject to the facility's reasonable cost. However the Middle Class Tax Extension and Job Creation Act included a provision that reduced allowable bad debt payment amounts as an offset to increased Medicare reimbursement for other Medicare Part B services. The proposed rule implements a phased-in reduction to these bad debt payments so that ESRD facilities will receive 88% of their allowable bad debt amounts in 2013, 76% in 2014, and 65% in 2015 and thereafter. The allowable bad debt amount will remain subject to the facility's reasonable cost.

The proposed ESRD QIP will include ten quality improvement measures, including five new measures. The five new measures are anemia management reporting, clinical measures for adult hemodialysis patients, clinical measures for adult peritoneal patients, clinical measures for pediatric hemodialysis patients, and the

proportion of patients with hypercalcemia. The rule also proposes to remove the urea reduction ratio dialysis adequacy measure from the existing ESRD QIP.

CMS also made two proposals regarding ESRD drug payments. CMS recommended that the antibiotic daptomycin will be reimbursed separately if furnished to treat an ESRD patient for non-ESRD related conditions. (Daptomycin is used to treat skin infections.) CMS also proposed to stop separate reimbursement for thrombolytics.

Bad Debt Reductions For All

The Middle Class Tax Extension and Job Creation Act also reduced the percentage of allowable bad debt to hospitals, skilled nursing facilities (SNF) and other entities. Hospitals, SNFs and other entities are responsible for collecting co-pays and deductibles from Medicare beneficiaries. Some beneficiaries, particularly those who are Medicaid eligible (dual eligible), are unable to pay these amounts and Medicare compensates the applicable health care entity for 70% (hospitals and some beneficiaries in a SNF) or 100% (all other cost-reporting entities) of the unpaid bad debt amount. Effective 2013, a hospital and a SNF with a non-dual eligible resident will be reimbursed 65% of the bad debt amount from that individual. The bad debt for a SNF with a dual eligible resident, a swing bed hospital, and any other provider will be reimbursed at 88% beginning fiscal year 2013, 76% beginning fiscal year 2014, and 65% effective fiscal year 2015.

Ober|Kaler's Comments

CMS' proposed regulations continue the transition to a 100% ESRD PPS system. Based on CMS' calculations, hospital-based and freestanding ESRD facilities should see a slight increase in their ESRD PPS Medicare reimbursement in 2013.

ESRD facilities should also note that the proposed rule included precautionary language to ESRD facilities about their billing practices. Laboratory tests and drugs covered under an ESRD facility's composite rate may not be separately billed or reimbursed. Certain non-related drugs and biologicals used in an ESRD facility for non-ESRD-related services are reimbursable if billed with an AY modifier. CMS

advised that it would monitor the use of the AY modifier for inadvertent or wrongful billing for ESRD-related services, and advised that it may consider eliminating the AY modifier in future rulemaking based on the results of that monitoring.

Likewise, CMS cautioned ESRD facilities that Medicare beneficiaries may not be required to purchase their renal dialysis drugs if those drugs were considered ESRD services. CMS noted that it believed that some ESRD facilities were requiring beneficiaries to purchase renal dialysis drugs and informing them not to use their Medicare Part D plan for the purchase.

The bad debt reduction mandated by the Middle Class Tax Extension and Job Creation Act will impact health care entities starting with cost reporting periods beginning in federal fiscal year 2013. Hospitals and SNFs will see a smaller, but meaningful, reduction from 70% to 65%. Other providers will see a greater, although phased-in, reduction to their bad debt reimbursement. Medicare reimbursement remains, and will likely remain in the future, a zero-sum game where an increase in reimbursement for one service, supplier, or provider usually means a decrease in reimbursement for other services, suppliers or providers.