Implications of the New ESRD Bundled Payment System: Clinician Perspective

Challenges and Opportunities

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Acknowledgements

Medical Advisory Council of the Forum of ESRD Networks
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Medical Review Board of ESRD Networks 9/10
George Aronoff, MD
Disclaimer

I did not write the law

I cannot change the law

Do not kill the messenger (please)

If you have a comment or a suggestion send it to your Representative and/or Senators
Not Much in Reform re Dialysis

- **Update factor adjusted for productivity**
  - Whatever the market basket would otherwise be in is reduced by “the 10 year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity”... averaged about 1.32% (replaces arbitrary 1% cut in law now)

- **Expanded coverage (32 million new)**
  - More commercial insured (+24m) but also Medicaid (+6m)

- **New payment models (significant for ESRD)**
  - Patient-Centered Medical Home (Nephrologist=coordinator?)
  - Accountable Care Organization (capitated payment)

- **Comparative effectiveness important**
Current Revenue

- LDO’s report $320 to $340 revenue / treatment

- Payer Mix Adjusted Dialysis Treatment Revenue
  - Case Mix Adjusted Composite Rate + Drug Add On
  - Medicaid (no drug add on) and Dual Eligible patients
  - Commercial Payers (FFS charges, global contracts)

- Separately billable parenteral medications
  - Charges (contract)
  - Average Sales Price +5%
Case Mix Adjusted Composite Rate

Freestanding base composite rate ($132)

Hospital-based base composite rate ($136)

Adjusted for geographic factors

53.7% adjusted by area wages

46.3% non-labor related portion

Drug add-on payment 15.5%

Case-mix budget-neutrality factor

Adjusted for case mix

Patient characteristics:
- Age
- Body mass index
- Body surface area

Payment
Current Medicare Payment

- 60% of what CMS pays is for the dialysis treatment itself and included labs ($4,788.5*)
- 40% of what CMS pays is for separately billed items
  - Parenteral drugs and biologicals ($2,763.8*)
  - Additional lab services ($333.2*)
  - Certain supplies ($40.2*)

*Total Medicare allowable payments, in millions, 2005
(c) Inclusion of Additional Services in Composite Rate
(1) Development.—The Secretary of Health and Human Services shall develop a system which includes, to the maximum extent feasible, in the composite rate used for payment under section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)), payment for clinical diagnostic laboratory tests and drugs (including drugs paid under section 1881(b)(11)(B) of such Act (42 U.S.C. 1395rr(b)(11)(B)) that are routinely used in furnishing dialysis services to Medicare beneficiaries but which are currently separately billable by renal dialysis facilities....
(1) Development.—The Secretary of Health and Human Services shall collect data and develop an ESRD market basket whereby the Secretary can estimate, before the beginning of a year, the percentage by which the costs for the year of the mix of labor and non labor goods and services included in the ESRD composite rate under section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395m(b)(7)) will exceed the costs of such mix of goods and services for the preceding year.
IOM directed by Congress MPDIM Act 2003 (MMA) (PL 108-173 sec 238)

To identify and prioritize options for aligning performance with payment in the Medicare program

- Measure set used and how to be updated
- Payment policy that should be used
- Key implementation issues such as data and information technology
Medicare Improvement for Patients and Providers (MIPPA, 2008)

- Implement January 1, 2011 (Final rules not published yet)
- Two Paragraphs in BIPA resulted in 547 pages of proposed rules for MIPPA.
  - All Composite Rate Services
  - ESA’s (oral if developed)
  - Other drugs and biologicals (currently separately billed and those currently covered by Part B & Part D). No phase in for this requirement
  - Lab tests and other items and services to treat ESRD
    - Includes all labs ordered by MCP physician
- MMA required the QIP in MIPPA
  - ≤ 2% reduction of CMA-PPS
  - URR ≥ 65%, HGB > 12 gm%, HGB < 10 gm%
  - Performance in 2010 compared to 2008 determines payment 2012
Medicare Improvement for Patients and Providers (MIPPA, 2008)

- Based on per patient, per treatment unit of service (3x/week model)
- Patient responsible for co-pays on all bundled services
- Method II home dialysis no longer acceptable
- Excludes vaccines
- No race or ethnicity adjustment
- No add on for home dialysis training (included in PPS)
- Outlier payments = 80% Actual Part D costs that exceed case adjusted predicted Part D costs by $134 ($175 for pediatrics)
Pediatric Patients

- Claims data not robust enough to develop case-mix adjusters
- Separately billable costs account for a smaller portion of total ESRD costs than in adult pts.
- Two age categories, <13 and 13-17
- Adjustment for dialysis modality
- No adjustment for other patient characteristics
- A work in progress; CMS invited comments
Calculation of the Base Rate

- Add up costs of
  - Outpatient dialysis services
  - Dialysis support services
  - Part B drugs and biologicals
  - Laboratory tests
    - Billed by dialysis facilities
    - Ordered by nephrologists billing MCP services
  - DME supplies and equipment
  - Other supplies and services billed by dialysis facilities (including blood and blood products)
  - Former Part D drugs (phos. binders and cinacalcet)
    - Actual Part D data available for 49% of ESRD patients
    - Use Retiree Drug Study as proxy for remainder
Base Rate

- Estimate of all costs CY 2007/ number Rx’s = 252.99
- Adjusted expected CY 2011 dollars = 261.58
- Case Mix adjustment neutral (.7827) = 204.74
- Outlier cost sharing (x .99) = 202.69
- MIPPA correction (x .98) = 198.64

After 2012 market basket adjustment (ESRDB)
  - Applied to CMACR during phase in
  - Estimated +~2.7%/ year
  - Current rules require reduction by 1% to promote efficiency +~1.7%/ year
MIPPA: PPS Bundled Payment

198.64 → ± 75.80 + 122.84 → TA X .97 → CMA fac/pat → .98 to 1.0 QIP → $ .50 → Outlier payment
Wage Adjusted

- Applies to 38.16% of Base Rate (75.80)
- No floor or ceiling protection
- CBSA and Hospital Wage Indices used
- If > 1 then $BR = (1.5 \times 75.80) + 122.84 = 236.51$
- If < 1 then $BR = (.65 \times 75.80) + 122.84 = 172.11$
Facilities’ option to go 100% PPS or to phase in over 4 years
- Decide by 11/1/2010 [irreversible decision]
- No phase in for drug bundling, starts 1/1/2011
- $14 added to CMACR during phase in to ‘cover’ Part D drugs

If phase in will get 3:1, 1:1, 1:3, ALL, blend over four years.

Payment calculated under both methods of payment by year appropriate weighted average.

Wage Adjusted Base Rate will be reduced by 3% in the first year, and 1 to 3% in subsequent years until phase in period over
# Case Mix Adjustment

## Facility Facility ±
- Wage Index
- Low Volume (< 3000 trtmnts)
- Training Only
- Outliers ($64.54 part D drug)
- Current Exceptions eliminated
- Bad Debt on CMACR
- Site Neutral
- No rural, Alaska, Hawaii adjustments

## Patient Based +
- < 18 yrs, AGE, BMI, BSA
- Gender (Female 1.132)
- < 120 days from initiation (1.473)
- co-morbidities (1.021 to 1.316)
  - Substance abuse, cardiac arrest, pericarditis, HIV/AIDS, Hep B, Infections, GIB, hemolytic/SS anemia, cancer, myelodysplasia, monoclonal gammopathy
Outlier Policy

- Outlier services limited to items previously separately billable under Medicare Parts B & D including drugs and lab tests.

- For estimating the imputed MAP (Medicare allowable payment) for such services, facility would use ASP for Part B drugs, annual lab fee schedules for lab tests, and unclear mechanism for Part D drugs.

- Patient qualifies for additional outlier payment if adjusted cost of separately billable items exceeds “donut hole” of $134.96 over reimbursement calculated the standard way.

- Excess is reimbursed at 80%.
Examples of extremes in CMAPPS

Both patients dialyzing in Cleveland, OH (0.92 wage adj)
Patient A= 45 y/o man, on dialysis 4 years, 5’9”, 70 KG, no co-morbidities

A. 198.64 → 192.75 \times 1.1 = 192.75

B. 198.64 → 192.75 \times 1.132 \times 1.194 \times 1.069 \times 1.473 \times 1.089 \times 1.28 = 503.92

Patient B = 44 y/o woman, on dialysis 2 months, 5’, 110 kg, hepatitis B and breast cancer (diagnosed in 2003)
Quality Incentive Program (QIP)

- 2012 payment effected by performance in 2010 compared to baseline of 2008
- First year baseline = the lesser of facility results or national average.
- HBG > 12 (26%), HGB < 10 (2%), URR ≥ 65% (96%)
- 2 point bonus if results better than national average AND 2008 results.
- 30 points earned among 3 measures. 2 points lost for every 2% lower than baseline (national average).
  - 0 reduction if ≥ 28 points (unless any category is < 4 points)
  - 0.25% reduction for each 2 point reduction starting at 28 points
Quality Incentive Program (QIP)

- Currently claims based
  - URR (ESRD ≥6 months)
  - HGB (ESRD >90 days and receiving ESA)
  - July 2010 adding Kt/V, Access, Access Bacteremia to claim

- MIPPA requires eventually
  - Anemia, Iron Management
  - Patient Satisfaction
  - Bone Mineral Metabolism
  - Vascular Access

- CROWNWeb
  - Implementation delayed, Phase 2 facilities
  - Will allow more timely application of standards and baseline
  - Move away from Claims Based QIP
Challenges & Opportunities
safe, effective, patient-centered, timely, efficient and equitable

- Care based on continuous relationships
- Based on patient needs and values
- Patient as source of control
- Free flow of information
- Evidenced based decision making
- Safety as a system property
- The need for transparency
- Anticipate needs
- Continuous decrease in waste
- Cooperation among clinicians
Challenge

- 3x/week assumption discourages innovative Rx
- Discourage transient HD
- Discriminate against pts who skip or are on 2x/week
- Method II loss increase admin complexity (peds esp)
- Loss of training fee may discourage home therapy

Opportunity

- Improve patient centeredness
- Work frequency into the mix to allow for more flexible home and in-center modalities
- Evidence based indications for more frequent treatments
- Portability of bundle to allow travel (rehab)
- Reconsider training fee for patients starting after 4 months
## Challenge

- Wage index punishes rural small local providers
- Race and ethnicity not captured in CM. Possible disparate care
- Doesn’t capture costs for pediatrics
- Impact analysis overestimates co-morbidity prevalence (and payment under PPS)
- Co-morbidities are not obviously related to higher costs in outpatient setting
- Burden of coding verification

## Opportunity

- Transparency, fairness
- Data driven modification of the CM that drive cost of therapy
- This can work if it is ‘fine tuned’ in real time
- Look beyond wage index to the actual salaries necessary in any market to attract and retain staff
- Impact analysis re-evaluated with working data
- Better data transfer among and between venues of care to capture events and dxs
Bundling Part B and Part D drugs

Challenge
- Co-pays
- Prediction equation $R^2 = 8.7$
- Abx for non ESRD infections given elsewhere (PICC lines)
- EMP will persist
- Rationing & Disparity
- Narrow Formulary
- Disincentive for development

Opportunity
- Evidenced based decision making
- Cooperation among clinicians
- Foster research on the true value of these medications
Responsible for Part D meds

Challenge
- Narrow Formulary
- No patient liability (premium)
- Administrative Burden (state pharmacy regulations)
- Add On of $14 not adequate
- Post Hospital Med Recon
- Multiple pharmacies
- Safety issues related to facility staff ‘dispensing’ meds
- Conflict with prescriber

Opportunity
- Safety as a system property
- Decrease waste
- Cooperation among clinicians
- Sound med reconciliation practices
- Drug interaction profiling
- Med compliance tracking and improvement
<table>
<thead>
<tr>
<th>Challenge</th>
<th>Opportunity</th>
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<tbody>
<tr>
<td>Patient co-pays</td>
<td>Decrease waste and duplication</td>
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<tr>
<td>Nephrologist as PCP</td>
<td>Develop a menu of ESRD tests</td>
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<tr>
<td>Fragmentation/Duplication</td>
<td>Improve information systems for sharing of lab results</td>
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<td>PCP labs in other lab</td>
<td>Collaboration among providers, data sharing</td>
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<tr>
<td>Extra labs drawn</td>
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<td>Some screening not done</td>
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<td>Access at risk</td>
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Quality Incentive Program

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Opportunity</th>
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<tbody>
<tr>
<td>- Opportunity Cost</td>
<td>- Evidence based decision making</td>
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<tr>
<td>- Source, accuracy of data</td>
<td>- Transparency</td>
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<tr>
<td>- Data Definition</td>
<td>- Focus on more meaningful measures (access, BP,</td>
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<tr>
<td></td>
<td>- infection, inflammation, depression etc.).</td>
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<td>- Home dialysis measures.</td>
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<td>- 4 year cycle, not timely. Lags community</td>
<td>- Agree on timing, source of data</td>
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<td>- Define methods (Kt/V, frequency, RRF)</td>
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<td>- CrownWeb to provide more timely data</td>
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<td>- Develop best practice</td>
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<td>- Myopic, QA not QI</td>
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<tr>
<td>- Averages, not best practice</td>
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<tr>
<td>- Not significantly related to mortality,</td>
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<td>hospitalization</td>
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And So ….

- **The challenge** to move from revenue enhancement to cost containment
  - Rational use of scarce resources
  - Appropriate risk adjusting

- **The opportunity** to improve patient outcomes
  - What are the indicators of quality?
  - Increase collaboration among and between all specialists/PCP
  - Sharing information across systems
  - How best to increase survival and health related quality of life?

- **The opportunity** for Medical Directors to step up and take a leadership role in QAPI
The reason ....
USA’S 2009 Health Care Tab
$2.5 trillion
More than the total economic output of these countries

<table>
<thead>
<tr>
<th>Country</th>
<th>GDP (in trillions)</th>
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<tbody>
<tr>
<td>UK</td>
<td>2.2</td>
</tr>
<tr>
<td>Russia</td>
<td>2.1</td>
</tr>
<tr>
<td>France</td>
<td>2.1</td>
</tr>
<tr>
<td>Brazil</td>
<td>2.0</td>
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In 2009, the U.S. **debt-to-GDP ratio was 53%**, according to the Congressional Budget Office. Although this figure suggests that we have some short-term flexibility, our large and **increasing structural deficits** will push us past the 90% mark by the end of 2020, absent major policy changes.…

Even if we halve the gap between the growth in health care spending and the growth in the GDP, **some estimates suggest that our debt-to-GDP ratio would drop only from 300% to 200% by 2050.**
I will not discuss off label use and/or investigational use in my presentation.

I have financial relationships to disclose:

Honoraria from: The Renal Network, Arbor Research, Renal Research Institute
Kidney Care Partners is a coalition of patient advocates, dialysis professionals, care providers and manufacturers working together to improve quality of care for individuals with Chronic Kidney Disease.