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

Minutes
May 24, 2005

The second 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 May 24, 2005 at the Holiday Inn Hotel at 890 Elkridge Landing Rd. in Linthicum, MD.

The meeting began with opening remarks from Dr. Robert Rubin, Co-Chair. Dr. Rubin then asked the Board to approve the minutes from the last meeting (February 13, 2005). The motion was seconded and the minutes were approved with no corrections.

Mr. Henry Bachofer from the Centers for Medicare and Medicaid Services (CMS) Office of Research, Development, and Information then gave an introductory presentation outlining the general framework that was developed following the February meeting. He reviewed the statutory charge of the ESRD Advisory Board which is to advise the Secretary and the Administrator of CMS concerning the establishment and operation of a demonstration of a fully case-mix adjusted payment system that includes "drugs and biologicals (including erythropoietin) furnished to end stage renal disease patients…and clinical laboratory tests related to such drugs and biologicals." Mr. Bachofer then described a bundling "continuum", which would go from a fee-for-service payment system for individual services that are provided by the dialysis facility to full capitation, which would include all services that are provided by all providers, including inpatient hospital services. Mr. Bachofer described several potential bundles. The bundles are termed Bundle 1A, Bundle 1B, Bundle 1C, Bundle 1D, Bundle 2A, and Bundle 2B.

Bundle 1 A includes composite rate services, Bundle 1B adds to 1A the remaining "major" or "ESRD" drugs and related lab tests, Bundle 1C adds to 1B all lab tests generally ordered for ESRD patients, Bundle 1D adds to 1C all remaining services currently billed by dialysis facilities. Bundle 2A would add to the facility payment the MCP payment. Bundle 2B would add to the facility payment non-professional payments for vascular access (and related procedures). He also discussed criteria against which bundling options could be evaluated. The materials from this presentation may be found on the ESRD Advisory Board website at http://www.cms.hhs.gov/faca/esrd/default.asp. Under the "Materials" section, the link is listed as CMS/ORDI Paper on Framework for Bundling Options.

Mr. Bachofer then further discussed the two broadly expanded bundles (Bundles 2A and 2B). During this presentation he also discussed the limitations of narrower bundles and the goals for a broader bundle; the limitations of MCP data for 2003 and the limitations of vascular access data; the MCP payment and the administrative issues that would occur if the bundle is expanded to include MCP payments; and vascular access, including the

analytic implications of including vascular access into in the bundle and the policy/ administrative implications. He concluded this discussion with an assessment of broadly expanded bundles. The materials from this presentation may be found on the ESRD Advisory Board website at http://www.cms.hhs.gov/faca/esrd/default.asp. Under the "Materials" section, the link is listed as CMS/ORDI Paper on Broadly Expanded Bundle (MCP and Vascular Access) .

The next presentation, a review of bundle definitions and descriptive characteristics, was also given by Mr. Bachofer. In this presentation, he discussed the descriptive data on the more narrowly-defined bundles, 1A through 1D. He briefly discussed the general framework and reviewed the nature of the data used in the analysis and highlighted the limitations and the implications of those limitations. The data used for the analyses is from 2003. Mr. Bachofer also discussed policy criteria and considerations – goals against which bundling options can be evaluated, which are: safety, effectiveness, patient centeredness, timeliness, efficiency and equitability.

He discussed technical criteria and considerations that include: size of bundle, amount and nature of variation, and implications.

Mr. Bachofer gave a brief description of the 50/50 rule. He was asked by a Board Member if he had any estimate as to the effect the 50/50 rule has had on the data. Mr. Bachofer stated that CMS is looking into developing some of that information. He then discussed case-mix adjustment, explaining that the data being discussed include no adjustments for case-mix.

There was a scheduled break in the proceedings for fifteen minutes.

After the break, Mr. Bachofer continued his presentation on descriptive statistics and possible bundle definitions. He began this discussion with a summary of differences between the four bundles. He gave the average Medicare Allowable Charge (MAC) for each bundle, which are: 1A ($2,828), 1B ($2,857), 1C ($2,900), and 1D ($2,916) per month.

He discussed the variation within bundles – as the scope of the services in the bundle increases, the variability of the resulting total costs marginally increases. He discussed the use of injectable drugs and the variation in injectable drug use and the use of laboratory tests and the variation of laboratory test use. He then summarized the points and conclusions from the data that he presented, which include that EPO, iron and vitamin D dominate the bundle, expansion of the bundle adds little to variability, and laboratory tests follow a similar pattern of episodic use.

Mr. Bachofer then discussed the amount and nature of variation. He listed the questions that are raised in the variation in use of EPO, iron and vitamin D, which are: To what extent is variation of this magnitude clinically justified? Does this variation reflect the differences in patient needs, or does it reflect differences in practice patterns? He also stated that the variation in the use of other drugs also raises the same questions, and also

several other slightly different questions, which are: To what extent can or should a payment system reflect episodic events that require substantial resources to treat? What are the implications for patients and providers if the payment system does not match payment to higher resource needs during acute episodes? Are these episodes simple, unpredictable, random events? He also noted that much of the variation among patients would be muted at the facility level. Lastly, he discussed the implications that the descriptive data have on what an appropriate unit of payment would be for a bundled payment system. The materials from this presentation may be found on the ESRD Advisory Board website at http://www.cms.hhs.gov/faca/esrd/default.asp. Under the "Materials" section, the link is listed as CMS/ORDI Paper on Descriptive Statistics .

The University of Michigan/ Kidney Epidemiology and Cost Center gave the next presentation. Dr. Jack Wheeler began the presentation by stating that he hoped that the data that would be presented would inform the Advisory Board's deliberations regarding the following topics:

- What are the components in the bundle?
- What might be the unit of payment?
- Should the modalities be treated differently in terms of case-mix adjustment and payment?
- What specific case-mix measures should be in the final model?

He stated that the data they used was Medicare allowable charge data. The data came primarily from CMS paid claims data for the year 2003 and the data included dialysis facility claims and claims from other providers.

The analyses of the data that were presented included:

- Face validity
- Effect of payment outliers
- Scope of the bundle
- Unit of payment
- Modality, and
- Other types of risk adjustors.

The materials from this presentation may be found on the ESRD Advisory Board website at http://www.cms.hhs.gov/faca/esrd/default.asp. Under the "Materials" section, the link is listed as University of Michigan Kidney Epidemiology and Cost Center (KECC) Presentation on Case Mix Adjustment .

After this presentation, the meeting adjourned for lunch.

The next segment of the day was a committee discussion that began with a discussion of whether or not MCP payments should be included in the bundle. Mr. Brady Augustine, Co-Chair, made a motion to not include MCP services in the bundle, dependent on the Board's approval of a reported recommendation on aligning incentives between facilities and providers. This motion was seconded and approved. A motion was then made by

Mr. Augustine to not include vascular access services in the expanded bundle, but to provide a report at the next meeting with regard to the recommendations on including vascular access measures into the pay for performance (P4P) portion of the demonstration. This motion was also seconded and approved. During this discussion, Mr. Augustine asked the Board if they were in agreement as to the fact that when a choice is made, that it be for just one bundle of services, as opposed to more than one. No one opposed choosing just one bundle in the future. Lastly, Mr. Augustine asked the University of Michigan staff to prepare detailed information for the Board on a potentially separate payment for home PD patients.

The last presentation of the day, on Pay-for-Performance, was given by Mr. Bachofer. Pay for performance topics that were discussed were:

- Purpose of P4P/ quality incentives
- Relationship of P4P and bundled payment
- P4P Technical/ Policy questions
- Funding of P4P
- P4P quality measures, and
- MedPac measurement principles for quality measures.

The materials from this presentation may be found on the ESRD Advisory Board website at http://www.cms.hhs.gov/faca/esrd/default.asp. Under the "Materials" section, the link is listed as CMS/ORDI Paper on Framework for Discussion of Pay-for-Performance .

The audience was then given a chance to make public comments. The first speaker was Mr. Rod Kenley, from AKSYS Limited, a company that makes an instrument for daily home hemodialysis. Mr. Kenley stated that they support the expanded bundle because they feel that it will lead to expanded choices for the patient. He commented that he strongly opposes a proposal in which lower-cost modalities would be paid for at a lower rate. He believes that the growth of PD in the 1980's is largely attributable to the composite rate. He stated that, in his opinion, the failure of the composite rate was the lack of an annual update. He also stated that an upfront disincentive for home dialysis is the "wrong way to go".

The next speaker was Ms. Leanne Zumwalt, from DaVita, regarding the challenges of implementing a bundle. One challenge is that patients are very different and their utilization of resources is very different, yet the bundled payment proposal is for just one single payment rate. Another consideration is the fact that much of the ESRD population is dually eligible. Research needs to be done into whether or not the states will pay the twenty percent coinsurance for the bundle. She stated that she found the lack of relationship between quality and payment to be disturbing. She wanted to know how the bundle will address the fact that EPO is made by a single source manufacturer, and that they will, by definition, change their pricing. Lastly, regarding pay for performance, she stated that if it is going to be incorporated into the bundled payment system, the unit of payment must be correct. She believes that the current payment is under funded.

The next speaker was Mr. Dolph Chianchino, from the National Kidney Foundation. Mr. Chianchino spoke briefly about his belief that the demonstration should be designed to monitor access to modalities, referrals for transplantation, patient satisfaction, and patient quality of life, as with the ESRD Disease Management Demonstration Project.

The last speaker was Mr. Jim Lordeman, an independent consultant employed by the Renal Care Group. Mr. Lordeman made a hypothetical suggestion in order to stimulate the thoughts of the committee. He suggested that if a model were created that could calculate the remainder of lifetime costs for a patient as they reach a certain creatinine clearance level, and then if some portion of that cost was given to a team of providers up front, then behaviors of the providers may change as a result of that incentive. He believes that pay for performance measures should be incorporated into the bundled payment demonstration.

Both Dr. Robert Rubin and Brady Augustine made closing remarks and the meeting was adjourned at 4:42 PM.