

**REPORT OF THE
VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**

History of Medicaid Reimbursement Rates for Dialysis Services in Virginia

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**



HOUSE DOCUMENT NO. 53

**COMMONWEALTH OF VIRGINIA
RICHMOND
2005**



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

PATRICK W FINNERTY
DIRECTOR

August 15, 2005

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

The Honorable Vincent F. Callahan, Jr.
Chairman of the House Appropriations Committee
General Assembly Building
Richmond, Virginia 23219

The Honorable John H. Chichester
Chairman of the Senate Finance Committee
General Assembly Building
Richmond, Virginia 23219

Dear Delegate Callahan and Senator Chichester:

Pursuant to Chapter 951, Section 326 YYY, of the 2005 Appropriations Act, the Department of Medical Assistance Services (DMAS) is directed to report on the history of Medicaid reimbursement rates for dialysis services.

In addition to their own research, agency staff met with dialysis provider representatives to solicit their input in the development of this report. This report is intended to fulfill the requirement under the 2005 Appropriations Act.

If you have any questions regarding this report, please contact me at (804) 786-8099.

Sincerely,

A handwritten signature in black ink that reads "PW Finnerty".

Patrick W. Finnerty

PWF:ccm

Attachment: History of Medicaid Reimbursement Rates for Dialysis Services in Virginia

Table of Contents

EXECUTIVE SUMMARY	1
BACKGROUND	1
REIMBURSEMENT RATES	2
EXPENDITURES AND RECIPIENTS	3
COMPARISON OF REIMBURSEMENT RATES	4
Comparison with Medicare	4
Comparison with Medicaid Rates in Neighboring States	7
CONCLUSION.....	8
ATTACHMENT A: Study Mandate	10

EXECUTIVE SUMMARY

Item 326 YYY of the 2005 Appropriation Act directs the Department of Medical Assistance Services (DMAS) to report on the history of reimbursement rates for dialysis services under Medicaid. DMAS staff has met with dialysis provider representatives to solicit their input in the development of this report. This report is intended to fulfill the requirement under the 2005 Appropriation Act.

End-stage renal disease (ESRD) is a clinical term for irreversible kidney impairment resulting in complete or near complete kidney failure. This results in an individual's inability to properly excrete wastes, concentrate urine and regulate electrolytes. The only treatment options for individuals with ESRD are dialysis and/or kidney transplantation.

Due to Medicare eligibility criteria specifically for individuals with ESRD, Medicare is the primary payer for most of the recipients of dialysis treatment. However, in the case of individuals who are both Medicare and Medicaid eligible (dual-eligibles), Medicaid covers coinsurance and deductibles. Furthermore, it is possible for some individuals with ESRD to be ineligible for Medicare. To the extent these individuals qualify for Medicaid, Medicaid becomes the primary payer for dialysis services.

Virginia Medicaid's reimbursement rate for dialysis services has been unchanged at \$138 per unit/visit since 1983. Medicaid's dialysis reimbursement rate is not directly comparable to the Medicare rate because the composite rate used by Medicare does not include identical components. Notwithstanding the different make-up of the two payment rates, the current Medicaid rate appears competitive with the current Medicare rate. Medicare reimbursement for dialysis services and related drugs was estimated at approximately 88 percent of Virginia Medicaid reimbursement prior to recent mandated changes; with Medicare methodology changes this figure increased to approximately 94 percent of Virginia Medicaid reimbursement. However, due to the enhancements to the Medicare rate under the recent Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, it is likely that the Virginia Medicaid rate will gradually lose ground relative to Medicare as the Medicare rate is adjusted to include newer pharmaceuticals under a more advantageous reimbursement method for providers and the Medicaid rate remains unchanged.

BACKGROUND

Item 326 YYY of the 2005 Appropriation Act (language included as Attachment A to this report) directs the Department of Medical Assistance Services (DMAS) to report on the history of reimbursement rates for dialysis services under Medicaid by August 15, 2005. This report is intended to fulfill that requirement.

Virginia Medicaid covers the coinsurance and deductibles for treatment of end-stage renal disease (ESRD) for those patients who are eligible for coverage under both Medicare and Medicaid (dual eligibles), and is the primary payer for those patients who

are only eligible under Medicaid. Patients with ESRD have irreversible kidney impairment resulting in a complete or near complete failure of the kidneys to function to excrete wastes, concentrate urine, and regulate electrolytes. Dialysis or kidney transplantation is the only treatment for ESRD. Two alternative forms of dialysis are hemodialysis and peritoneal dialysis.

Because most coverage for the treatment of ESRD under Virginia Medicaid is secondary to Medicare, Medicaid withholds payment until a determination is made concerning the patient's Medicare eligibility. For Medicare-eligible patients, Medicare is billed first. Medicaid is then billed for coinsurance and deductibles, usually the 20 percent coinsurance required by Part B. The claims for dual eligible patients are called crossover claims.

For patients not covered by Medicare who meet Medicaid income criteria, Virginia Medicaid covers dialysis and kidney transplantation directly. It also covers drugs required as part of ESRD treatment. Professional staffs in Medicare-certified facilities are responsible for the management of the treatment program and determination of the appropriate type of services needed; e.g., outpatient, home, or nursing facility treatments. Dialysis centers enrolled in the Virginia Medicaid Program are responsible for submitting charges for outpatient and home dialysis services.

REIMBURSEMENT RATES

Since 1983, DMAS has reimbursed freestanding renal dialysis centers an established rate of \$138 per unit for hemodialysis and peritoneal dialysis services for those recipients for which Medicaid is the primary payer. It appears that this rate was based on an early Medicare rate, but no documentation was found concerning how the DMAS rate was first established. Prior to the introduction of the Medicare composite rate in 1981 by the Omnibus Budget Reconciliation Act, Medicare paid for dialysis based on actual cost incurred with an upper screen limit of \$138.¹ The \$138 rate used by DMAS includes the supplies used during treatment and certain routine laboratory tests. In addition to the rate of \$138 for basic dialysis services, DMAS reimburses freestanding renal dialysis facilities separately for other non-routine laboratory tests performed by the facility and for dialysis-related drugs that are administered during treatment using the Medicare rates as a guideline.

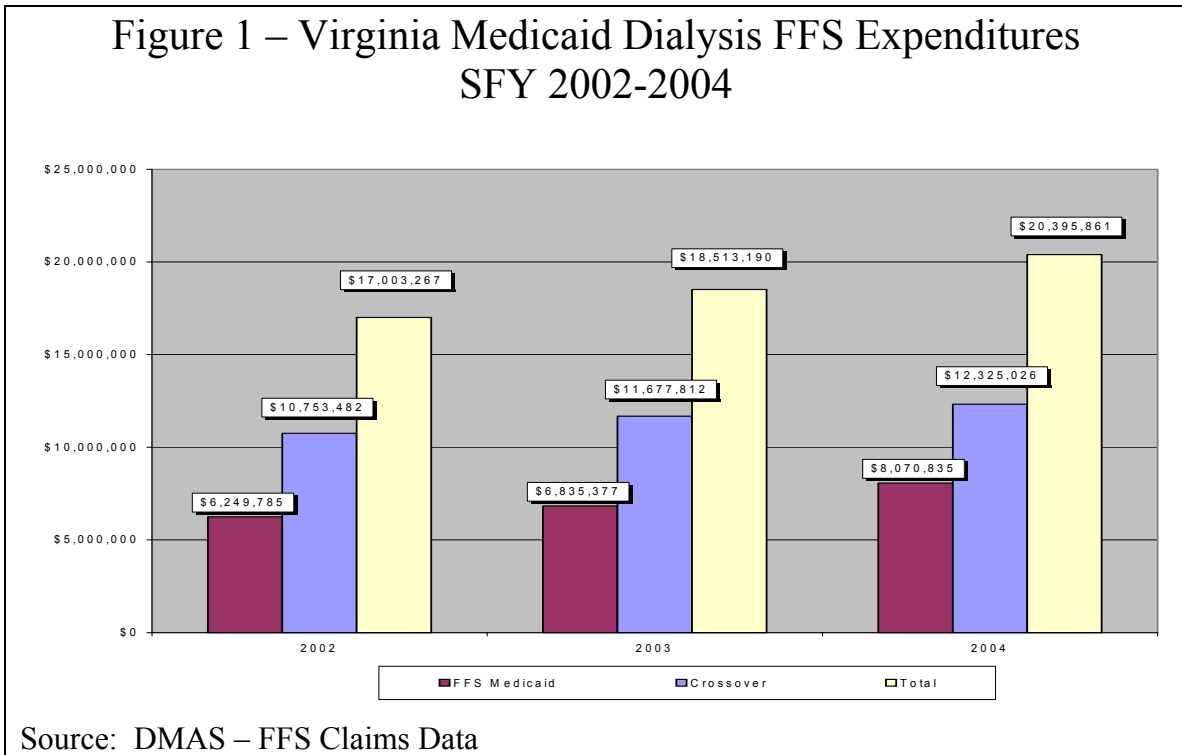
The Virginia Administrative Code does not specifically address the reimbursement methodology for dialysis services, and does not provide for rate changes or updates. Thus, without specific budget language and appropriation, the flat rate of \$138 for hemodialysis and peritoneal dialysis services has not changed since its implementation. However, laboratory tests and drugs that are billed separately are updated periodically based on the Medicare fee schedule.

¹ Eggers, Paul W. *Medicare's End State Renal Disease Program*. Health Care Financing Review, Fall 2000, 22(1): 56.

For crossover claims, Medicare makes the primary payment to the provider for the dialysis services rendered, and Medicaid covers the deductible and coinsurance amounts up to a defined maximum. Virginia Medicaid is limited to only paying the Part B (supplementary medical insurance) coinsurance up to the difference between Virginia Medicaid’s maximum allowable fee and Medicare’s payment for the procedure. In other words, the sum of the Medicare primary payment and Medicaid payment for coinsurance and deductibles may not exceed Medicaid’s allowable fee for the procedure.

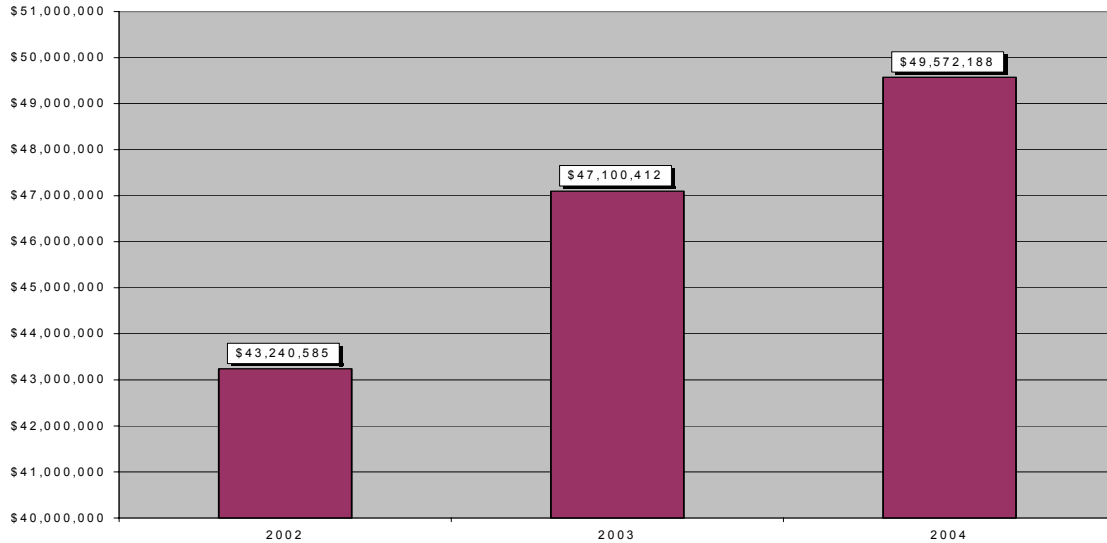
EXPENDITURES AND RECIPIENTS

Although the Medicaid reimbursement rate has not changed, dialysis expenditures have grown over time in Virginia. Virginia Medicaid fee-for-service (FFS) expenditures have increased steadily from SFY 2002 through 2004 (Figure 1). In SFY 2004 Virginia Medicaid paid \$8,070,835 for FFS claims to freestanding dialysis centers as the primary payer for 558 dialysis recipients. In that same year, Medicaid’s total expenditure for crossover claims from Medicare was \$12,325,026 for 2,698 dual-eligible dialysis recipients, for a total combined FFS expenditure for dialysis services of approximately \$20.4 million (approximately half of which would be General Funds). These figures do not include expenditures for recipients in managed care organizations (MCOs).



For those same Virginia Medicaid dual-eligible recipients Medicare’s total expenditures were \$49,572,188. Medicare’s expenditures for Virginia Medicaid dialysis recipients also significantly rose from SFY 2002 through 2004 (see Figure 2).

Figure 2 – Medicare Expenditures for Virginia Medicaid Recipients SFY 2002-2004



Source: DMAS - Crossover (Title XVIII) Claims Data

COMPARISON OF REIMBURSEMENT RATES

Comparison with Medicare

In the past, Medicare used a composite rate to pay for dialysis services. CMS has rarely updated the composite rate, with only Congress holding the authority to initiate an update to the composite rate. The initial composite rate was effective August 1, 1983. The composite rate included the cost of some drugs, laboratory tests, and other supplies and services provided to dialysis patients. However, the composite rate did not account for specific characteristics of the patient, generally referred to as case mix.²

In a 2003 Report to Congress, the Secretary of Health and Human Services, Tommy G. Thompson, discussed the need for revision of the reimbursement system for outpatient ESRD services. This report detailed the recommendations of the Benefits Improvement and Protection Act (BIPA) of 2000, including (1) the expansion of the bundle of services included in the composite rate to encompass separately billable laboratory tests and drugs most commonly used during dialysis treatment and (2) the development of an ESRD market basket to update the composite rate on an annual or periodic basis. These recommendations will be phased over the next few years.³

² Centers for Medicare & Medicaid Services, Medicare Learning Network. *ESRD Contractor Training Guide*, January 2005.

³ Thompson, Tommy G., Secretary of Health and Human Services. *Report to Congress: Toward a Bundled Outpatient Medicare End Stage Renal Disease Prospective Payment System*. 2003.

In 2003, the enactment of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) mandated that Medicare change the payment methodology for facilities that provide dialysis treatment and the corresponding separately billable drugs. The goal of this mandate is to eliminate the cross-subsidization of composite rate payment by drug payments. That is, it is believed that the composite rate is too low relative to the costs it is intended to cover, and that the payment for drugs is too high. In addition, more accurate payment of the composite rate and separately billable drugs is expected. Overall, Medicare's expenditures will be budget neutral during the transition, but the cross-subsidy will be eradicated. That is, the composite rate will be increased slightly, and reimbursement of drugs reduced to an approximately equal extent.

The ESRD Composite Rate System Fact Sheet published by CMS in January 2005 summarized the changes to the payment methodology as the following:

Changes effective January 1, 2005:

- *Composite rate payments increase by 1.6 percent*
- *Payment for separately billable drugs based on acquisition costs*
- *Facilities paid separately for syringes used for administering EPO*
- *Facilities **should** begin to report two new value codes:*
 - *Value Code A8 – patient weight in kilograms (after dialysis)*
 - *Value Code A9 – patient height in centimeters (as patient presents)*
- *Drug add-on adjustment of 8.7 percent added to the composite rate*

Changes effective April 1, 2005

- *Case mix adjustments for limited patient characteristics*
- *Budget neutrality with respect to aggregate payments*
- *Facilities **must** report the two new value codes*
 - *If facilities do not report these value codes, bills will be returned to them*
- *New exception window opens for ESRD facilities that qualify as pediatric facilities⁴*

In addition to these changes, Medicare also continues to apply a geographic (wage) index, derived from the Metropolitan Statistical Areas (MSAs) used for hospitals, to the facility specific base rate. Effective January 1, 2005, the Medicare base rates are \$132.41 for hospitals and \$128.35 for independent facilities. Figure 3 details the calculation of the Medicare rate for an independent ESRD facility.

⁴ Centers for Medicare & Medicaid Services, Medicare Learning Network. *End Stage Renal Disease Composite Rate Payment System Fact Sheet*, January 2005.

Figure 3 Medicare Rate Calculation for Independent ESRD Facility in Richmond, VA	
2005 Composite Rate	\$128.35
Wage Adjusted Rate	\$125.53
Drug Add-On	\$125.53 Plus 8.7 Percent = \$136.45
Budget Neutrality	\$136.45 Times 0.9116 = \$124.39
Final Rate	\$124.39

Medicare’s composite rate includes certain drugs and drug administration not included in Virginia Medicaid’s flat rate (see Figure 4). Virginia Medicaid’s flat rate only includes certain supplies and laboratory tests. Medicare adjusts the composite rate by geographic location and a budget neutrality factor; Virginia Medicaid makes neither of these adjustments. Medicare applies an additional 8.7 percent to the composite rate as a drug add-on; Virginia Medicaid pays all drugs separately. Although both Medicare and Virginia Medicaid use the Average Sales Price (ASP) for separately billable drugs, Medicare pays Average Acquisition Payment (AAP) for the top ten drugs and adds 6 percent to all other separately billable drugs. All of these variations in methodology result in very distinct Medicare and Virginia Medicaid rates and create a marked difference between the levels of Medicare reimbursement and Virginia Medicaid reimbursement for the same services performed in dialysis facilities.

Figure 4 Drugs Included in the Medicare Composite Rate / Paid Separately Under Medicaid			
Antiarrhythmics	Antihistamines	Antihypertensives	Dextrose
Glucose	Heparin	Mannitol	Pressor Drugs
Protamine	Saline	Local Anesthetics	Heparin antidotes
Antibiotics (when used at home to treat infection at catheter site or peritonitis)			

Source: Centers for Medicare & Medicaid Services, Medicare Claims Processing Manual – Chapter 8, Section 50.2

In April 2005, Virginia Medicaid adopted the new Medicare separately billable drug rates, but without the additional 6 percent to the ASP. Prior to April 2005, Virginia Medicaid reimbursed separately billable drugs at a percentage of Average Wholesale Price (AWP). Based on SFY 2004 claims experience and the new Virginia Medicaid drug rates effective April 1, 2005, drug reimbursement associated with dialysis treatment is expected to decrease 27 percent. The change in Virginia Medicaid rates is expected to occur quarterly based on the CMS the publication of the updated ASP rates. Virginia Medicaid drug reimbursement will vary according the ASP rates CMS publishes.

Prior to adopting the ASP rates in April 2005, Medicare reimbursement for dialysis services and related drugs was approximately 88 percent of Virginia Medicaid reimbursement. Since the implementation of the new drug rates, Medicare reimbursement climbed to approximately 94 percent of Virginia Medicaid. While these estimates suggest that prior to this change in reimbursement of drugs Virginia Medicaid reimbursement likely exceeded the Medicare payment for the same services, over time these changes will significantly impact Virginia Medicaid's reimbursement rates and may reduce the overall reimbursement for dialysis services relative to Medicare by eliminating "overpayment" of drugs, that has in effect compensated for the flat rate. At this time, the long-term impact of these changes may not be accurately predicted because of the fluctuations in the Medicare drug rates that Virginia Medicaid recently adopted.

The next phases of the changes to the Medicare composite rate include adjustments to the rate to accommodate changes in the market and patient characteristics. The Virginia Medicaid flat rate does not account for special patient populations or geographic challenges in reimbursement to facilities. As these rate modifiers are incorporated into the Medicare methodology, the Virginia Medicaid rate will remain flat, as regulations do not provide authority to update these rates. If the Medicare update of the composite rate becomes an annual or periodic update, Medicare reimbursement may eventually surpass Virginia Medicaid reimbursement.

In a public meeting held at DMAS on May 16, 2005 with representatives from Fresenius Medical Care, DaVita, and Albers & Company, Virginia Medicaid's reimbursement rates and methodology were discussed. Overall, the representatives concurred that Virginia Medicaid's reimbursement rates are competitive. However, the representatives expressed concerns that the new reimbursement methodology implemented by Medicare to eliminate cross-subsidization of the composite rate by the drug payments may result in Virginia Medicaid rates no longer being competitive with Medicare. In addition, the introduction of Medicare Part D on January 1, 2006 and the implementation of the ASP and AAP for the top ten drugs instead of AWP for all separately billable drugs may also have a significant impact on Virginia Medicaid dialysis reimbursement.

Moreover, the provider representatives stated that the levels of reimbursement from both Medicare and Virginia Medicaid are below their cost, and below the rates of commercial payers. For most dialysis providers, Medicare and Medicaid account for most of the patients serviced, but only half of the total revenue. They stated that revenue from the minority of patients with private coverage must be used to subsidize services to Medicare and Medicaid patients.

Comparison with Medicaid Rates in Neighboring States

As with Medicare, comparison of reimbursement among state Medicaid programs is difficult at best, as states have flexibility in both reimbursement method and in the definition of benefits. What is included in a rate for one state may not be in the rate for another. Notwithstanding these issues, DMAS has collected the following information from our neighboring states.

North Carolina

The North Carolina Department of Medical Assistance closely follows Medicare's guidelines in the reimbursement of dialysis services. When CMS implemented a composite rate increase for ESRD of 1.6 percent effective January 1, 2005, North Carolina Medicaid also increased the composite rate for dialysis services by the same percentage. However, North Carolina Medicaid does not plan to change the reimbursement rates for drugs associated with dialysis treatment that Medicare adopted.

Maryland

The Department of Mental Health and Hygiene (DHMH) reimburses the Medicare composite rate based on collection of the rate letters sent to providers by Medicare. Although DHMH enrolls 75 percent of Maryland Medicaid recipients in MCOs and pays capitation rates for these recipients, DHMH requires that the MCOs pay dialysis services at the Medicare composite rate.

Tennessee

The majority of Medicaid patients in TennCare are managed by MCOs. The Bureau of TennCare allows the MCOs to negotiate flat rates directly with the dialysis facilities including the services covered in each rate. For the crossover claims from Medicare for recipients that are not enrolled in managed care plans, TennCare reimburses the entire 20 percent coinsurance amount.

South Carolina

For dialysis treatments, the South Carolina Department of Health and Human Services pays a composite rate that includes all equipment, items and services necessary to provide a dialysis treatment, lab tests, oral and nutritional supplements as well as staff time required to provide treatment. The facilities are also allowed to bill separately for EPO and injections. The rate for home hemodialysis and in-center hemodialysis is \$121.44 and the rate for peritoneal dialysis is \$53.13. The coverage and payment methodology has been comparable to Medicare; however, the last rate increase was 1.2 percent in 2000.

CONCLUSION

Virginia Medicaid's reimbursement rate for dialysis services has remained unchanged since 1983, yet has historically been and is currently competitive with reimbursement levels under Medicare. The Virginia Medicaid rate also appears to be competitive with neighboring state Medicaid programs for which we have obtained rate information. While the Virginia rate has been competitive with other public sector payers, commercial payers and reimbursement for associated drug treatments have according to the providers tended to cross-subsidize the cost of dialysis services for both Medicaid and Medicare recipients. The changes in drug reimbursement methodology by Medicare to level the

playing field and the adoption of Medicare drug rates by Virginia Medicaid without a methodology change may cause Virginia Medicaid drug reimbursement to be less competitive with Medicare drug reimbursement. Estimates indicate that current reimbursement from Medicare rose from approximately 88 percent of Virginia Medicaid reimbursement to approximately 94 percent of Virginia Medicaid in April 2005. While it is more than likely that the current reimbursement from Medicaid including separately billable drugs is higher than Medicare's total reimbursement, recent changes in Medicare payment policy make it possible that the Virginia Medicaid payment rate will gradually lose ground compared to the Medicare rate and may be surpassed by Medicare in the future.

ATTACHMENT A: Study Mandate

2005 Appropriation Act Item 326 YYY:

The Department of Medical Assistance Services shall report on the history of Medicaid reimbursement rates for dialysis services by August 15, 2005, to the Chairmen of the House Appropriations and Senate Finance Committees.