Advisory Board on the Demonstration of a Bundled Case-Mix Adjusted Payment System for End-Stage Renal Disease Services

Minutes
February 13, 2005

The first meeting of the Advisory Board on the Demonstration of a Bundled Case-Mix Adjusted Payment System for End-Stage Renal Disease Services (ESRD Advisory Board) was held on February 13, 2005 at the Hyatt Regency Hotel at 300 Light Street in Baltimore, MD.

The meeting opened with remarks from Linda Magno, Director of the Medicare Demonstrations Program Group, which is part of the Office of Research, Development, and Information at the Centers for Medicare and Medicaid Services (CMS) in Woodlawn, MD. Ms. Magno is also the Executive Officer of the ESRD Advisory Board.

Brief background information was provided to the Advisory Board. The Board members, including the Co-Chairmen, were introduced. The members are: Dr. Robert Rubin (Co-Chair), Brady Augustine (Co-Chair), Dr. John Burkart, Thomas Cantor, Paula Cuellar, Dr. Paul Eggers, Bonnie Greenspan, Dr. J. Michael Lazarus, Dr. William Owen, Nancy Ray, Kris Robinson, and Dr. Jay Wish. Contract staff from the University of Michigan were also introduced. They included: Dr. Robert Wolf, Dr. Richard Hirth, Dr. Mark Turenne, and Dr. Jack Wheeler.

Ms. Magno briefed the Advisory Board on the history of the Federal Advisory Committee Act (FACA) and the rules that Federal Advisory Committees must follow. The ESRD Advisory Board is a FACA Committee. FACA requirements include that a charter be filed, minutes be taken for each meeting, that the committee be chaired, or attended, by a federal official, that advance notice be given for public meetings, that public participation be granted, and that all minutes, reports, transcripts, and records be made available to the public. Ms. Magno noted that the ESRD Advisory Board is chartered through 2008 to cover the three year demonstration period that is mandated by the Medicare Modernization Act to begin next January, 2006.

Christine Barnett, from the CMS Ethics Office, was then introduced. She stated that all Board members had received and viewed the ethics training video. She distributed a summary of conflict of interest laws as they apply to the special government employees. She advised that the Special Government Employees are: Dr. Robert Rubin, Thomas Cantor, Bonnie Greenspan, Dr. William Owen, and Dr. Jay Wish.

Brady Augustine offered welcoming remarks and discussed administrative issues, such as how to send an e-mail to the advisory board (esrdadvisoryboard@cms.hhs.gov). He also reviewed the agenda for the day. Mr. Augustine then discussed the legislation that mandated the Advisory Board and the demonstration to test a bundled case-mix adjusted payment system (Medicare Modernization Act, Section 623e) and he discussed the charter for the Advisory Board.

Ms. Magno then discussed the immediate project timeline that concludes with the 2006 implementation date. To accomplish this, two more meetings of the ESRD Advisory Board will be held before the end of June 2005. Recommendations from the ESRD Advisory Board will be used to finalize a solicitation and the solicitation will then begin to work its way through the CMS and HHS clearance process.

Teresa Rudisill, from the CMS Baltimore Human Resources Center, then swore in the five Special Government Employees.

Each Advisory Board member was then asked to give a five minute statement summarizing their professional background and outlining their perspectives on the issue of bundled payment.

The member perspectives began with Dr. Robert Rubin, Co-Chair of the Advisory Board. Dr. Rubin summarized his background: a nephrologist, currently at Georgetown University School of Medicine, a consultant, and from 1981 – 1984 he was the Assistant Secretary for Planning and Evaluation at HHS and in that capacity, he was Chair of the Intra and Interdepartmental groups that were involved in constructing the second prospective payment system for the department (the first being the composite rate for ESRD, the second being the inpatient hospital prospective payment system). Some principles that he thought would be constructive to think about would be to reward efficient providers and to ensure that all providers feel that the playing field is level. He also stated that he feels that it is important that any prospective payment system require a random distribution of patients as well as underlying diagnoses.

Kris Robinson, the Executive Director of the American Association of Kidney Patients then spoke. She is a patient of almost nineteen years with a living-related kidney transplant. She began by stating that the patients today starting on Social Security Disability have a life expectancy of less than 5 years. Her hope is that any innovation, whether it's restructuring of payment or clinical outcomes, will take into consideration how it can increase life expectancy for patients. She also hopes that the project will provide critically needed data about the value of an expanded bundle of services. She also noted that the best case scenario would be for the new bundled payment options to give dialysis facilities more flexibility to provide care for patients.

Thomas Cantor, President and Owner of Scantibodies Laboratory, spoke of his background as a biochemist and businessman. He spoke of his concern that the new demonstration focus on measures of quality improvement as they relate to lab values. He would also like to see some type of patient satisfaction measure be included as part of the demonstration.

Dr. John Burkart is a nephrologist with the Wake Forest University Medical Center. He spoke of hoping for a bundled payment project which would improve patient outcomes. He hopes that the new bundled system will allow for patient choice, home therapies, some of the new developments that individual patients may need, even though they may

be more costly, whether it be in home or in center, and allow for new technology development.

Dr. William Owen, Adjunct Professor of Medicine, Duke University School of Medicine, spoke of the goals of an expanded bundle, which he feels should include: better service coordination between providers, a strategy to serve without the distraction of clerical tasks, a way of offering greater autonomy in the ability to care for patients, fewer overhead expenses, and a potential strategy to drive greater scientific and therapeutic innovation.

Dr. Jay Wish, President of ESRD Networks 9 and 10, spoke of a hope that a properly designed bundle would increase system efficiency without sacrificing equitability. He spoke of the three key factors that the bundle should include, which he believes are: a sound case-mix adjustment methodology, features that support patient-centeredness by providing resources for education and rehabilitation for patients at risk for non-adherence, and an alignment of incentives between all providers, physicians, and facilities with possible rewards for Medicare Part B from funds in savings from Part A.

Bonnie Greenspan, a dialysis nurse and healthcare consultant, was nominated by the American Association of Nephrology Nurses. She spoke of the key factors that she believes the bundle should include, which are: that it be straightforward, understandable, sustainable, and outcome sensitive. She feels that the bundle should avoid financial reward for poor care, limit distraction, and have a reasonable way to judge performance level.

Dr. Paul Eggers, Program Director for Kidney and Urology Epidemiology at the National Institute of Diabetes and Digestive and Kidney Diseases (National Institutes of Health) spoke of a bundled payment that falls in the middle of full fee-for-service and full capitation. He stated that there are downsides to case-mix adjustment, one of which is that it lends itself to a certain amount of gaming on the system.

Paula Cuellar is a nurse and Care Center Director for Dialysis at the University of Chicago. She spoke of a hope that there is an assurance of quality at the highest level and that there be access to quality therapies for all patients and an appropriate case-mix adjustment to prevent adverse patient selection bias.

Nancy Ray, a policy staff analyst with the Medicare Payment Advisory Committee, spoke of the key features that a bundle should include, which are: preventive services and diabetic services. She also spoke of including adjusters for factors that affect a provider's cost and a belief that payment should be linked to quality.

Dr. Michael Lazarus, a nephrologist and Senior Vice President of Clinical Quality and Medical Director for Fresenius Medical Care, spoke of a belief that quality outcome measures, clinically correct case-mix adjustment, and an annual update should be included in the demonstration project.

Brady Augustine then made a few summary statements. He stated that he is not on the Advisory Board as a senior executive of the ESRD Program. He is on the Board as a member of the community. His goals are to improve the payment system, so that people get the most value for their money, that care is improved and that it is fair to providers. He added that CMS is very interested in this project to provide additional flexibility.

After a short break, Lana Price, Centers for Medicare Management at CMS, gave a brief history of the composite rate payment system in order to set the context for the rest of the day's discussions. She stated that the composite rate payment is based on a specific bundle of items and services related to dialysis treatments and represents payment for outpatient maintenance dialysis in a dialysis facility or in a patient's home. The bundle includes all patient care services in addition to actual supplies and equipment related to the dialysis process as well as specific drugs and labs. The composite rate payment system was established in 1983. Until the recent MMA provisions it has been virtually unchanged. The only adjustment to the rate is a geographic adjustment, which Ms. Price said is an outdated adjustment. Ms. Price stated that ESRD facilities are finding it more difficult to maintain profitability. Payment for separately billable drugs and services has continued to grow and currently accounts for over 40 percent of Medicare revenues to ESRD facilities. She further stated that, according to facilities, the margins on separately billables have historically subsidized shortfalls in composite rate payments. Ms. Price also described the shortcomings of the composite rate system which are:

- that the bundle is old and may not reflect current medical practices
- there is no update mechanism nor is there a mechanism for recognizing technological advances
- the current system does not give facilities the flexibility they need to provide appropriate care for its patient population

Brady Augustine then gave an overview of bundled payment . He spoke of overall demonstration goals of a payment system that would create incentives to reward efforts, improve the clinical management of patients, create incentives to treat patients with the greatest needs, create incentives to improve the efficiency with which dialysis is provided, and reward efficient facilities.

A presentation was then given by Dr. Marc Turenne, from the University of Michigan Kidney Epidemiology and Cost Center (KECC) . He briefly described the data sources that are available and the tools that the University of Michigan are using to begin to address some of the issues that have been raised regarding what an expanded bundle might look like. He also gave an overview of data to be presented later in the day. Both Co-Chairs raised the issue that it is important for the University of Michigan staff to differentiate between databases which are unique to KECC, and those which are accessible to everyone. Dr. Turenne stated that he would be careful to identify which databases belong to KECC. He then identified key characteristics of payment to dialysis facilities that should influence the recommendations for a bundled payment system.

After this presentation, the meeting was adjourned for lunch.

The next segment of the day was focused on payment system design issues. Dr. Rubin opened this segment with a list of eight elements that a bundled payment system would have to address which are: the scope of payment, the unit of payment, case-mix adjustment, input price adjustment, "outlier" / special circumstance adjustments, price updating, and pay for performance/ quality incentives. Dr. Rubin then discussed the potential options of services which could be included in the bundle. They are:

- Drugs and drug-related lab tests
- Drugs and dialysis-related lab tests
- Drugs and all lab tests
- All "routine" services related to dialysis
- All related services including vascular access

Dr. Robert Wolf from the University of Michigan, KECC then discussed the data which would help to shape the discussion of what services may be included in the bundle. He stated that the focus for most of the afternoon would be the different parts of the separately billable items. He also stated that KECC has spent a lot of time on the question of what are "related" lab tests. He listed the drugs that are currently bundled into the composite rate and then lab tests that are bundled into the composite rate. He then discussed dialysis related lab tests. The University of Michigan, KECC has identified the top ten laboratory providers and from there identified the top fifty lab tests billed by those providers.

The topic then moved to defining the facility's responsibility. Dr. Rubin introduced the topic with a list of options which include:

- Services under a plan of care
- Services ordered by an MCP
- A list of services by HCPCS codes

Dr. Richard Hirth from the University of Michigan, KECC then described the data pertinent to this topic which include: services provided to dialysis patients, sources of laboratory tests, and use of multiple facilities by a patient. This presentation was followed by a discussion by the group regarding what data would help inform the choice of a scope of services to include in the bundle and what factors/ considerations should limit the extension of facilities responsibilities.

Dr. Rubin then introduced the next topic, defining the unit of payment with a statement that the critical question is to determine what time span should be covered by the payment (i.e. is it a single dialysis session, per week, per month, etc.).

The six main points from the members' perspectives earlier in the day were summarized, they were:

- 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

Dr. Richard Hirth then presented data to help the Advisory Board think about what the length an "episode" of dialysis in a bundled payment system would cover. The data included:

- Frequency of dialysis sessions
- Whole or partial/ interrupted months

Dr. Rubin then introduced the last topic of discussion: case-mix adjustment. He summarized the perspectives on the issue that were offered by Advisory Board members earlier in the day, which was that they be clinically relevant.

Dr. Richard Hirth then presented the data relevant to this discussion which included hospital cost report data and patient level billing data. After discussion on this topic, the floor was opened for public comment.

Dick Cronin, Medical Director of the American Renal Association made the comment that in bundling payment, CMS must be careful not to fragment the patient and make their lives more difficult. He further commented that it might be useful for the University of Michigan to take the Medicare Allowable Charge data and to correlate it with comorbidities and ICD-9 codes.

Dr. Brian Pereira, President and Chief Executive Officer of the New England Health Care Foundation offered what he termed a "roadmap" for how discussion could be structured. This includes:

- looking at how to treat the patient rather than how to treat the ESRD
- are we going to bundle based on modality
- what should and should not be included in the bundle
- unit of payment/ case-mix/ other adjusters
- quality of care

Dr. Rubin then listed some of the topics that will be covered in the next meeting which are: case-mix adjustment, issues for outliers, quality incentives and pay for performance.

The meeting concluded at 4:31 PM.