ESRD Bundled Payment Demonstration (MMA §623e)

Advisory Board:
First Meeting Agenda

February 16, 2005

Welcome

- Introductions
- FACA Committees
- Swearing In
- Agenda / Meeting Objectives

Introduction of Members

- **Robert Rubin, MD** (co-chair)
  Clinical Professor of Medicine
  Georgetown University School of Medicine
- **Brady Augustine** (co-chair)
  Centers for Medicare & Medicaid Services
- **John Burkart, MD**
  Professor of Internal Medicine/Nephrology
  Wake Forest University
- **Thomas Cantor**
  Biochemist
  President & Owner
  Scantibodies Laboratory
- **Paula Cuellar, RN**
  Dialysis Care Center Director
  University of Chicago Hospitals
- **Paul Eggers, PhD**
  Program Director for Kidney & Urology Epidemiology
  NIDDKD/National Institutes of Health
- **Bonnie Greenspan, RN**
  Health Care Consultant
- **J. Michael Lazarus, MD**
  Chief Medical Office & Senior Vice President of Clinical Quality
  Fresenius Medical Care
- **William Owen Jr., MD**
  Adjunct Professor of Medicine
  Duke University School of Medicine
  Senior Scholar
  Fuqua School of Business
- **Nancy Ray**
  Research Director
  Medicare Payment Advisory Commission
- **Kris Robinson**
  Executive Director
  American Association of Kidney Patients
- **Jay Wish, MD**
  President
  ESRD Networks 9 and 10

CMS / Contractor Staff

- CMS / ORDI Staff
  - Ron Deacon
  - Henry Bachofer
  - Jody Blatt
  - Heather Grimsley
  - Pam Kelly
  - Cindy Massuda
  - Jason Petroski
- CMS / CMM Staff
  - Paul Olenick
  - Suzanne Asplen
  - Bill Cymer
  - Lana Price
  - Gene (Henry) Richter
  - Carolyn Rimes
- URREA / KECC Staff
  - Robert Wolfe
  - Richard Hirth
  - Marc Turenne
  - Jack Wheeler

What is FACA?

- Federal Advisory Committee Act (FACA)
- Became law in 1972 (Public Law 92-463)
- Established a system to govern the creation and operation of advisory committees in the Executive Branch of the Federal Government

What FACA Does

- FACA governs **any** group a Federal agency convenes to develop formal findings or propose recommendations, **where one or more members of the group are not Federal employees**

Role of FACA Committees

- Drawing upon the expertise and experience of its membership, the committee is utilized to advise or make recommendations on matters relating to the programs, responsibilities, or activities of the department or agency.
- The public, in return, is afforded an opportunity to participate actively in the Federal Government's decision making process.

FACA Requirements

- File a Charter
- Keep detailed minutes
- Chaired or attended by a Federal official
- Provide advance notice of meetings
- Open meetings to the public (participation)
- Availability of minutes, records, reports
- Fairly balanced in terms of points of view
- Limit to two years unless specially exempt

Swearing In

- Ethics Presentation
- Swearing In

Agenda

- Welcome / FACA Background / Swearing In
- Charter / Charge
- Member Perspectives
- The Composite Rate: Past, Present & Future
- Vision / Goals of Bundled Payment
- Payment System Design / Data Issues
  - Scope of Payment
  - Facility's Responsibility
  - Unit of Payment
  - Case Mix Adjustment
- Public Comments
- Next Steps / Wrap-up

Meeting Objectives

- Share central concerns and perspectives of committee members and CMS
- Build consensus on goals for bundled payment demonstration
- Establish common understanding of key data related to bundled payment
- Define (when possible) general direction for demonstration payment system design
- Identify basic questions / data needs for future meetings and discussions

Administrative Matters

- Lunch break
- Public participation / comment
  - Public comment opportunity
  - Written comments
  - Sharing of information and data
  - Website: http://www.cms.hhs.gov/faca/esrd
- Evaluation form (for use by board members)

Charter / Timelines

- Charter / Charge / Vision
- Advisory Board topics
- Demonstration project timeline

Charter / Charge

- Statutory directive for expanded bundle
  - 623(e): “drugs and biologicals … [and] laboratory tests related to such drugs and biologicals”
  - 623(f): “drugs, clinical laboratory tests, and other items that are separately billed”
- Advisory Board charter
  - “… advise the Secretary and the Administrator of the CMS concerning the establishment and operation of [the] demonstration”

Advisory Board Topics

- The scope of the bundle (what's included)
- Case mix adjustment
- Consolidated billing & payment
- Quality payment incentives (P4P)
- Role of disease management
- Selection criteria for demonstration sites

Meeting Schedule

- 2005: 4 Meetings
- 2006: 2 Meetings
- 2007: 1 Meeting
- 2008: 1 Meeting

Project Timeline: 2005

- February — June 2005
  - Meeting 1: Scope / Overview
  - Meeting 2: Case Mix / Quality
  - Meeting 3: Demonstration Design / Parameters
- June 2005
  - Solicitation Clearance Process
- July 2005
  - Publication of Solicitation
- September 2005
  - Meeting 4: Evaluation Design / Implementation Review
- October 2005
  - Receipt of Proposals
- November 2005
  - Recommend Awards for Administrator Approval
- December 2005
  - Clearance Process for Demonstration Awards
- January 2006
  - Statutory Implementation Date

Member Perspectives

- Professional background
- Demonstration of payment based on an expanded bundle

Bundled payment demonstration

- What do you hope payment based on an expanded bundle accomplishes / achieves?
  - For patients?
  - For providers / facilities?
- What are the downside risks of expanding the bundle?
- What three key features should a bundled payment system have?
- What three key features should a bundled payment system avoid?
- How can or should pay-for-performance concepts be incorporated in the bundled payment demonstration?

The Composite Rate Past, Present & Future

- Evolution of composite rate
- 2005 changes to composite rate
- Improving the payment system

Evolution of composite rate

- Payment for facility services
  - Costs of dialysis (both PD and HD)
  - Costs of certain drugs and laboratory tests
- Separately billable services
  - EPO and other injectable drugs
  - Other services
- Issues / problems
  - Updating (or lack thereof)
  - Growth of separately billable costs

2005 changes to composite rate

- Revision of composite rate payment amount
  - Increase in composite rate payments
  - Revised payment for separately billable drugs & biologicals
- Introduction of case mix adjustment
  - Applies only to composite rate services
  - Limited number of patient characteristics
    - Age – 6 age groupings
    - Body size measurements
      - Low Body Mass Index (BMI)
      - Body Surface Area (BSA)
  - Future refinements to case mix adjustment
    - Comorbidities

Improving the payment system

- Issues with the composite rate
- Payment system reform
  - Report to Congress in October 2005
  - Coordination with bundled payment demonstration

Vision / Overview of Bundled Payment

- Vision / goals for payment system
- Quality / performance incentives
- Data preview

Goals for Bundled Payment

- In general:
  - Create incentives to improve quality & efficiency
  - Role of process and outcome in payment
- More specifically:
  - Incentives to improve clinical management
    - Choice of dialysis modality / frequency
    - Management of complications / co-morbidities
  - Incentives to improve efficiency
    - Choice of how best to meet needs for dialysis
    - Reduce fragmentation of care / lack of coordination
  - Incentives to treat patients with greatest needs

Quality / P4P Incentives

- Quality issues / opportunities
  - Vascular access
  - Diabetic care
  - Cardiovascular disease
  - Anemia
- Quality / performance incentives
  - Withhold approaches
  - Payment adjustment approaches
- Primary focus of future meeting

Payment System Design Issues

- Scope of payment
- Facility responsibilities
- Unit of payment
- Case mix adjustment
- Input price adjustment
- ‘Outlier’ / special circumstance adjustments
- Price updating — including new technology
- Pay-for-performance / quality incentives

Data Preview

- Data sources and issues
- Overview of the data
  - Trends in Medicare payments
  - What Medicare pays for
    - Composition of facility payments
    - Drugs & biological products
    - Laboratory tests
  - Who receives Medicare payments

Data sources

- Medicare claims, Jul 2000 - Dec 2003
  - Outpatient renal dialysis facilities (type 72 claims)
  - Independent laboratories, suppliers, physician offices (carrier claims)
  - Other institutions (inpatient, outpatient hospital, SNF, hospice claims)
- CMS / REBUS / REMIS Database
  - ESRD Patient identification
  - Medical Evidence Form (CMS 2728)
  - Death Notification Form (CMS 2746)
  - Annual Facility Survey (CMS 2744)
- SIMS
  - Tracking of non-Medicare patients by ESRD Networks
- Medicare Dialysis Facility Cost Reports, 2000-03
- Other secondary data sources

Dialysis Patient Services

- Type of service
  - Type of dialysis
  - SB injectable drugs (HCPCS)
  - SB laboratory tests (HCPCS)
  - Other
- Utilization
  - Number of dialysis sessions
  - Medicare payments / allowed charges
  - Dose of SB injectable drugs
  - Frequency of SB lab tests
  - Dialysis facility costs (cost reports)
- Type of provider
  - Dialysis facilities
  - Laboratories
    - Independent
    - Outpatient hospital
  - Hospitals
    - Outpatient department
    - ER
  - Other institutions
    - SNF
    - Hospice
  - Suppliers
  - Physicians (UPIN)
    - Dialysis
    - Non-dialysis

Patient Characteristics / Events

- Patient demographics
  - Age, sex, race, ethnicity, duration of ESRD (2728 Form)
- Patient comorbidity
  - At start of RRT (2728 Form)
  - Longitudinal (ICD-9 diagnoses from claims)
- Patient body size
  - Height and weight (➔ BSA, BMI, TBW) at start of RRT (2728 Form)
- Treatment indicators and patient outcomes
  - URR and HCT (dialysis claims)
  - Hospitalization (inpatient claims)
  - Mortality (2746 Form, SSDMF)
  - Not yet available: Clinical performance data from ESRD Networks

Key Challenges / Limitations

- Difficult to determine which services billed by other providers are related to dialysis (e.g., laboratory tests)
- Vascular access services
  - Difficult to identify
  - Non-specific ICD-9 codes
  - Payment reflects other PPS (e.g., inpatient)
- Patient-specific data
  - Payment data only
  - Cost data not available

General notes on data sources

- 'Payments' refers to maximum allowable costs or charges (MAC) including patient cost sharing obligations.
- Payments to dialysis facilities are based on claims with 0 to 20 dialysis sessions.
- Payments for laboratory tests
  - Some tables include only tests billed by facilities.
  - Other tables include tests billed by independent or hospital labs.
  - Independent laboratories include those 'affiliated' with facilities.
- The 'top 50' laboratory tests were identified using methods that will be discussed in the section on scope of payment.
- The definition of clinical categories for laboratory tests will be discussed in the section on scope of payment.
- Payments assigned to the 'other' category include only services billed by dialysis facilities.

Notes on Terminology

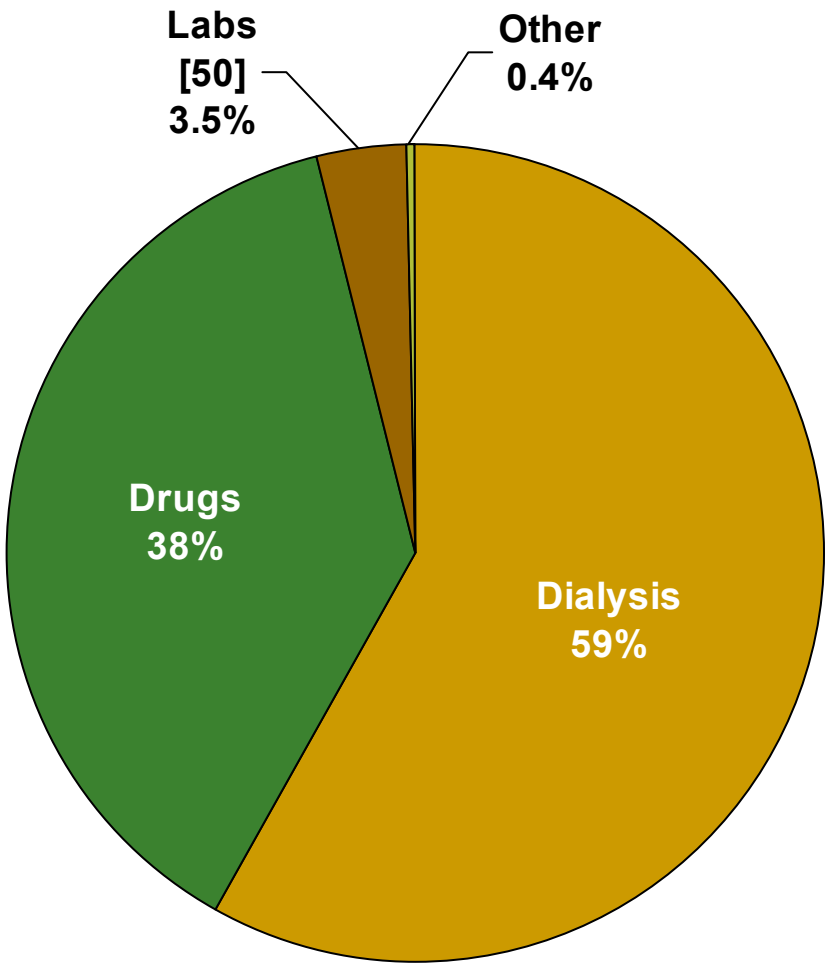
- **MAC**: Maximum ‘allowable’ charge or cost — the maximum Medicare ‘payment’ to the facility including beneficiary cost-sharing

Facility MAC: 2000—2003*

Counts	2001	2002	2003
Patients	244,404	258,482	264,161
Unique Facilities	3,990	4,183	4,312
Sessions (thousands)	26,569	28,328	29,704
Total MAC (in millions)			
Composite rate	$ 3,473	$ 3,703	$ 3,880
EPO	$ 1,466	$ 1,625	$ 1,776
Iron	$ 254	$ 304	$ 339
VitD	$ 385	$ 476	$ 488
Other drugs	$ 91	$ 97	$ 78
Lab	$ 19	$ 20	$ 20
All Other	$ 20	$ 22	$ 26
Total	$ 5,697	$ 6,234	$ 6,595

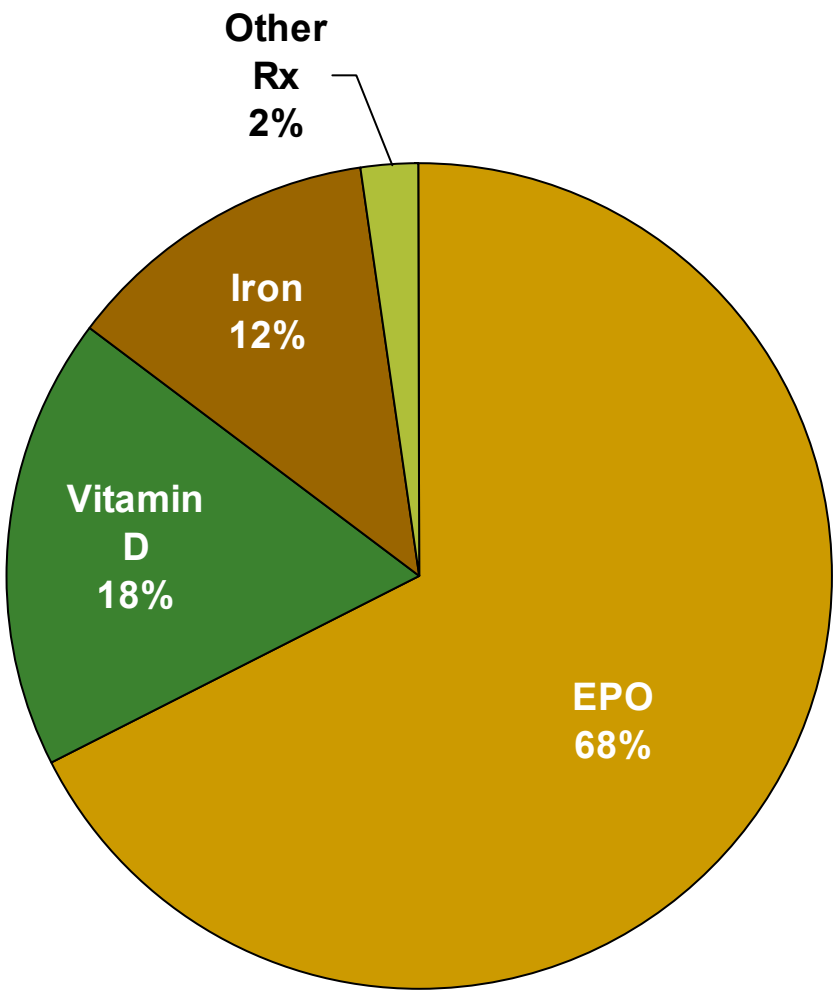
* Dollar amounts (MAC) include patient cost-sharing obligations. Applies to hemodialysis only.

What Medicare pays for: 2003



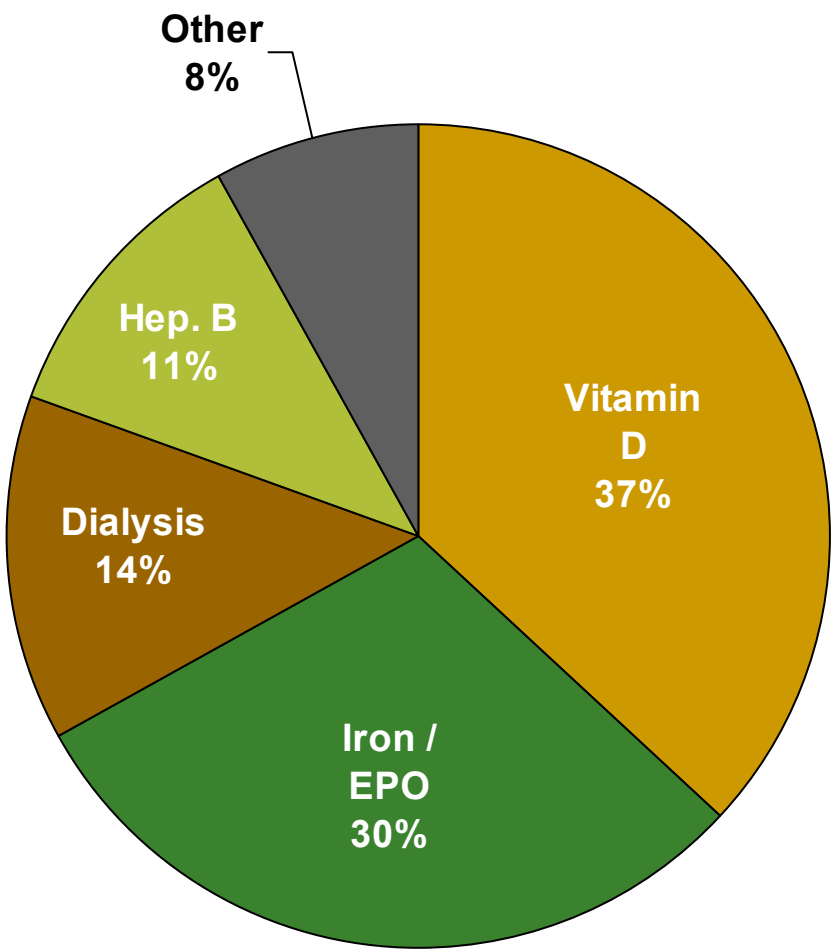
- MAC includes:
  - Facility costs
  - Payments for laboratory services
- MAC does not include:
  - Non-facility MAC other than lab tests
    - Surgical services
    - Imaging
    - etc.
  - Inpatient services
  - Physician / professional services

What kind of drugs? 2003



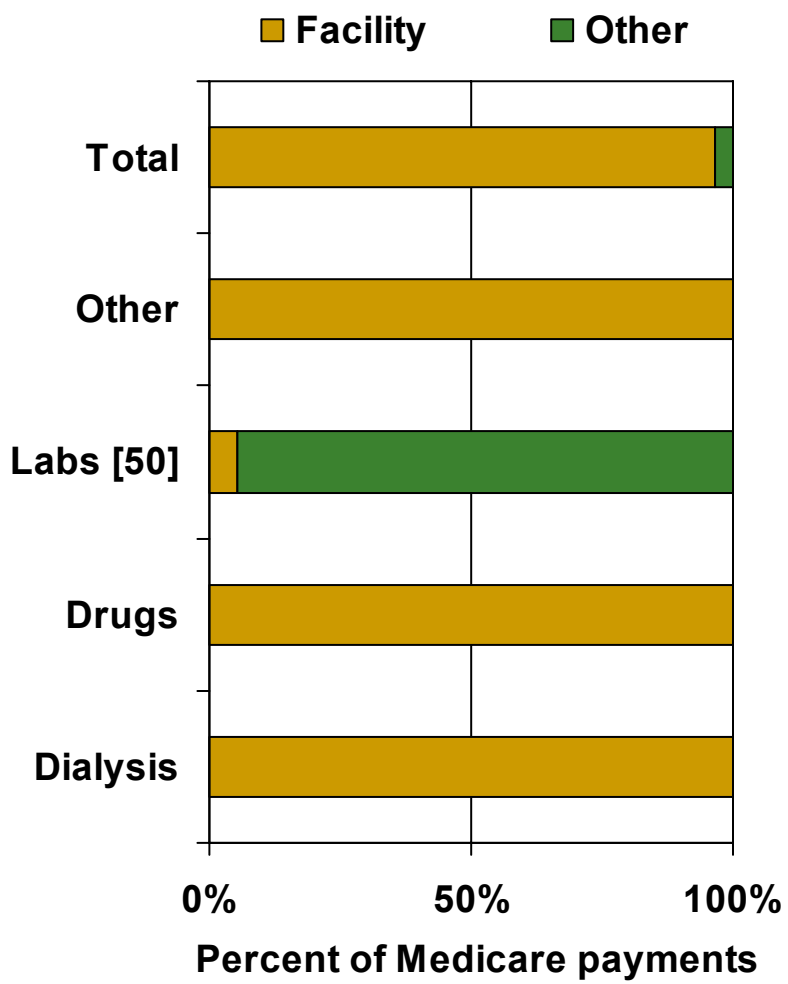
- MAC for injectable drugs / biologicals includes:
  - Facility MAC
  - Supplier MAC
- EPO, 'vitamin D', and iron account for 98% of MAC to dialysis facilities for selected drugs and biologicals

What kind of lab tests? 2003



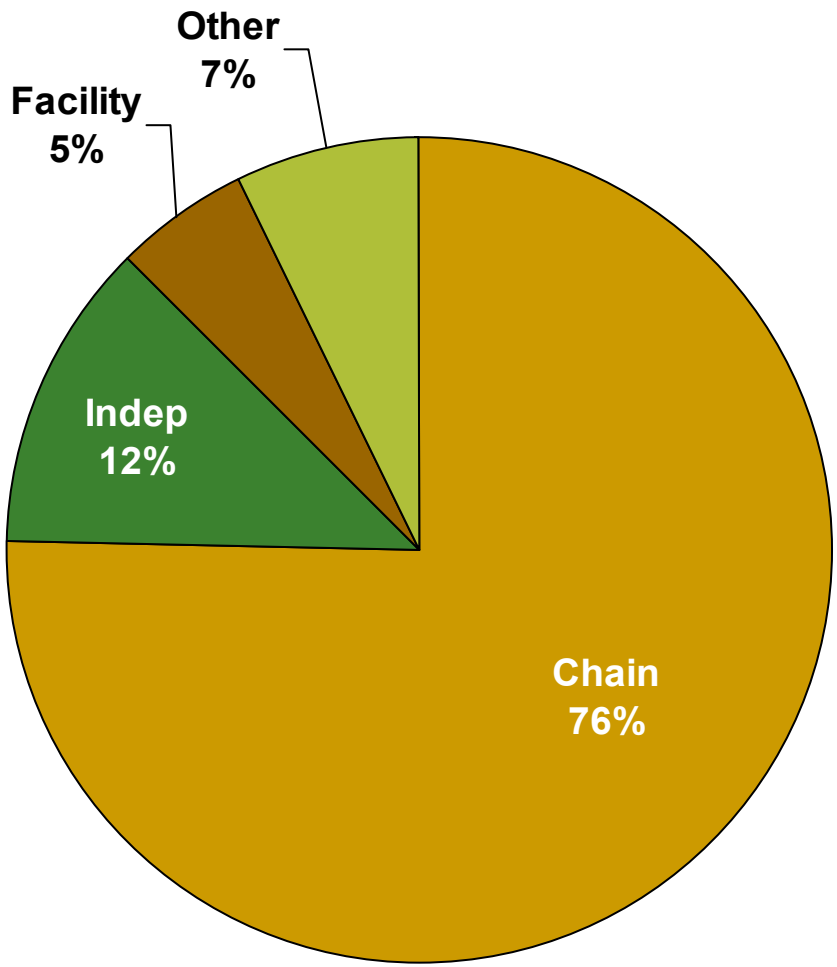
- MAC includes:
  - Facility MAC
  - 'Independent' lab MAC (including labs owned by related organizations)
- Tests associated with conditions such as diabetes account for 8% of MAC for laboratory tests
- Method of associating tests with conditions will be discussed in scope of payment section

Who Medicare Paid: 2003



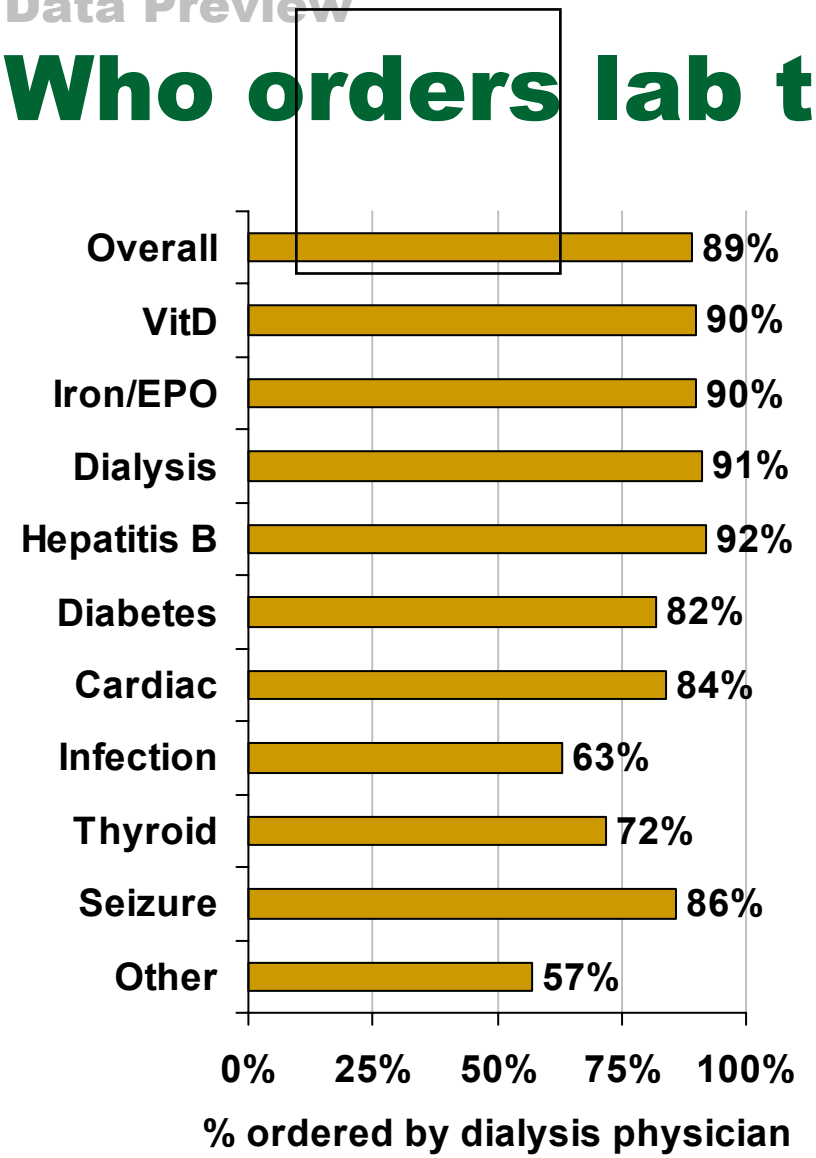
- Facilities receive 98% of MAC for dialysis patients
- Laboratory tests account for most of the MAC not made to dialysis facilities
- Note: Does not include MAC for—
  - Physician services
  - Inpatient hospital care
- Note: Related laboratories are classified by Medicare as ‘independent’

Who provides lab tests? 2003



- Preliminary estimates
  - 88% of the ‘top 50’ tests are from ‘supplier’ labs
    - 85% of these tests are from chain laboratories
    - 76% of the ‘top 50’ tests are from chain labs
  - Note: the ‘chain’ labs’ share of all labs is roughly proportionate to chains’ share of all facilities

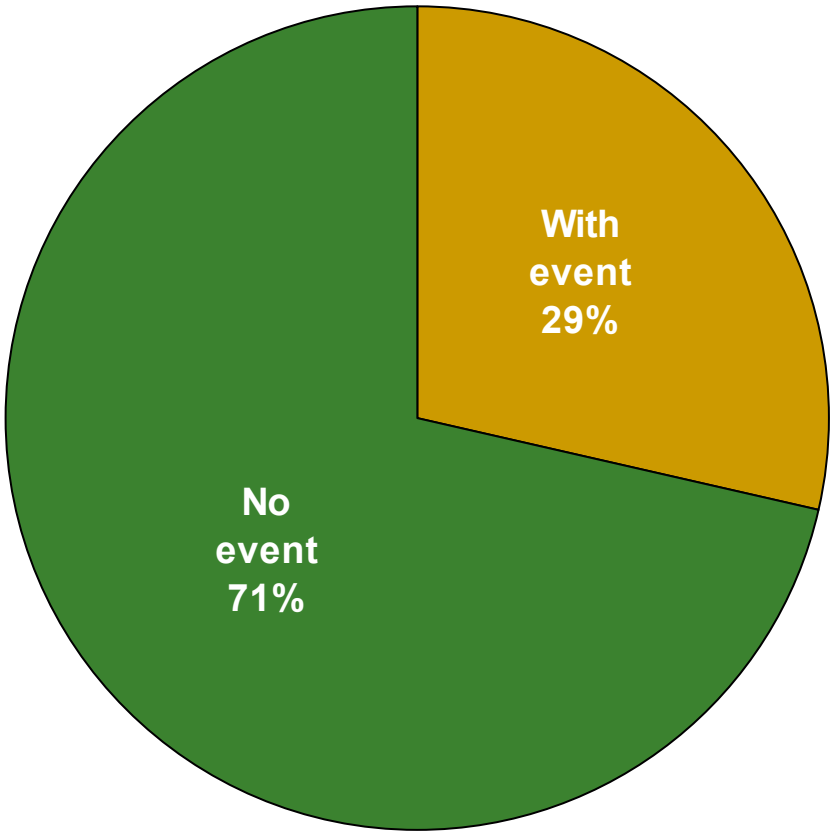
Who orders lab tests? 2003



- Figure shows only ‘top 50’ tests billed by ‘independent’ laboratories
- Most of the ‘top 50’ tests provided to dialysis patients are ordered by the ‘MCP practitioner’
- Dialysis-related tests are more likely to be ordered by the ‘MCP practitioner’
- Raises the questions: who orders remaining tests, when, and why?

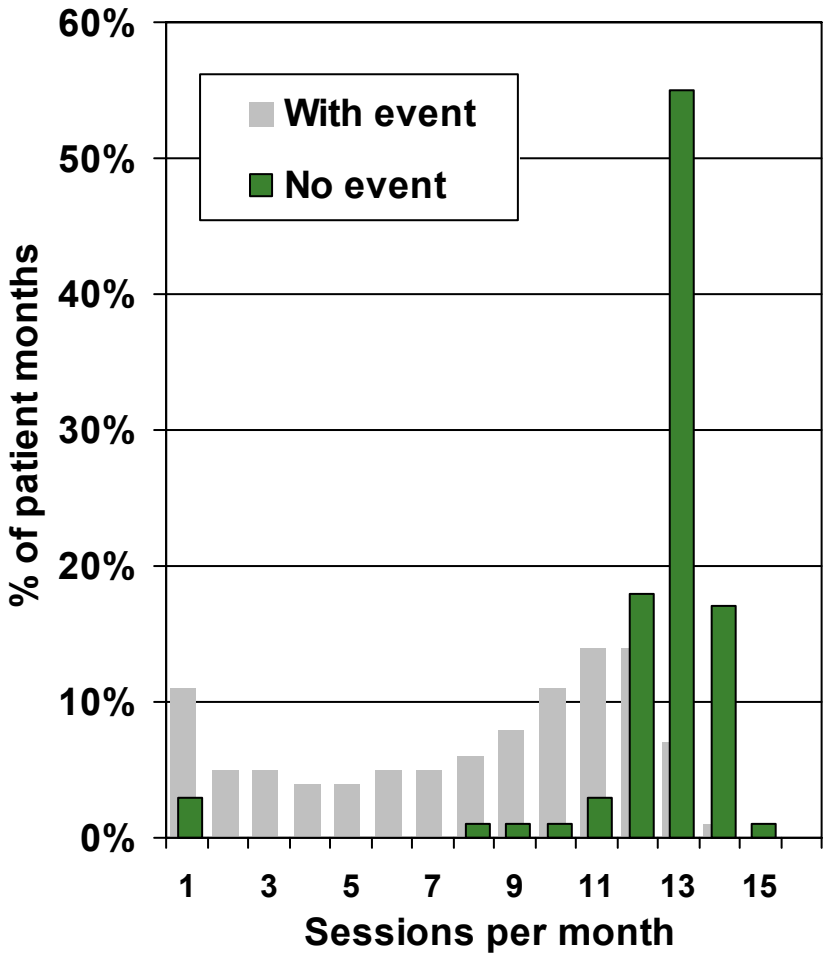
Data Preview

Patterns of Utilization



- Nearly 3 out of 10 months appear to involve an event that may interrupt a ‘full’ month of dialysis
- Leading causes of interruption include:
  - Hospitalization
  - Start-up
  - Death

Frequency of Dialysis



- Typical utilization
  - 12 to 14 sessions: 79%
  - <12 sessions: 20%
- Population
  - CY 2003
  - 2.8 million patient months
- Leading correlates of fewer than 12 sessions
  - Hospitalization
  - Start-up
  - Death

Overview of Payment System Design Issues

Payment System Design Issues

- Scope of payment
- Facility responsibilities
- Unit of payment
- Case mix adjustment
- Input price adjustment
- 'Outlier' / special circumstance adjustments
- Price updating — including new technology
- Pay-for-performance / quality incentives

Payment System Design: Scope of Payment

- Issue definition / goals
- Potential / illustrative options
- Pertinent / related data
- Discussion

Issue Definition / Goal

- What services /costs should the expanded bundled payment pay for?
- Summary of member perspectives:
  - Should provide flexibility for treatment
  - Encourage service coordination / integration
  - Consistency with clinical guidelines / consensus
  - Clear statement of what's in bundle – and what's not
  - Include services that are commonly furnished
  - Simplification of administrative requirements
  - Avoid possible incentives to reduce care (need quality measures)
  - Impact on access to care for all patients
  - Provision for 'outlier' patients
  - Ability to collect / obtain needed data
  - Are the data we have up to the task?
  - Can case mix measures explain enough variation?

Potential / Illustrative Options

- Drugs & drug-related lab tests
- Drugs & dialysis-related laboratory tests
- Drugs & all laboratory tests
- All ‘routine’ services related to dialysis
- All related services including vascular access

Pertinent Data

- Payments for dialysis patients
  - Composite rate payments
  - Separately billable items / services
    - Injectable drugs
    - Laboratory tests
    - Other
  - Outside suppliers / providers
- 'Related' laboratory tests

Drugs Bundled in Composite Rate

- Anti-arrythmics
- Antibiotics (under certain conditions)
- Antihistamines
- Antihypertensives
- Apresoline (hydralazine)
- Benadryl
- Dextrose
- Dopamine
- Glucose
- Heparin
- Heparin antidotes
- Hydralazine
- Inderal
- Insulin
- Lanoxin
- Levophed
- Lidocaine
- Local anesthetics
- Mannitol
- Pressor drugs
- Protamine
- Saline
- Solu-cortef
- Verapamil

Source: CMS Pub. 100-2, Chapter 11, §30.4.1

Tests Bundled in Composite Rate

- Per Month
  - Alkaline Phosphatase
  - AST
  - Complete Blood Count
  - Lactic Dehydrogenase
  - Serum Albumin
  - Serum Bicarbonate
  - Serum Calcium
  - Serum Chloride
  - Serum Glutaminic Oxaloacetic
  - Serum Phosphorus
  - Serum Potassium
  - Total Protein
  - CO2*
  - Dialysis Protein*
  - Magnesium*
  - Sodium*
- Per session
  - Clotting Time
  - Hematocrit (HCT)
  - Hemoglobin (HGB)
- Per week
  - Blood Urea Nitrogen (BUN)
  - Prothrombin
  - Serum Creatinine

Source: CMS Pub. 100-2, Chapter 11, §30.2

* CAPD

Medicare MAC: 2003*

Type of service		MAC (millions)*	% of Total
Outpatient dialysis and other composite rate services	$	4,176.2	57.8%
Drugs and biologics [1]	$	2,768.2	38.3%
EPO	$	1,857.5	25.7%
Vitamin D	$	489.6	6.8%
Iron	$	344.4	4.8%
Other injectables [2]	$	76.7	1.1%
Laboratory tests ("top 50") [3]	$	249.5	3.5%
Supplies and other services [4]	$	26.6	0.4%
Total	$	7,220.5	100.0%

* MAC includes full patient co-pay. Facility MAC based on claims with 0-20 sessions.
[1] Includes claims submitted by facilities, hospitals, laboratories and other providers.
[2] Includes 11 injectables comprising 90% of 'other' MAC for injectables on facility bills.
[3] The method used to identify 'top 50' tests will be discussed elsewhere.
[4] Includes services billed by dialysis facilities only.

Injectable Drugs: 2003

Category	MAC (millions)*	% of Total
EPO	$1,856.88	67.0%
Vitamin D	$489.62	17.7%
Iron	$342.65	12.4%
Levocarnitine	$21.33	0.8%
Hepatitis B vaccine	$20.33	0.7%
Alteplase recombinant	$18.79	0.7%
Vancomycin HCl	$5.74	0.2%
Flu Vaccine	$1.50	0.1%
Cefazolin sodium	$1.04	0.0%
Darbepoetin alfa	$0.93	0.0%
Ceftriaxone sodium	$0.92	0.0%
Ceftazidime	$0.91	0.0%
Heparin sodium	$0.72	0.0%
Filgrastim	$0.64	0.0%
Other	$7.47	0.3%
Total	$2,769.46	100.0%

*** From claims submitted by facilities only.**
MAC includes beneficiary cost-sharing.

- Only injectables billed by dialysis facilities
- MAC includes patient cost sharing obligations

Dialysis-related Lab Tests

- Which services?
- Which providers?
- Ordered by dialysis physician? (UPIN)

Dialysis-related Lab Tests

- Identified top 10 laboratory providers based on total MAC submitted for dialysis patients
- Identified top 50 lab services from these providers by MAC amount (98.5% of MAC submitted by these providers)
- MAC amounts for these lab services were summarized for all laboratory providers (12,365)
- Lab services were categorized into clinical groups

Who provides lab tests? 2003

Type of provider / claim		MAC (millions)	%
Freestanding laboratory providers (carrier claims)	$	218.670	87.6
Institutional providers	$	30.982	12.4
13 Hospital-outpatient (HHA-A also)	$	9.899	4.0
72 Clinic-hospital based or independent renal dialysis facility	$	13.045	5.2
14 Hospital-other (Part B)	$	6.120	2.5
12 Hospital-inpatient or home health visits (Part B only)	$	1.290	0.5
85 Special facility or ASC surgery-rural primary care hospital	$	0.467	0.2
22 SNF-inpatient or home health visits (Part B only)	$	0.084	0.0
83 Special facility or ASC surgery-ambulatory surgical center	$	0.036	0.0
23 SNF-outpatient (HHA-A also)	$	0.040	0.0
Total	$	249.653	100.0

MAC includes patient cost-sharing obligations.

More

Top 10 Lab Tests

HCPCS	Title	Frequency	Medicare MAC Millions of $	Medicare MAC % of Total
83970	ASSAY OF PARATHORMONE	1,259,217	$ 72.1	40%
82728	ASSAY OF FERRITIN	1,120,274	$ 20.1	11%
87340	HEPATITIS B SURFACE AG, EIA	1,544,911	$ 19.5	11%
83550	IRON BINDING TEST	1,594,511	$ 16.6	9%
83540	ASSAY OF IRON	1,842,528	$ 16.1	9%
82108	ASSAY OF ALUMINUM	446,508	$ 15.3	8%
84466	ASSAY OF TRANSFERRIN	479,556	$ 6.5	4%
86706	HEP B SURFACE ANTIBODY	376,697	$ 5.1	3%
83036	GLYCATED HEMOGLOBIN TEST	402,861	$ 4.9	3%
86803	HEPATITIS C AB TEST	217,865	$ 3.9	2%

MAC includes patient cost-sharing obligations.

Discussion

- What data would help inform the choice of a scope of services to include in the bundle?
- What factors / considerations should limit the extent to which the bundle is expanded?

Payment System Design: Facility Responsibilities

- Issue definition / goals
- Potential / illustrative options
- Pertinent / related data
- Discussion

Issue Definition / Goals

- What services provided / ordered by other entities will the facility be responsible for?
- Summary of member perspectives
  - Need to understand who is providing what care
  - Often unclear who the dialysis provider is
  - Encourage service coordination / integration
  - Consider the ability of facilities to coordinate care
  - Increase alignment of incentives across providers
  - Promote patient-centered care
  - Hold all stakeholders accountable
  - Impact on smaller and independent facilities

Potential / Illustrative Options

- Services specified under plan of care
- Services ordered by MCP practitioner
- List of services / HCPCS codes
  - Inclusive list (any services on list)
  - Exclusive list (any not on list)
  - Use of modifiers to identify exceptional situations

Pertinent Data

- Services provided to dialysis patients
  - By ESRD facility
  - By outside suppliers
- Sources of laboratory tests
  - Related to injectable drugs
  - Related to dialysis
  - Other laboratory tests
- Use of multiple facilities by single patient

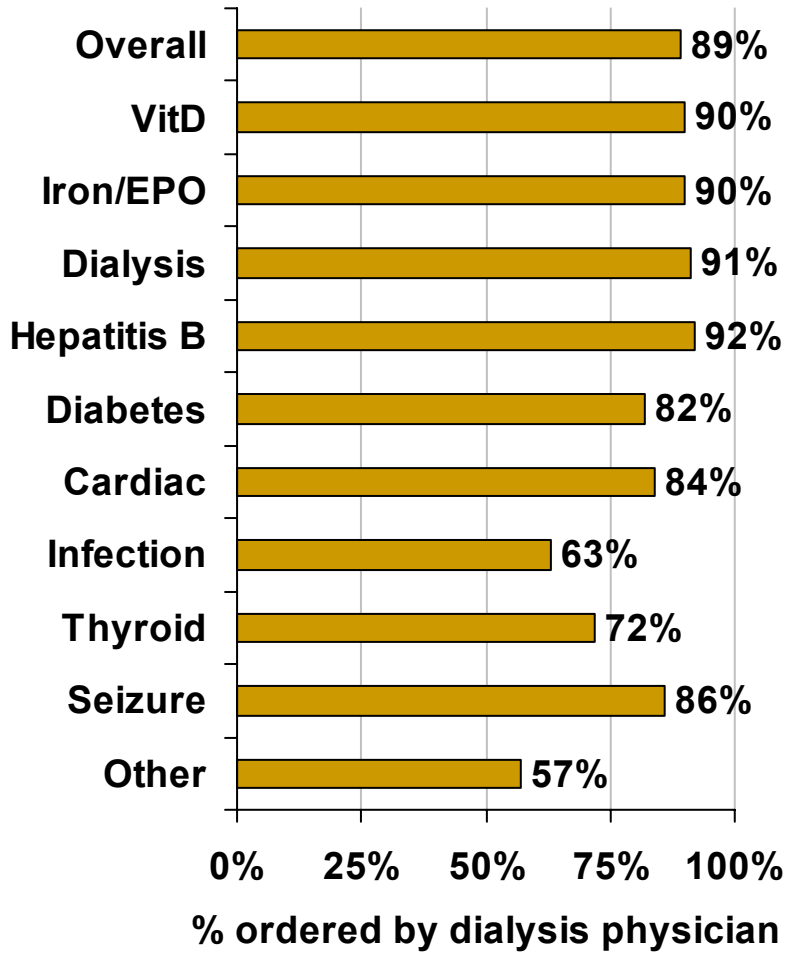
Who Medicare Pays: 2003

Type of service	MAC (in millions) Total	Facility	Other	Facility %
Outpatient dialysis & other CR services	$ 4,176.2	$ 4,176.2	$ -	100.0%
Drugs and biologics[1]	$ 2,768.2	$ 2,762.0	$ 6.2	99.8%
EPO	$ 1,857.5	$ 1,856.9	$ 0.6	100.0%
Vitamin D	$ 489.6	$ 489.6	$ -	100.0%
Iron	$ 344.4	$ 342.7	$ 1.8	99.5%
Other injectables[2]	$ 76.7	$ 72.8	$ 3.9	95.0%
Laboratory tests ("top 50")	$ 249.5	$ 13.0	$ 236.5	5.2%
Drug-related tests	$ 183.2	$ 8.2	$ 175.0	4.5%
Other dialysis-related tests	$ 35.7	$ 1.4	$ 34.3	3.9%
Other "top 50" tests	$ 30.7	$ 3.4	$ 27.3	11.1%
Supplies and other services[3]	$ 26.6	$ 26.6		100.0%
All services	$ 7,220.5	$ 6,977.7	$ 242.8	96.6%

* MAC includes full patient co-pay. Facility MAC based on claims with 0-20 sessions.
[1] Includes claims submitted by facilities, hospitals, laboratories and other providers.
[2] Includes 11 injectables comprising 90% of 'other' MAC for injectables on facility bills.
[3] Includes services billed by dialysis facilities only.

More

Who orders lab tests? 2003



- Figure shows only lab tests billed by 'independent' laboratories
- Most of the 'top 50' laboratory tests provided to dialysis patients are ordered by the 'MCP practitioner'
- Dialysis-related tests are more likely to be ordered by the 'MCP practitioner'

Discussion

- What data would help inform the choice of a scope of services to include in the bundle?
- What factors / considerations should limit the extension of facility responsibilities?

Payment System Design: Unit of Payment

- Issue definition / goals
- Potential / illustrative options
- Pertinent / related data
- Discussion

Issue Definition / Goals

- What time span is to be covered by the bundled payment?
- Summary of member perspectives:
  - Increase flexibility for clinical management
  - Reward value / performance
  - Match case mix adjustment to unit of payment
  - Reduce administrative costs / overhead
  - Promote patient-centered focus
  - Limit risk of underservice / loss of access

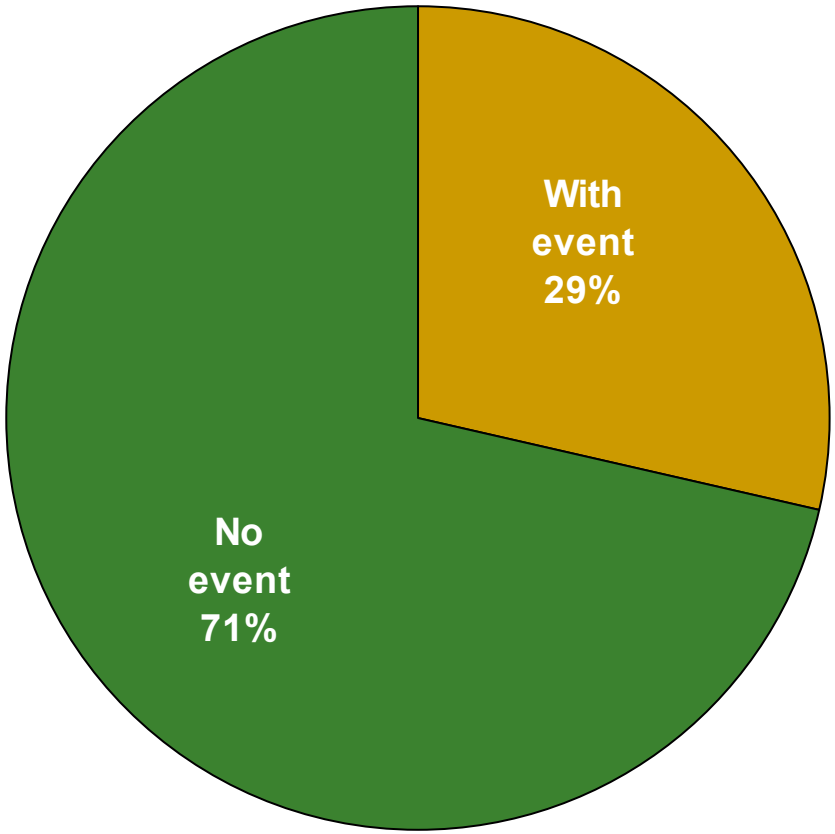
Potential / Illustrative Options

- Dialysis session / treatment (per diem)
- Month-long episode of treatment
- Week-long episode of treatment

Pertinent Data

- Frequency of dialysis / sessions
- 'Whole' and 'partial/interrupted' months
  - Impact on frequency of dialysis / sessions
  - Impact on separately billable service payments

Whole / Partial Months



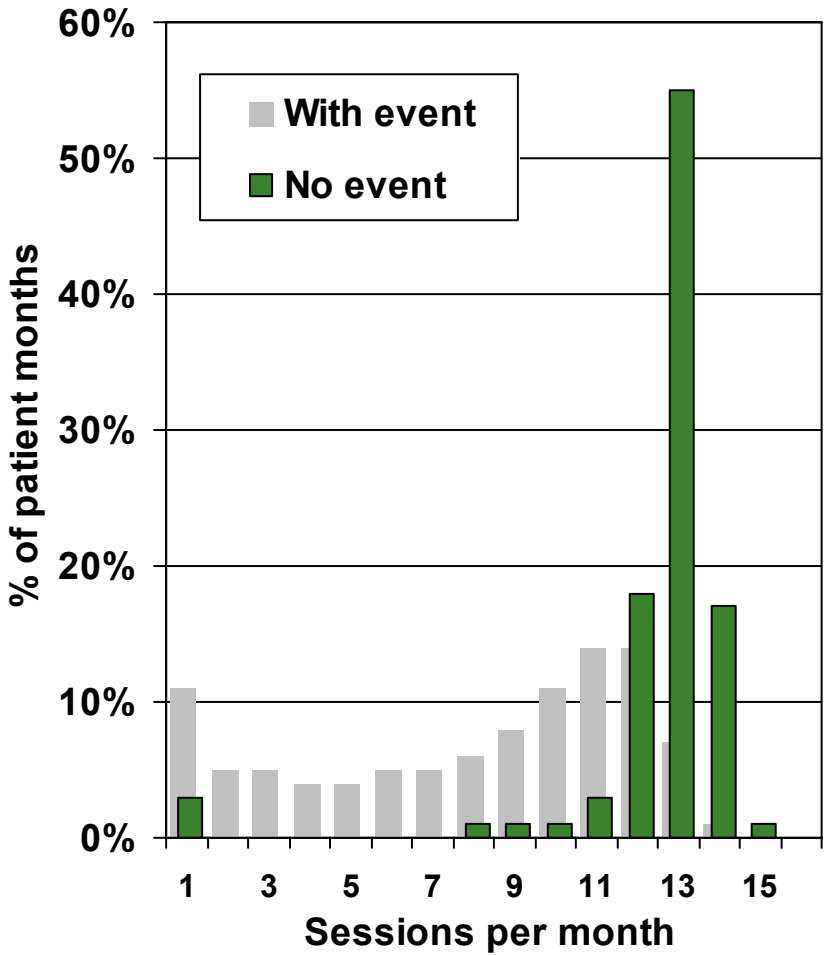
- Includes both HD & PD
- Nearly 3 out of 10 months appear to involve an event that may interrupt a 'full' month of dialysis
- Partial month causes:
  - Hospitalization
  - Start-up
  - Death / withdrawal

Whole / Partial Months

Events during the month	% of patient-months	Sessions per month	Separately Billed MAC* Per month	Separately Billed MAC* Per session
No Event				
Full month-HD	66.9%	13.0	$905	$69
Full month-PD	4.4%	13.2	$313	$24
With Event				
Hospitalization only	14.5%	9.4	$880	$93
Unexplained partial month	7.7%	6.6	$906	$136
Transfer between facilities only	3.0%	6.2	$432	$70
Death/Withdraw (w. or w/o hosp.)	1.3%	5.1	$485	$95
Starting dialysis (w. or w/o hosp.)	0.9%	5.4	$470	$88
Transplant (w. or w/o hosp.)	0.2%	6.2	$403	$65
Training sessions only	0.2%	10.9	$486	$44
Switch dialysis modality only	0.1%	12.8	$815	$63
Multiple events	1.0%	5.2	$436	$84
Overall	100.0%	11.3	$830	$73

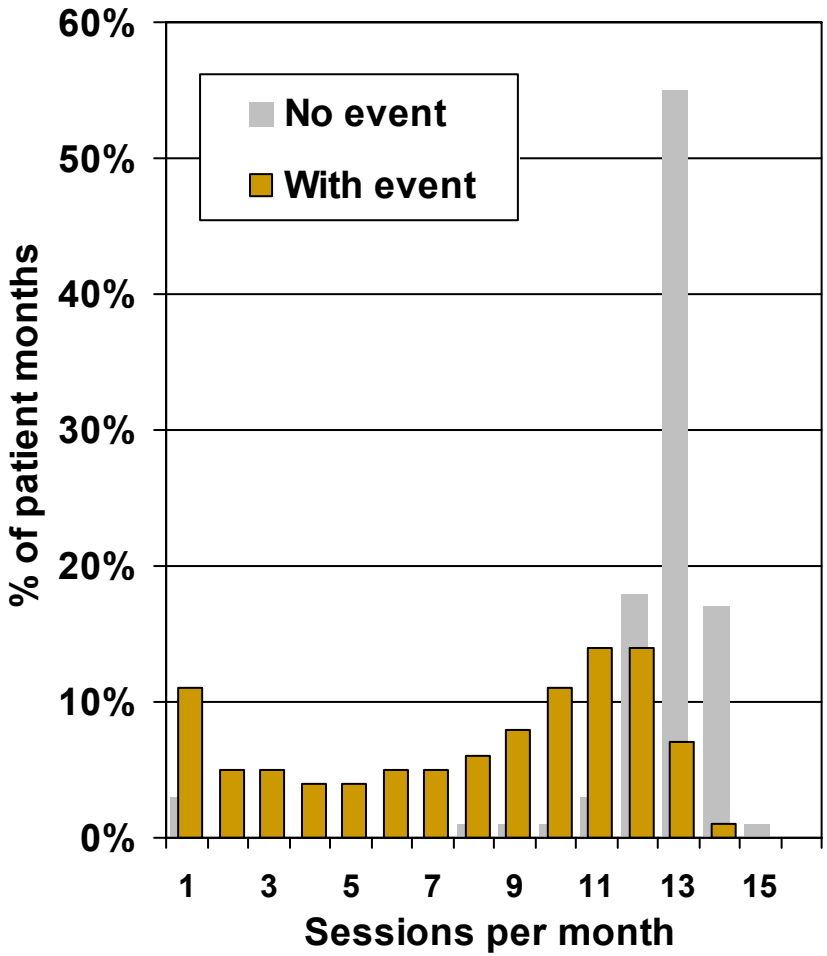
* Includes MAC to dialysis facilities only.

Frequency of Dialysis



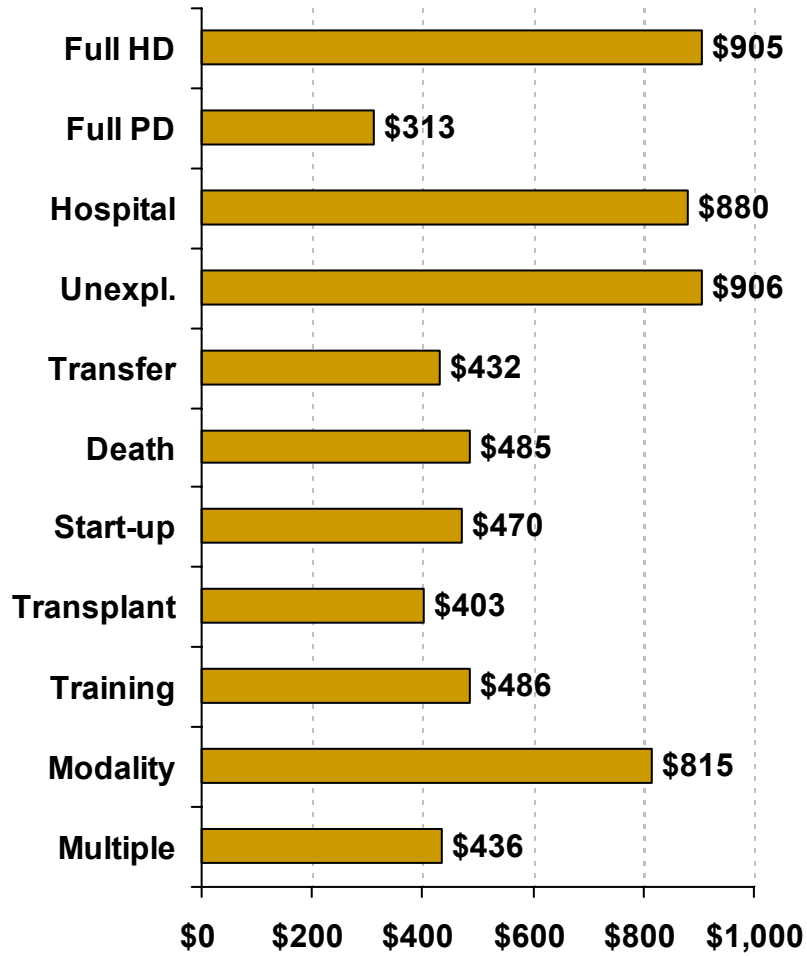
- Typical utilization
  - 12 to 14 sessions: 79%
  - <12 sessions: 20%
- Population
  - CY 2003
  - 2.8 million patient months
- Leading correlates of fewer than 12 sessions
  - Hospitalization
  - Start-up
  - Death

Sessions per Month: With Event



- Wide variation
  - 12+ sessions: 22%
  - 10 to 11 sessions: 25%
  - 7 to 9 sessions: 19%
  - 4 to 6 sessions: 13%
  - 0 to 3 sessions: 21%

SB Payments / Month



- MAC for facility claims only
- Full month PD about ⅓ of full month HD
- Similar to Full HD:
  - Hospitalization months
  - Unexplained
  - Modality switch
- About ½ of full HD:
  - Facility transfer
  - Death / withdraw
  - Start-up
  - Training

Discussion

- What data would help inform the choice of a unit of payment?
- How might the down-side risks of expanding the unit of payment be mitigated?

Payment System Design: Case Mix Adjustment

- Issue definition / goals
- Major questions / issues
- Pertinent / related data
- Discussion

Issue Definition / Goals

- How should payments be adjusted to reflect patient needs?
- Summary of member perspectives:
  - [To be completed based on morning discussion]
  -
  -
  -

Major Questions / Issues

- What kind of factors should affect payment?
- How do data limitations affect case mix adjustment?
- How should the effectiveness / adequacy of case mix adjustment be evaluated?

Available Data Sources

- Hospital Cost Report data – as indicators of Composite Rate costs
- Patient level billing data – as indicators of
  - Utilization of separately billable services
  - Medicare allowable charges for separately billable services
- Patient level billing and other records – as indicators of:
  - Outcomes of treatment
  - Patient risk factors, comorbidities

Discussion

- What data would help evaluate approaches to case mix adjustment?
- How should the validity and effectiveness of case mix adjustment be evaluated?

Public Comment

Next Steps / Wrap-up

- Meeting 2 agenda topics
- Meeting 3 agenda topics

Meeting 2 Agenda Topics

- Review / revisit meeting 1 issues
  - Scope of payment
  - Facility responsibilities
  - Unit of payment
- Case mix adjustment
- Other price adjustments
- ‘Outlier’ / special circumstance adjustments
- Quality incentives / pay-for-performance

Meeting 3 Agenda Topics

- Review payment system design
- Price updating — including new technology
- Review demonstration design / plan
- Quality incentives / pay-for-performance