

OCTOBER 2003

REPORT TO THE CONGRESS

Modernizing the
Outpatient Dialysis
Payment System

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MEDPAC Medicare
Payment Advisory
Commission

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Executive summary

Executive Summary

Medicare's policies do not appropriately pay for outpatient dialysis services because neither payments for services in the payment bundle nor payments for certain services outside the payment bundle accurately reflect facilities' expected costs. In March 2001, MedPAC recommended that the outpatient dialysis payment system be modernized so that Medicare could better achieve its objectives of providing incentives for controlling costs and promoting access to quality services. The important design questions that will need to be addressed as the outpatient dialysis payment system is modernized are:

- What services should be included in an expanded bundle? Along with widely used injectable drugs and laboratory services that are currently excluded from the bundle, the Secretary should consider including other services needed by end-stage renal disease patients, such as vascular access monitoring services, nutritional management, and Medicare-covered preventive services.
- Should the unit of payment for the facility remain a single dialysis session? Changing the unit of payment to either a week or a month might give providers more flexibility in furnishing care and better enable Medicare to include in the broader bundle services that are not always furnished during each session.
- What factors should be used to adjust payments? The Secretary should adjust payments for dialysis method, dialysis dose and the frequency that dialysis is furnished, and patient case mix. Doing so will better ensure that payments reflect efficient providers' costs and will reduce the incentive that providers may have to select less costly patients.
- What issues need to be considered when setting and updating the base payment rate? MedPAC suggests that the Secretary use audited cost report data to ensure that only Medicare-allowable costs are included in the calculations when setting the base payment rate. The Secretary also will need to address how a broader payment bundle will be updated to account for changes in the cost of services and how they are delivered.
- What steps need to be taken to ensure quality? We commend the past and current efforts of the Centers for Medicare & Medicaid Services to monitor, report on, and improve the quality of dialysis care. It will be critical for the Secretary to continue these efforts and to develop new measures that monitor the use of services included in a broader payment. In addition, linking providers' payments to quality may also promote the delivery of clinically appropriate care for the services included in an expanded bundle. The Secretary should also monitor patient satisfaction with care and other access indicators to determine whether patients face obstacles in obtaining needed care.

Along with these steps to modernize the payment system, MedPAC believes that the payment rate for home dialysis supplies received by DME suppliers should reflect efficient suppliers' costs. Currently, suppliers are paid up to 30 percent more than dialysis facilities for furnishing one form of home dialysis (continuous cycling peritoneal dialysis). There is no evidence to suggest that in this instance suppliers incur higher costs. Consequently, we recommend that the Congress should give the Secretary the discretion to modify the home dialysis payment rates for suppliers so that payment can better reflect the costs of efficient suppliers. This recommendation is consistent with the Commission's belief that payments for services furnished in different settings should not create financial incentives that inappropriately affect decisions about where care is provided.

**Modernizing the
outpatient dialysis
payment system**

R E C O M M E N D A T I O N

- 1 The Congress should give the Secretary the discretion to modify the home dialysis payment rates for DME suppliers—the method II rates—so that payment can better reflect the costs of efficient suppliers.

***YES: 16 • NO: 0 • NOT VOTING: 1 • ABSENT: 0**

***COMMISSIONERS' VOTING RESULTS**

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) required the Secretary of Health and Human Services to develop a system that includes in the outpatient dialysis payment rate—the composite rate—drugs and laboratory tests that are routinely furnished during dialysis but that are currently separately billable by facilities. BIPA also required the Secretary to develop a dialysis market basket index that can be used to update the composite rate.

The Secretary’s report outlines payment design issues that will be considered as he proceeds with developing an expanded payment bundle. Specifically, the report presents:

- an overview of the outpatient dialysis payment system,
- an outline of the payment issues—such as defining the payment bundle, defining the unit of payment, and accounting for differences in case mix and treatment practices—that will be considered as an expanded payment bundle is developed, and
- findings from a feasibility (Phase I) study sponsored by Centers for Medicare & Medicaid Services (CMS).

The report also explains the methods used to develop a market basket for services in the current composite rate.

MedPAC considered several issues in evaluating the Secretary’s report, from the general design questions for a prospective payment system (PPS) to the specific operational issues for the outpatient dialysis system. Based on our evaluation and guided by our previous review of these issues, we highlight the following conclusions:

- MedPAC reiterates its March 2001 recommendation that Medicare should, as soon as possible, refine the outpatient dialysis payment system by broadening the dialysis payment bundle to include commonly furnished services that are currently excluded from it and by accounting for factors that affect providers’ costs, including dialysis method, dose, and patient case mix. In addition, to promote the delivery of clinically appropriate care, the Secretary needs to continue to emphasize efforts to develop measures and monitor and improve dialysis care.
- The Congress should give the Secretary the discretion to modify the home dialysis payment rates for DME suppliers—the method II rates—so that payment can better reflect the costs of efficient suppliers.
- In the next phase of research, the Secretary needs to address how a broader payment bundle will be updated to account for changes in the cost of services and how they are delivered.¹

¹The Secretary has initiated the next phase of research to develop a broader payment bundle. CMS is sponsoring research that will develop bundled ESRD payment and implementation options.

Issues to consider when refining the outpatient dialysis system

The Secretary's study on broadening the bundle stems from concerns raised by the Congress and MedPAC about the appropriateness of the PPS for outpatient dialysis services. In March 2000, MedPAC raised concerns that the payment system did not pay appropriately for outpatient dialysis services because neither payments for services in the payment bundle nor payments for certain services outside the payment bundle accurately reflect facilities' expected costs (MedPAC 2000). In March 2001, we recommended refining the payment system by broadening the payment bundle and adjusting for factors that affect facilities' costs so that Medicare could better achieve its objectives of providing incentives for controlling costs and promoting access to quality services (MedPAC 2001).

Expanding the payment bundle

Facilities have strong incentives to control the costs of services included in the payment bundle. However, they have few incentives to control the costs of commonly furnished drugs and biologics—including erythropoietin, intravenous iron, antibiotics, and vitamin D analogues—billed outside the composite rate. Medicare spending for separately billable drugs is substantial, increasing, and becoming a larger share of end-stage renal disease (ESRD) spending. In 2001, spending for these drugs totaled more than \$2.3 billion; it grew 16 percent annually between 1996 and 2001. By comparison, dialysis spending totaled \$3.3 billion in 2001 and it grew 6 percent annually between 1996 and 2001.

MedPAC and others have shown that Medicare's payments for these drugs greatly exceeds facilities' costs, and that the profitability of these services may provide incentives for inefficiency and overuse.² Consequently, the Commission reiterates its March 2001 recommendation that the payment bundle should be broadened, as soon as possible, to include these services as well as other services that can be separately billed by providers, including laboratory tests, supplies, and blood products.

The mix of services, labor, and supplies included in the payment bundle varies based on the dialysis method, so the bundled payment rate may need to vary for each dialysis method. In particular, the Secretary will need to address key differences in the use of separately billable drugs between hemodialysis and peritoneal dialysis patients. For example, data from CMS show that hemodialysis patients more frequently received intravenous iron, a Medicare-covered service, whereas peritoneal dialysis patients more frequently received oral iron, which is not a Medicare-covered service.

We also indicated in our March 2001 report that the Secretary should consider broadening the bundle to include other services needed and commonly used by dialysis patients. Using a more comprehensive approach in paying for ESRD services, when coupled with quality measurement and case-mix adjustment, is an important step in lowering the high level of morbidity and

²The financial incentive to furnish as many services as possible is inherent in this fee-for-service payment arrangement. Several multicenter dialysis companies own laboratories and thus have an incentive to increase revenues by directing more tests to the company-owned laboratory.

mortality among this population and controlling total spending. We highlight three types of services the Secretary should consider including in the payment bundle: vascular access monitoring, nutritional management, and Medicare-covered preventive services.

- Vascular access services are furnished to the 90 percent of all dialysis patients who undergo hemodialysis.³ Including vascular access monitoring in the broader bundle and then measuring outcomes may ultimately decrease hospital admissions for the treatment of related complications, the second most frequent cause of hospitalization among dialysis patients. CMS's new disease management demonstration proposes to pay for a broader bundle that includes vascular access care.
- Because malnutrition is a frequent complication of ESRD, including medical interventions used to prevent or treat malnutrition in the bundle may improve patients' outcomes.⁴ CMS's clinical performance measures show that a high proportion of dialysis patients suffered from malnutrition between 1993 and 2001, and that patients' malnutrition status did not improve during this time period.⁵ The National Kidney Foundation's clinical guideline on nutrition care recommends that dialysis patients who are unable to meet their protein and energy requirements with food intake for an extended period of time should receive nutrition support. Nutritional supplements were furnished to patients participating in CMS's first ESRD managed care demonstration.
- The more than half of all ESRD patients who have diabetes are less likely to receive diabetic preventive services, such as lipid and glycemic control testing, than the general Medicare population. Including these and other preventive services, such as vaccinations for influenza and pneumococcal pneumonia, in the bundle may increase their overall use, minimize the extent of geographic variation, and, in the longterm, improve patients' outcomes. If the bundle is broadened to include these services, then the Secretary will need to develop measures to hold providers accountable for delivering these services.

Policymakers are also interested in including disease management services in a broader dialysis payment bundle. CMS's new ESRD disease management demonstration requires that fee-for-service providers furnish disease management services in an expanded payment bundle that also includes separately billable drugs (CMS 2003a). MedPAC is currently examining the use of disease management for ESRD beneficiaries.

³ Services related to vascular access care include: 1) surgically placing the vascular access, the site on a patient's body where blood is removed and returned during hemodialysis; 2) ongoing monitoring of the site to minimize the risk of complications, such as stenosis (narrowing of graft and blood vessel) and infection; and 3) treating and managing complications.

⁴ Available interventions include intradialytic parenteral nutrition for hemodialysis patients and intermittent parenteral nutrition for peritoneal dialysis patients.

⁵ In June 1999, the Commission recommended that Medicare determine clinical criteria for ESRD patients to be eligible for oral, enteral, or parenteral nutritional supplements and provide coverage for these supplements.

The Secretary will need to address two important issues when broadening the payment bundle. First, the Secretary will need to take steps to ensure that providers furnish clinically appropriate care for all the services included in an expanded bundle. As we noted previously, the Secretary will need to develop measures that can be used to monitor the use of services in a broader payment bundle. In addition, the Secretary could also link providers' payments to quality. In our June 2003 report, the Commission supported the use of linking providers' payments to quality performance (MedPAC 2003a). CMS will be linking providers' payments to quality in the new disease management demonstration for ESRD beneficiaries.

Second, the Secretary will need to consider whether new money will be required to pay for an expanded bundle. At issue is whether the current pool of dollars—for composite rate services, separately billable medications and laboratory tests, and any other services the Secretary includes in an expanded bundle—is sufficient. MedPAC plans on conducting research to address this issue, but two points are worth noting: 1) Medicare's payments for injectable drugs significantly exceeds providers' costs (MedPAC 2003b); and 2) there is wide variation in the use of these injectable drugs, suggesting that some providers may not be as efficient as others in furnishing these services (MedPAC 2003a; USRDS 2002).

Refining the unit of payment

Currently, the composite rate's unit of payment is a single dialysis session. Changing the unit of payment to either a week or a month might give providers more flexibility in furnishing care and better enable Medicare to include in the broader bundle services that are not always furnished during each session. The Secretary noted the challenges in lengthening the unit of payment because patients may receive care from more than one facility or may switch ESRD modalities during the course of the year, but this does not occur frequently.⁶

Other aspects of this setting are consistent with a longer unit of payment: 1) a weekly unit payment corresponds to the typical weekly interval for peritoneal dialysis; and 2) Medicare pays nephrologists a monthly capitated payment for caring for dialysis patients. Finally, the Secretary overcame similar data challenges when designing other payment systems, such as the monthly capitated payment for the first ESRD demonstration and the 60-day episode for the PPS for home health services. MedPAC intends to conduct further research concerning the appropriate unit of payment for an expanded bundle.

Adjusting payment for factors affecting providers' costs

The costs of different dialysis methods vary, and payments should reflect any differences. Medicare currently pays the same rate for in-center and home dialysis even though providers' costs for the most frequently used home method (peritoneal dialysis) are lower than in-center

⁶USRDS data show that among in-center hemodialysis patients who did not die during their first two years of dialysis, 22 percent of patients under 65 years of age and 4 percent of patients 65 years and older switched to a different treatment modality.

hemodialysis costs. This payment policy has not achieved the intent of the Congress to promote the use of home dialysis, as its use has declined during the past decade. Several factors may explain this trend:

- Certain patients may either prefer the social interaction of in-center care or may be unable to perform home dialysis.
- The rapid growth in the number of dialysis facilities throughout the 1990s has created an incentive to direct patients to treatment in-center so that facilities operate at capacity.
- The profitability of separately billable drugs may also provide an incentive for in-center care. Facilities can separately bill for all clinically necessary injectable drugs for in-center patients; for home patients, they can only bill for erythropoietin.

It is worth noting that the coinsurance incurred by beneficiaries undergoing home dialysis would be reduced if the payment rate reflected providers' efficient costs. Beneficiaries are responsible for a 20 percent coinsurance for composite rate services.

Researchers have noted that providers incur higher costs for furnishing daily hemodialysis versus thrice weekly hemodialysis (Kroeker et al. 2003, Mohr et al. 2001). Providers may also incur higher costs for furnishing higher doses of thrice-weekly hemodialysis and peritoneal dialysis compared with lower doses (Sehgal 2003). We encourage the Secretary to collect information from a representative sample of providers to confirm these findings.

Payment for a broader payment bundle needs to account for differences in case mix; otherwise, facilities may be underpaid for treating medically complex patients. Our June 2003 analysis showed that aggregate costs for composite rate services and injectable drugs varies widely, suggesting that some of the difference in facilities' costs may be explained by the health status of their patients.

Revising Method II payment provisions

The Secretary's report does not address the payment issues surrounding the method II payment option. However, because the report contemplates important changes to the payment system, we encourage an even broader look at how Medicare pays for dialysis services. A small subset of home dialysis patients may either bill Medicare directly or have suppliers bill Medicare under an assignment agreement; this payment method is referred to as method II. The amount paid under method II cannot exceed the amount of the median payment that would have been made under the composite rate payment for hospital-based facilities. The exception to this policy—the payment rate for one form of peritoneal dialysis—continuous cycling peritoneal dialysis (CCPD)—was set by the Congress to be 30 percent greater under method II than under the composite rate payment (i.e., method I). About 5,500 patients are currently receiving CCPD under method II (CMS 2003b).

Our analysis of 2001 cost reports shows that facilities' costs for furnishing CCPD were lower than their costs for furnishing in-center hemodialysis. Furthermore, there is no evidence to suggest that the costs incurred by suppliers for furnishing CCPD are any different than the costs incurred by facilities.

RECOMMENDATION

The Congress should give the Secretary the discretion to modify the home dialysis payment rates for DME suppliers—the method II rates—so that payment can better reflect the costs of efficient suppliers.

IMPLICATIONS

Spending

If the Secretary sets the payment rate for method II CCPD supplies to that of method I, this recommendation would decrease spending by less than \$50 million in one year. Over five years, spending would decrease \$50 to \$200 million.

Beneficiaries and providers

This recommendation would not adversely affect beneficiaries' access to high-quality care and would reduce their spending on the 20 percent coinsurance for dialysis services. This policy would reduce payments to DME suppliers but would better align Medicare payments to the costs of efficient suppliers.

Generally, the Commission believes that payments for services furnished in different settings should not create financial incentives that inappropriately affect decisions about where care is provided. Specific to dialysis payment policy, the payment bundle, base rate, and adjustments to the base rate should not vary based on whether the service is furnished by a facility or supplier so long as costs do not vary. If suppliers incur higher costs for furnishing CCPD to a more severely ill patient population, then adjusting payment to account for case mix will appropriately align payments to providers' costs.

The Office of Inspector General (OIG) found that the higher CCPD payment limit may be driving patterns of care:

- An increasing number of CCPD patients selected method II from 1997 to 2001.
- Medicare paid an additional \$15.3 million, and beneficiaries paid an additional \$3.1 million for CCPD under method II compared to method I (OIG 2003).

Based on this analysis, the OIG recommended that CMS limit method II payments for CCPD to those of method I. In its response to this report, CMS stated that the statute intends that the payment limits for CCPD to be higher than those for the composite rate.

The analyses by MedPAC and the OIG show that the congressional intent in establishing method II—to save beneficiaries money on coinsurance by allowing them to deal directly with suppliers—is not currently being achieved. In addition to the lack of savings, the program is burdensome to administer and requires additional program oversight; for example:

- The fiscal intermediaries (FIs) process all claims for method I; both the DMERCs and the FIs process method II claims.
- The OIG found that CMS incorrectly paid \$9.5 million because the required form indicating beneficiaries' home payment method was not submitted.

These findings—that beneficiaries are not saving money on their coinsurance under method II and that it is complex to administer—raise the broader issue of whether Medicare should continue using this payment method. The Commission will begin to consider the effect on beneficiaries' access to care if this payment method is eliminated.

Setting the base payment rate

The Secretary will need to set a base payment rate to reflect the costs efficient providers incur in furnishing a broader bundle of services. Sources of information the Secretary can use when setting the base payment rate are:

- Providers' cost reports for services furnished during dialysis—composite rate services and injectable drugs;
- Claims data for services that are covered and paid for by Medicare, such as vascular access care; and
- Data from demonstration projects and from a representative sample of providers for services not currently paid for by Medicare, such as higher doses of dialysis.

Two important issues about using cost reports when setting the base payment rate are worth noting. First, the costs submitted by hospital-based facilities, which account for about 20 percent of all facilities, are difficult to interpret because they are affected by cost allocation decisions made by hospitals.⁷ Second, recent cost report data have not been audited by CMS. MedPAC

⁷To set the initial base payment rate in 1981, CMS analyzed 1977-1979 cost report data and found that the costs for hospital-based facilities were \$4 higher than the costs for freestanding facilities. CMS attributed the higher costs incurred by hospital-based facilities to overhead, rather than to patient case mix or complexity.

believes it is important to consider the effect of the difference between reported and allowable costs when using cost reports. Our analysis of 1996 cost reports showed that the allowable cost per treatment for composite rate services and injectable drugs for freestanding facilities was about 96 percent of the reported cost of treatment.

Updating the broader payment bundle and other related factors

As the Secretary modernizes the outpatient dialysis payment system, he will need to update the broader payment bundle over time to account for changes in:

- the cost of services,
- how providers code across service categories and within service categories (if payment is case-mix adjusted), and
- how services are delivered.

CMS should conduct this assessment annually and MedPAC should annually assess payment adequacy and make update recommendations for the broader payment bundle to the Congress.

Monitoring quality of care

One concern about paying a fixed payment rate for a broader bundle is the potential for providers to stint on care. This occurred with Medicare's fixed payment policy for erythropoietin from 1989 to 1991. Consequently, the Congress changed the payment from a fixed rate to a dose-dependent rate in 1991, and CMS data show that the average dose has steadily increased during the past decade.

It will be critical for the Secretary to continue current efforts to monitor and report on the quality of dialysis care. Since 1993, CMS has monitored key aspects of the dialysis process, including anemia and nutrition levels, dialysis adequacy, and most recently, vascular access management, in the agency's annual survey of dialysis patients. In addition, the Secretary will need to develop new measures to monitor the use of other services included in a broader payment bundle, such as vitamin D analogues and laboratory tests. The agency's annual survey of dialysis patients could be expanded to include collection of these additional measures.

In addition to measuring the provision of services in a broader payment bundle, it is also important to measure and report on patients' satisfaction with their quality of care. In our March 2000 report, we recommended that the agency collect information on ESRD patients' satisfaction with the quality of and access to care (MedPAC 2000). Such information would enable policymakers and providers to identify access and quality problems and vulnerable subpopulations among ESRD patients.

Finally, the Secretary should explore the effectiveness of other ways to collect information on patients' quality of care. First, information on selected intermediate outcomes could continue to

be collected on the bills submitted by providers.⁸ Second, the recently implemented Standardized Information Management System, a national information infrastructure that electronically links all 18 ESRD network organizations with CMS, is expected to help the development of consistent quality improvement efforts and the collection and analysis of information on processes and outcomes of care.⁹

Issues to consider when developing the market basket for services currently included in the composite rate bundle

BIPA also required the Secretary to construct a market basket for the current composite rate bundle. The Secretary met this mandate by developing a market basket that reflects how much it would cost providers, over time, to purchase the same mix of goods and services that were purchased in a base period. This approach uses methods consistent with those used to develop the hospital, skilled nursing facility, and home health agency market baskets.

We raise two issues concerning the Secretary's methods to develop a dialysis market basket for composite rate services. First, the Secretary should address how frequently the base weights will be updated. For the inpatient hospital PPS, for example, the base weights are updated every five years. Second, the Secretary does not specifically address whether the weights were developed from audited cost report data. As mentioned above, it is important to recognize the difference between reported and allowable costs and that this difference varies across different cost categories.

Finally, we disagree with the Secretary's conclusion that the net effects of non-market basket factors—cost increasing and decreasing technological advancements and productivity improvements—offset each other and that updating the composite rate by just the change in the market basket would be technically supportable.¹⁰ By contrast, MedPAC reached a different conclusion in its most recent update recommendation included in our March 2003 report. Specifically, the Commission recommended that the composite rate payment be updated by the projected change in input prices, less an adjustment for productivity growth of 0.9 percent. Implicit in this recommendation is MedPAC's conclusion that the costs of most medical advances will be accounted for primarily through payments for separately billable drugs and that providers should be able to reduce the quantity of inputs required to produce a unit of service each year while maintaining service quality.

⁸Currently, dialysis facilities are required to report selected intermediate outcomes—hemoglobin or hematocrit levels to assess anemia status and urea reduction ratio to assess dialysis adequacy—on their bills for erythropoietin and composite rate services, respectively.

⁹The network organizations, under contract to CMS, promote improved quality of care through education and the collection, analysis, and dissemination of data.

¹⁰This conclusion was based on a preliminary analysis that showed that the market basket grew by 2.0 percent annually while composite rate costs grew by 1.8 percent from 1996 to 2000.

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A P P E N D I X

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**Commissioners' voting
on recommendation**

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Commissioners' voting on recommendation

In the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, the Congress required MedPAC to call for individual Commissioner votes on each recommendation, and to document the voting record in its report. The information below satisfies that mandate.

Recommendation

The Congress should give the Secretary the discretion to modify the home dialysis payment rates for DME suppliers—the method II rates—so that payment can better reflect the costs of efficient suppliers.

Yes: *Burke, DeBusk, DeParle, Durenberger, Hackbarth, Muller, Nelson, Newhouse, Raphael, Reischauer, Rosenblatt, Rowe, Smith, Stowers, Wakefield, Wolter*

Not voting: *Feezor*

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