MCP & Vascular Access Payments

Discussion Paper for the MMA §623e Advisory Board

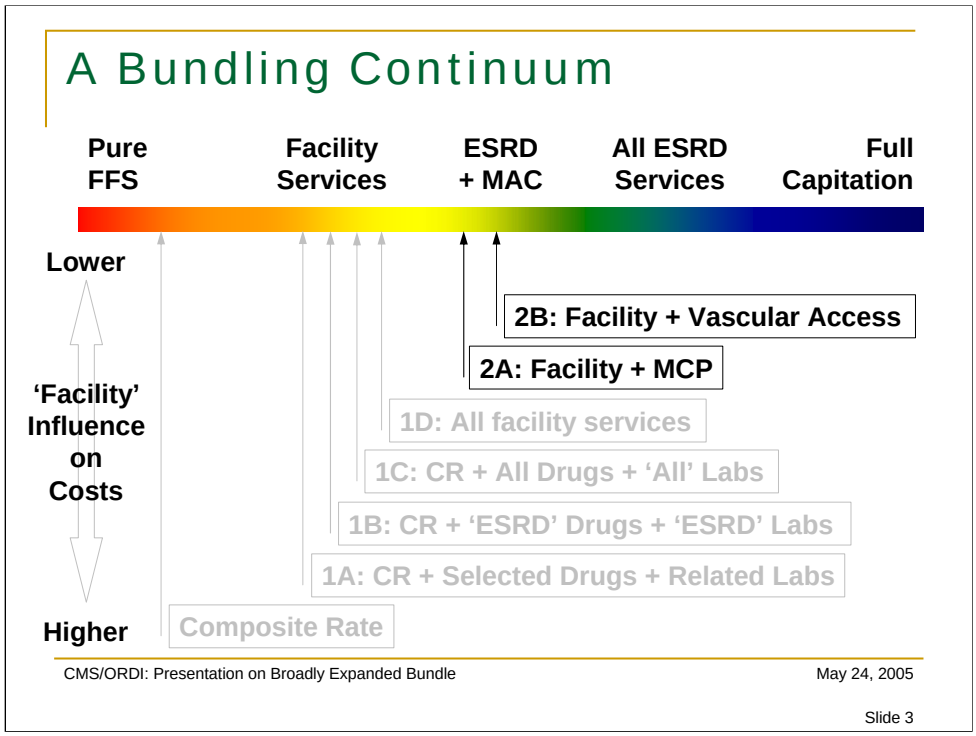
Prepared by CMS/ORDI/MDPG

May 24, 2005

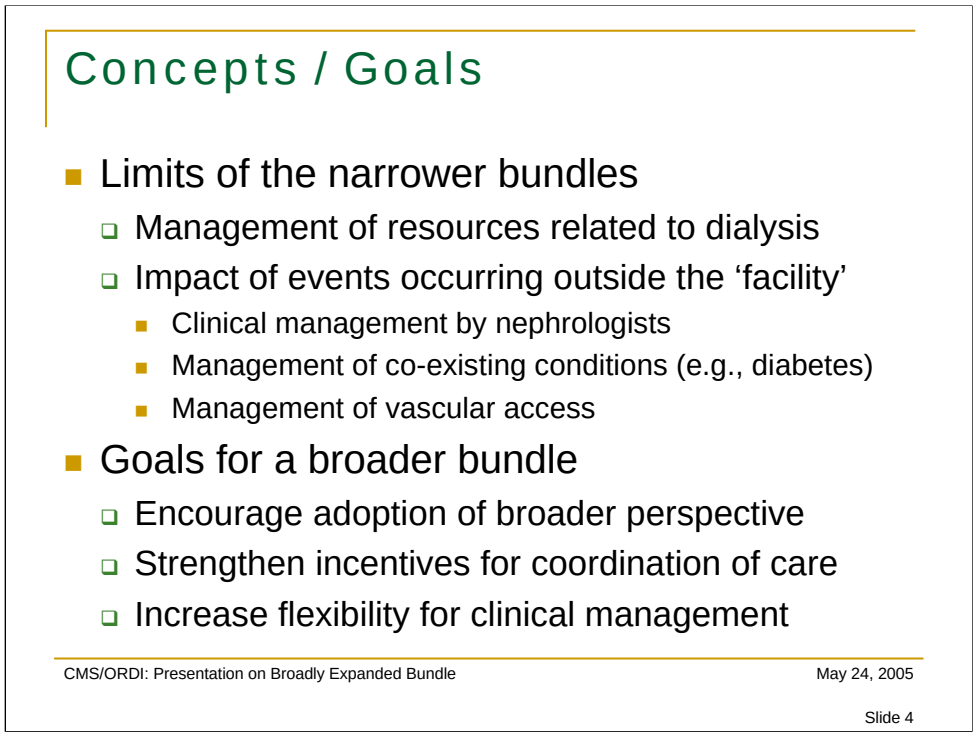
- This document discusses two broadly expanded bundles: one would add MCP payments into the bundle; the other would add payments related to vascular access into the bundle.
  - It reviews the goals or purposes of expanding the bundle to include these components.
  - It discusses the nature of the data issues that the expansion of the bundle to include these components would encounter.
  - It reviews what is known about variation in MCP payments across patient months in 2003 and briefly discusses the implications of these patterns of variation.
  - It reviews the administrative issues that are likely to be encountered if these components were added to the bundle.
- Finally, it suggests alternative ways in which the goals or purposes of a broadly expanded bundle might be pursued.

Notice to Reader

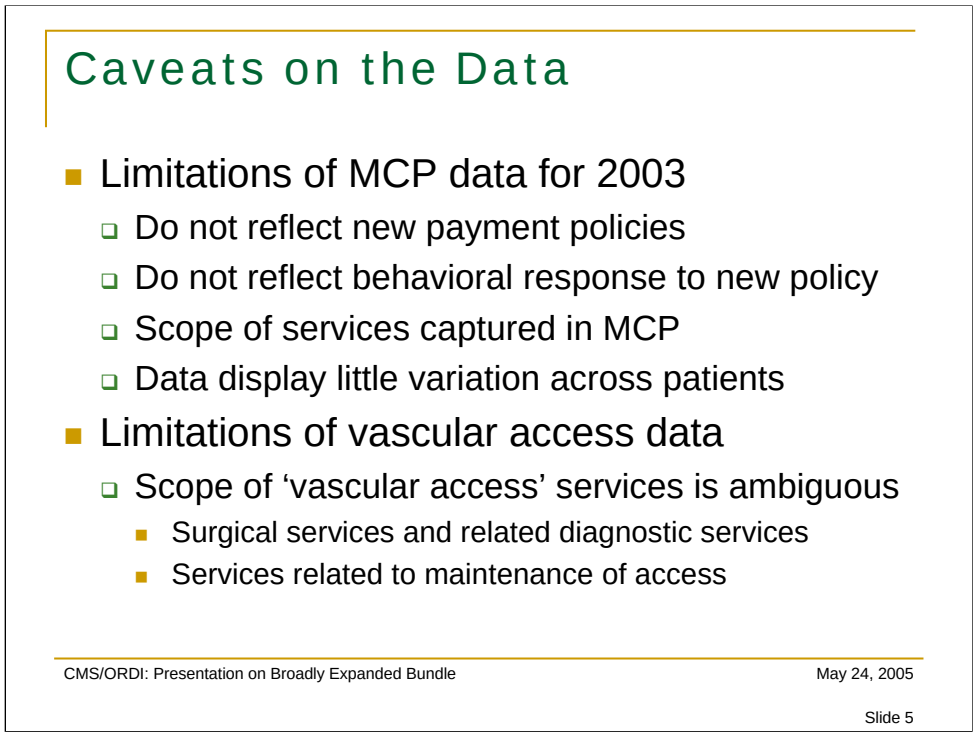
The following discussion represents one perspective on the preliminary data on possible bundle definitions. It does not present an official position of CMS on the question of what services should be included in the bundled payment system, nor does it represent the opinions or perspectives of KECC, the CMS contractor who developed the data displayed in the figures and contained in the related tables.



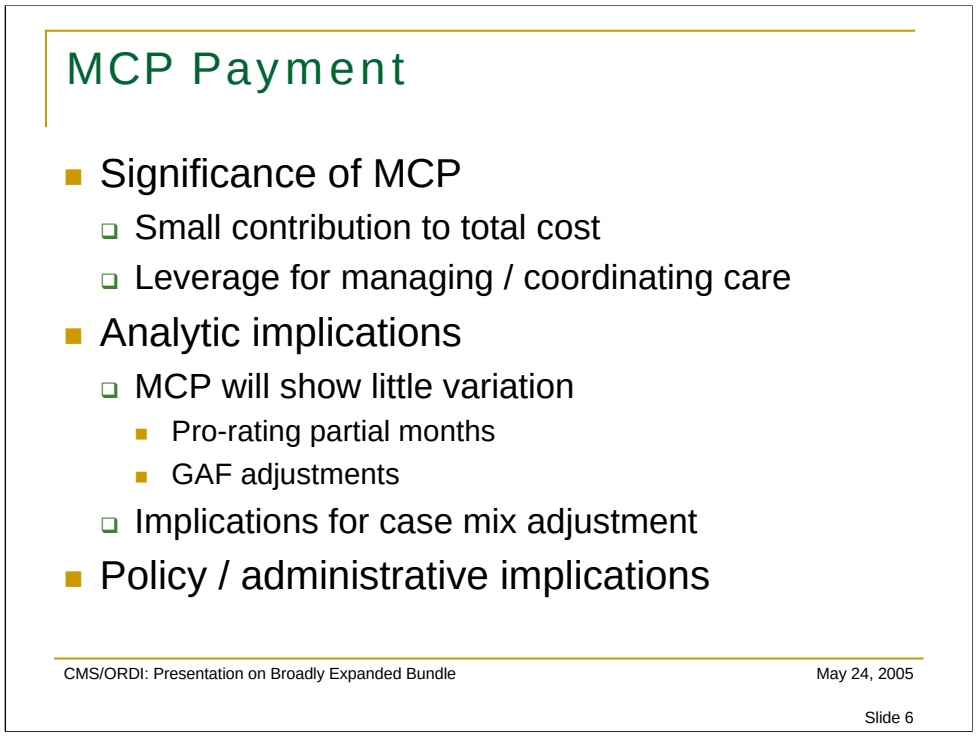
- The two bundles that are the focus of this presentation represent a significant departure from the four more narrowly focused bundles that will be discussed in the next presentation. Both bundles would include services that are less directly under the influence of the dialysis facility. Both would also imply significant changes in organizational relationships between the dialysis facility and other providers.
- Bundle 2A would add to the facility payment the MCP payment. Adding the MCP payment to the bundle will have an obvious impact on the organizational relationship between nephrologists and dialysis facilities. Specifically, it will create an explicit financial relationship. Payments to nephrologists would, in some sense, come 'through' the dialysis facility.
- Bundle 2B would add to the facility payment non-professional payments for vascular access (and related) procedures. These additional payments potentially include payments to hospitals for both outpatient and inpatient surgery and payments to imaging centers and hospitals for imaging services that are related to vascular access. It would create a financial relationship between the dialysis facility that receives the payment under the expanded bundle from Medicare and these providers of services who would no longer bill Medicare directly.



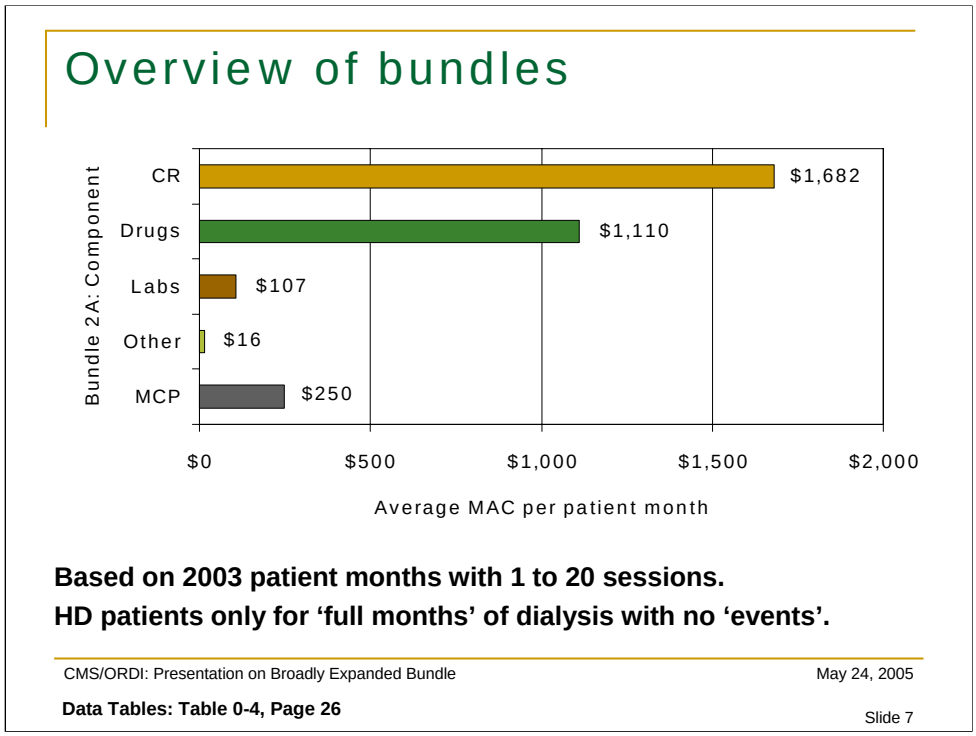
- The narrower bundles (1A – 1D) include services either provided by the dialysis facility or laboratory tests in which the facility and its affiliated nephrologists are directly involved. While such a bundle may create incentives to better manage the care provided by the facility, it does not change the incentives under which other providers operate that influence other components of a patient's overall care. In effect, the narrow bundles are more narrowly focused on the management of dialysis not the overall management of End Stage Renal Disease.
- A broader bundle offers the possibility of changing incentives affecting the care provided outside the dialysis facility. This care includes: clinical management of the patient by nephrologists; management of complications and co-morbid conditions by other providers (e.g., management of diabetes or cardiac conditions); and management of vascular access.
- The goals for a broader bundle are, in general, similar to those for the more limited bundles.
    - First, a broader bundle may encourage and enable dialysis facilities and their affiliated practitioners and providers to adopt a broader perspective emphasizing the management of more than just dialysis.
    - Second, a broader bundle may create stronger incentives and means of encouraging coordination of care across providers and the sharing of responsibility.
    - Third, a broader bundle may increase the ability of facilities and affiliated practitioners to find innovative ways of meeting patient needs (i.e., it should increase flexibility).
- The questions addressed in the following sections are: (1) the technical implications of attempting to expand the bundle to include MCP payments and vascular access; (2) the potential benefits of expanding the bundle to include these services; and (3) the potential risks of expanding the bundle to include these services.



- A serious limitation of data of the MCP data for 2003 is that they pre-date the introduction of new methods of paying physicians that are intended to better reflect the time a physician spends managing the care of individual patients.
    - Payment amounts do not reflect the new payment policies, i.e., the new 'G' codes for physician services. As a result, the 2003 data may understate variation in MCP payments among patients or across patient months, and in any case will probably not track payments under the new system. This limitation may affect both the calculation of payment amounts and the development of possible case mix adjustments.
    - Second, the 2003 data do not reflect changes in behavior in response to the new "G" codes and payment policies. Until more recent data become available it will be impossible to evaluate rigorously and quantitatively the impact of behavior changes on either payment or potential case mix adjustments.
- A different set of data-related issues affect the difficulty of expanding a bundle to include services and procedures related to vascular access. More will be said concerning these problems later in this presentation. In brief, the problems involve the extreme difficulty of identifying all services that are related to vascular access procedures.

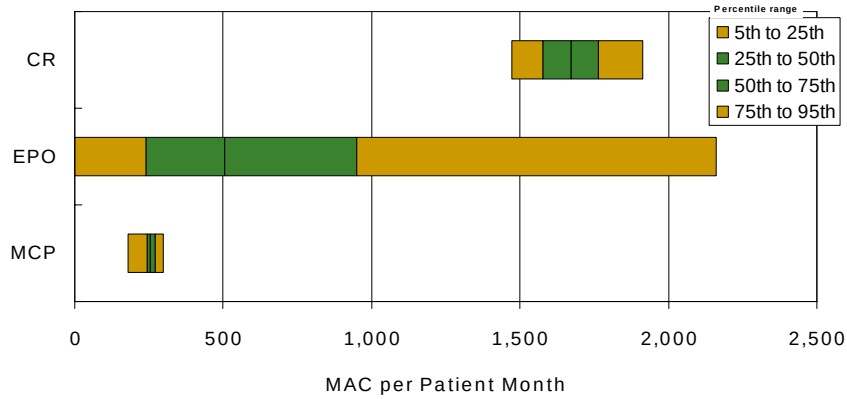


- The first of the 'broadly expanded' bundles (Bundle 2A) includes the payments to the 'capitated' physician or practitioner.
  - These payments represent, in relative terms, a small contribution to total costs: about 10% (or less) of total payments under the broadest of the 'limited' bundles, on average.
  - However, paying for the 'clinical management' of the patient through the bundled fee *may* increase the ability of the 'facility' and its medical staff to coordinate care.
- Including the MCP payment in the bundle may, however, have significant analytic implications:
  - The MCP payment shows little variation across patients within a facility. Partial months will cause some variation across patients although this variation is likely to track frequency of dialysis. Geographic Adjustment Factors will cause some variation across facilities.
  - However, patient characteristics have little effect (historically) on MCP payments. As a result, it will be very difficult to construct (using statistical methods) a case mix adjustment (which relates patient characteristics to the cost / effort required to manage care).
- Including the MCP payment in the bundle also has substantial implications for policy and administration, ranging from the determination of which facility should receive the payment to concerns related to coordination with fraud and abuse rules.



- MCP payments average $233 per month across all patient months for patients receiving hemodialysis only. However, the MCP payment, like the composite rate payment, varies based on the number of days during the month that the patient was receiving treatment.
- The above figure focuses on patient months with 1 to 20 sessions and includes only 'full months' during which no events (e.g., hospitalization) interrupted dialysis. In these months, MCP payments in 2003 averaged $250 per month.
- The MCP payment was, therefore, less than one quarter of the monthly payment for all drugs included in the most expansive of the 'limited' bundles (1D), but was nearly 2½ times the monthly payment for laboratory tests.

Variation within components



Based on 2003 patient months with 1 to 20 sessions.

HD patients only for 'full months' of dialysis with no 'events'.

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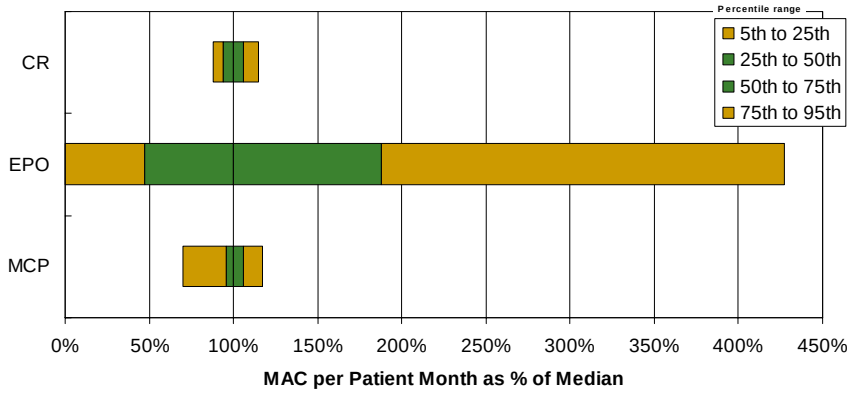
Slide 8

- MCP payments per month in 2003 displayed approximately the same amount of variation as composite rate payments. Like composite rate payments, MCP payments displayed considerably less month-to-month variation than separately billed items and services.
  - In half of all patient months, use of EPO was greater than $506. However, in one quarter of all patient months, use of EPO was $240 or less and in one quarter of all patient months use of EPO was $950 or more.
  - In contrast, half of all patient months had MCP payments that were within about 5% of the median month's MCP payment.
- **Note that these figures are based on patient months in 2003 for hemodialysis patients only. They include only those patient months with between 1 and 20 sessions in which an 'event' did not disrupt a 'full month' of dialysis.**

Variation within components



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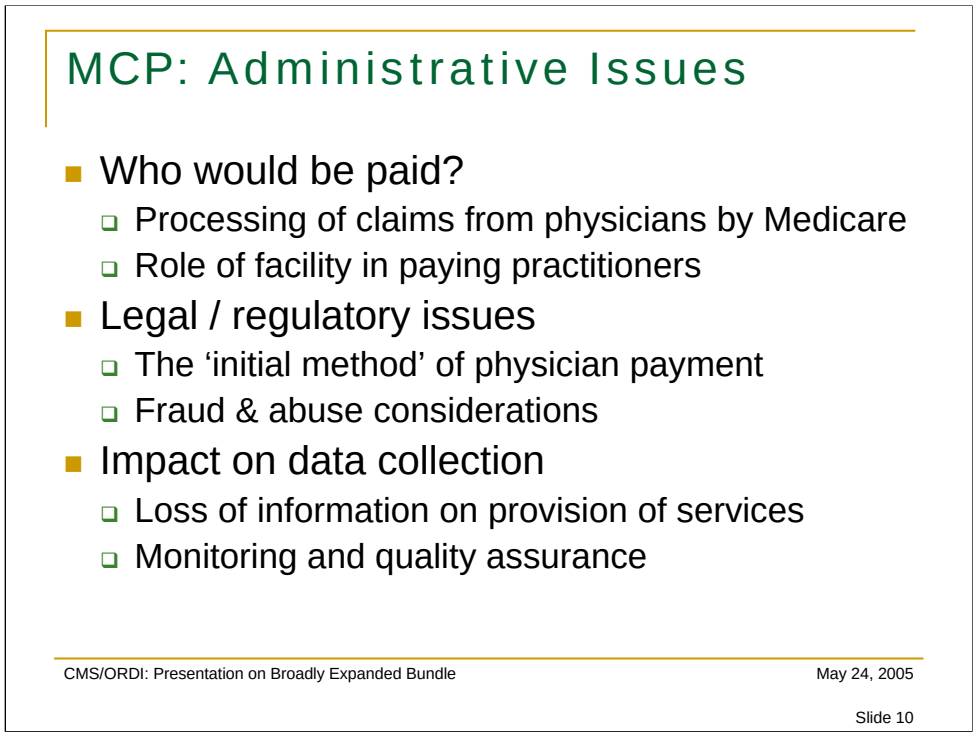
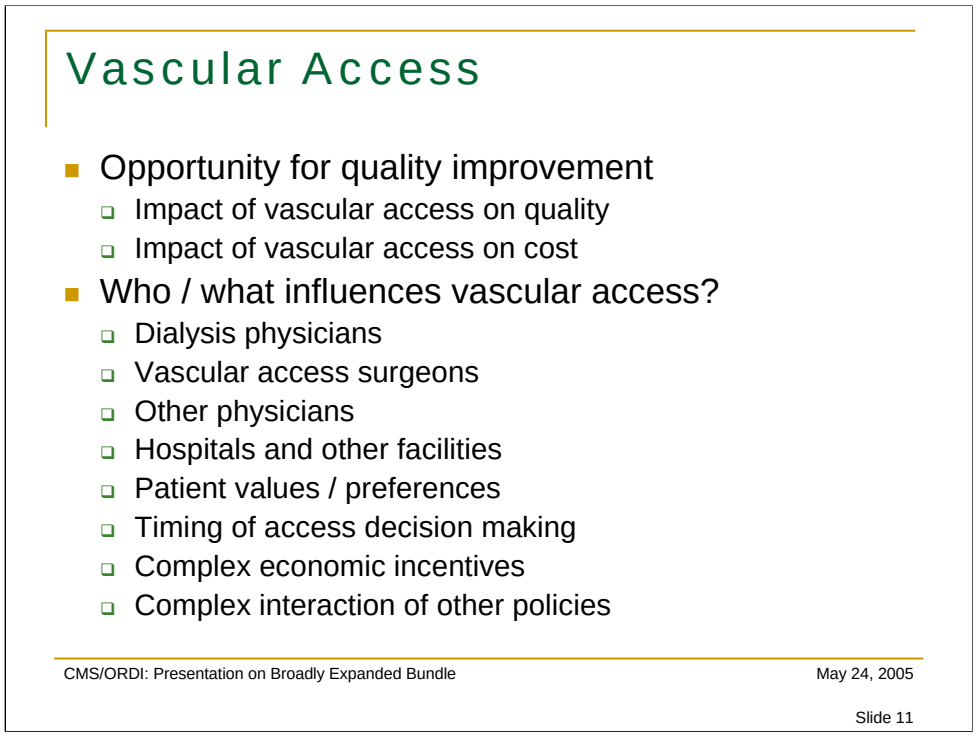
Slide 9

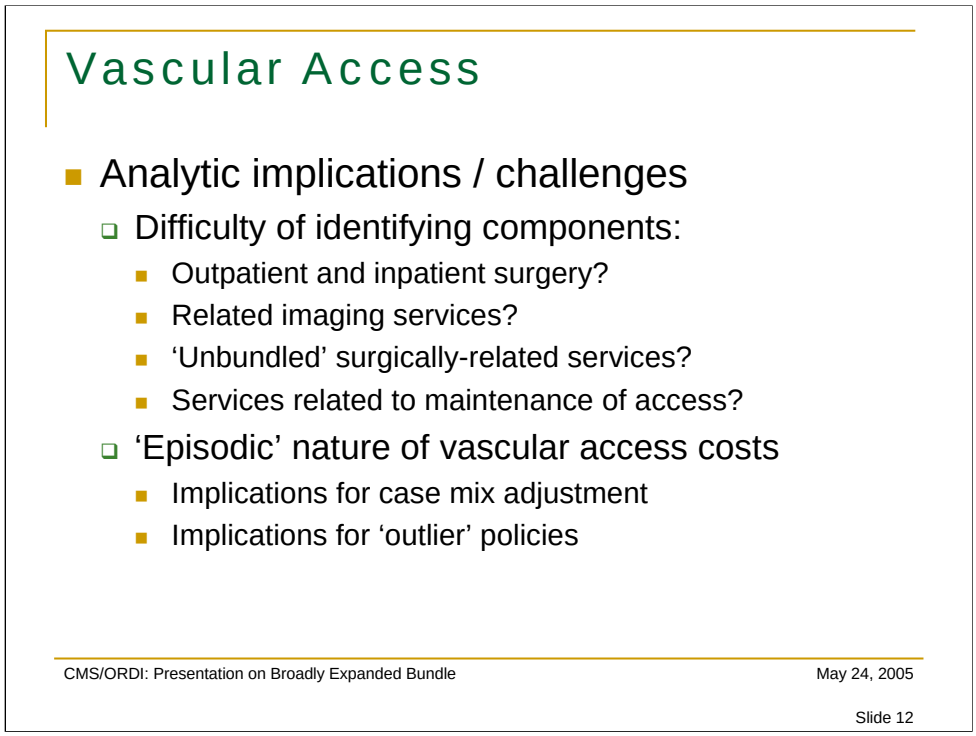
- The above figure presents the same data that were presented on the previous slide. Instead of displaying dollar values, however, it expresses composite rate, EPO and MCP payments as a percentage of the median month.
- This figure more clearly shows that MCP payments display a pattern of variation that more closely resembles that of composite rate payments than EPO payments. EPO dominates separately-billed items and services.
- One implication of these data is that expanding a bundled payment to include MCP payments may compound the difficulty of adjusting payments to reflect variation in patient needs.
- **Note that these figures are based on patient months in 2003 for hemodialysis patients only. They include only those patient months with between 1 and 20 sessions in which an 'events' did not disrupt a 'full month' of dialysis.**



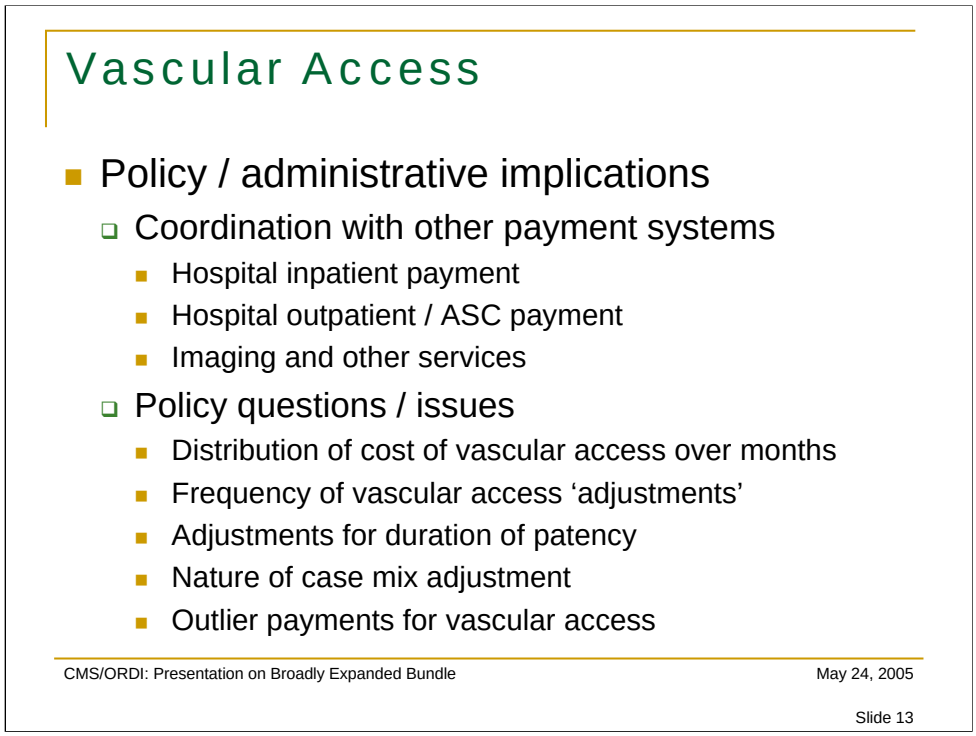
- Expanding the bundle to include MCP payments would require efforts to address a number of administrative issues.
- First, who would be paid? A bundled payment would be made to the dialysis facility that bills for the composite rate. That facility would then pay the nephrologist(s) or other practitioner who was responsible for directing the patient's care. Other providers of services that are within the scope of the MCP would not be able to bill Medicare and would, instead, submit claims to the facility. The facility would need to determine which of these claims are payable and would need to negotiate arrangements for payment with each of its affiliated nephrologists or other practitioners.
- Second, what legal or other regulatory issues would need to be addressed? Although there is an historical precedent for routing payment to nephrologists through facilities, the 'initial method' is not currently used by any providers. The election of the "initial method" would need to be a requirement of the demonstration. All of the physicians "of a facility" (in the language of the Medicare manual) would need to choose to be paid using the "initial method"; if one physician terminated the election of the "initial method" then that method would be terminated for all of the facility's physicians. Absent the use of the "initial method" it is likely that any method of paying physicians through the facility would require the resolution of potentially complex fraud and abuse issues.
- Third, bundling the MCP payment into the facility payment would potentially result in the loss of information on the services provided to individual patients. This loss has significant implications for both maintenance of the payment system and for monitoring and quality assurance.



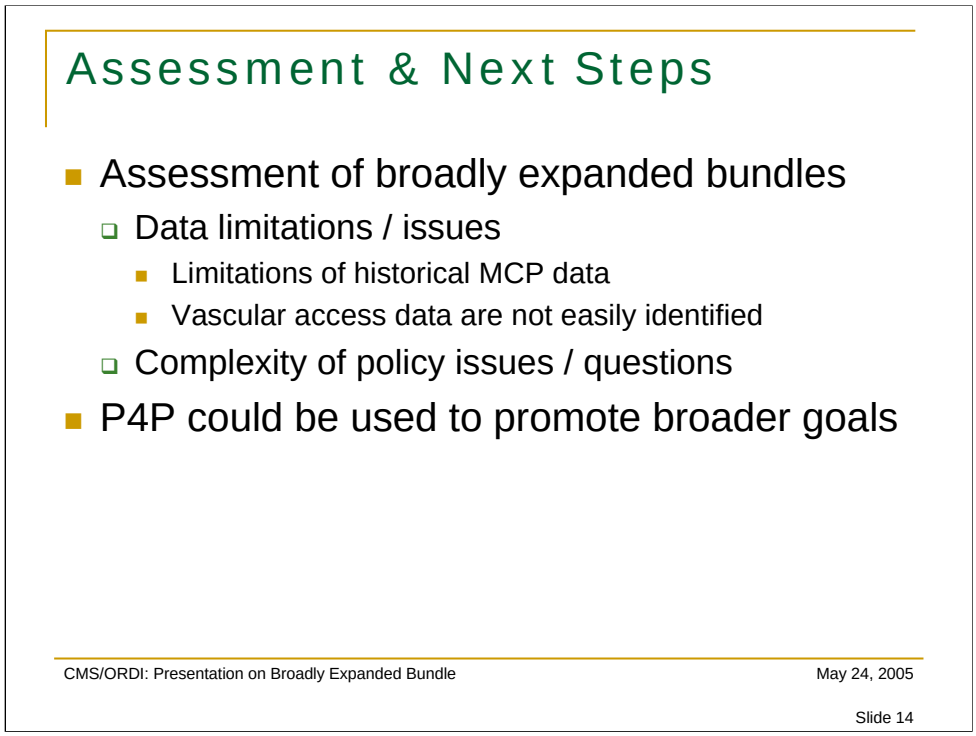
- Vascular access has become a focus of efforts to improve quality in the provision of dialysis. A broad consensus has developed favoring fistula as the preferred method of access.
  - Fistula is associated with lower rates of complication.
  - It is also associated with lower costs, both in the first year of dialysis and over time.
  - Efforts to increase reliance on fistula are, in fact, succeeding.
- The choice of a method of vascular access is the product of a complex process involving many decision makers, a complex set of incentives and policies, and a complex array of facts and circumstances.
  - The health care providers involved in these decisions include the patient's nephrologist, vascular access surgeons, and other physicians (e.g., radiologists). Recent experience with the Fistula First initiative has shown the importance of making sure that all clinical decision makers, and patients themselves, understand the benefits and risks of alternative access methods.
  - The timing and "facts and circumstances" of the vascular access decision has a significant influence on access methods. Increasing reliance on fistulas requires advance planning so that a fistula has time to mature before dialysis becomes necessary.
  - The economic incentives influencing choice of an access methods are also complex. Physician fee schedules create implicit incentives that may favor one access method over another. Other payment systems may also fail to create incentives that encourage adoption of access methods that are more efficient and effective over the long run.
  - Other policies (e.g., eligibility and coverage policies) also may affect choice of access methods—or may limit efforts to promote fistula.



- Including vascular access services in the bundle presents enormous analytic challenges:
  - First, it is difficult to clearly and unambiguously identify the components of 'vascular access' that should be included in the bundle: Would both inpatient and outpatient surgical procedures be included? Related imaging services? How would 'ancillary' services that may not be 'bundled' into the surgical fees be identified? What services related to the maintenance of vascular access would be included? From a technical perspective, the very broad and often ambiguous nature of the services that are involves make it extraordinarily difficult to extract data that are clearly related to fistula and, hence, would be candidates for including in a bundled payment.
  - Second, two types of vascular access costs can be identified conceptually. The first occur irregularly and involve major procedures (surgical creation of a fistula, placement of a catheter, etc.). When these occur they are (relatively) expensive. The second type of cost involves maintenance of patency. These costs are probably more evenly distributed across months. The (anticipated) high level of variability in vascular access has significant implications for both the construction of a case mix adjustment and the need for outlier policies.



- The difficulty of clearly and unambiguously identifying services related to vascular access has significant implications for the administration of a bundled payment system that includes these services.
    - Such a bundled payment would potentially affect policies related to payment for inpatient hospital care. If a vascular access procedure for a patient requires inpatient admission bundling vascular access would mean that the hospital would need to bill the dialysis facility for the inpatient surgical stay. If the vascular access procedure is performed during an inpatient stay that was precipitated by another event, then how should payment for the inpatient stay be adjusted?
    - Outpatient surgical procedures related to vascular access would also be affected by bundling. Ambulatory surgical centers or hospital outpatient surgical centers performing vascular access procedures would need to bill dialysis facilities for services identified as related to vascular access.
    - Similarly, if imaging services related to the vascular access procedure are included in the bundle, payment for outpatient (or inpatient) radiological procedures would be affected.
- A second policy implication is of bundling vascular access is that such a bundle poses a number of complex policy questions or issues. For example:
    - How would the 'cost' of vascular access be spread across months?
    - How frequently would vascular access procedures be reflected in payment?
    - Would adjustments be necessary for duration of patency?
    - How would case mix adjustment work? Would separate payment categories be assigned for months involving a 'major' vascular access procedure?
    - What kind of 'outlier' policy might be required for patients with complex vascular access needs?



- The concept of broadly expanding the bundle to include MCP payments and services related to vascular access has a certain logic and appeal. It would, perhaps arguably, create broader incentives to seek improvements in quality and efficiency. However, such an effort encounters two significant obstacles.
    - The first obstacle involves data:
        - The data on MCP payments do not reflect variation across patients in their use of physician resources. Moreover, the available data do not reflect current payment methods and, because the new payment methods rely on a new coding system, cannot be updated to reflect current payment policies.
        - Reliable and valid data on services related to vascular access are readily extracted from available administrative (claims) data. In part this reflects limitations of available data sources. But in part it reflects the inherent difficulty of identifying unambiguously claims submitted by a broad range of providers for services that are related to vascular access.
    - The second obstacle involves the complexity of the policy questions that bundling these additional services with the composite rate would pose.
- Finally, the goals of broadly expanding the bundle could be pursued using other means. For example, pay-for-performance may be a means of encouraging adoption of fistulas as the preferred vascular access method. There are, of course, a number of issues that would need to be addressed to adopt this policy. These issues are outlined in the paper / presentation on pay-for-performance.