Bundled Payments for Kidney Care

By By Jula Inrig , Subodh Saggi, Daniel Weiner, Rachel Shaffer, and Rajnish Mehrotra on behalf of the ASN Dialysis Advisory Group

This month the Centers for Medicare and Medicaid Services (CMS) will implement the most substantial payment reform in the end stage renal disease (ESRD) program since 1983, the new case-mix adjusted bundled prospective payment. Over 90 percent of dialysis units opted to be paid using this system at the outset, but implementation of the bundled payment system will be highly complex, particularly given the absence of evidence-based quality measures for ESRD care. There is a critical need for facile, accurate monitoring of practice trends and patient outcomes that may occur with the impending changes in dialysis care.

Anemia management

The most discussed—and potentially influential—element of the new payment system for 2011 is the inclusion of erythropoiesis stimulating agents (ESAs) and intravenous iron preparations in the bundle. ESAs drive cost variability in dialysis patient care, and have represented a profit source for many dialysis providers for years. Beginning in 2012, two competing forces will affect ESA use: 1) cost of ESAs, and 2) CMS's Quality Incentive Program (QIP), which will financially penalize facilities when patients' hemoglobin levels rise above 12 g/dL or fall below 10 g/dL. Given the inherent variability in hemoglobin levels, maintaining 98 percent of patients within this range will be challenging.

In the absence of data to guide care patterns, providers may accept a substantially larger number of patients with higher hemoglobin levels to meet this target, or reduce ESA dosing across the board, exchanging the financial penalty associated with levels below 10 g/dL for lower costs resulting from less ESA use.

Mineral and bone disorder

Optimal treatment of mineral and bone disorder (MBD) among dialysis patients remains unclear with therapeutic decisions often individualized and frequently based on nephrologists' interpretation of the best available evidence. Effective this month, CMS will include all intravenous (IV) vitamin D preparations and their oral equivalents in the bundle. Oral medications without IV equivalents (most notably cinacalcet and prescription phosphorus binders) will not be included until 2014.

Considering the paucity of data to support the use of one treatment for hyperparathyroidism over another, it is anticipated that use of more expensive vitamin D analogues will decline and that, at least until 2014, there may be preferential use of cinacalcet. Moreover, in response to broad therapeutic ranges for parathyroid hormone, phosphorus, and calcium levels suggested in current KDIGO guidelines, some dialysis organizations have modified protocols to allow higher levels of these parameters—and less medication for MBD management. While treatment decisions should not solely be based on financial considerations, this approach may provide new information about the cost-effectiveness of different MBD agents and therapeutic strategies, assuming appropriate monitoring strategies are in place.

Home dialysis

CMS has long offered incentives to providers intended to increase home dialysis use. The new bundle enhances existing incentives by offering identical payments for home dialysis and in-center hemodialysis. Home dialysis patients use fewer intravenous medications, likely making their care less costly to providers than in-center patients overall. Furthermore, in response to feedback from ASN and others, CMS will pay facilities to train patients for home dialysis (if the training occurs after the first four months after initiating dialysis). These incentives, along with the reimbursement for pre-dialysis education for stage 4 chronic kidney disease CMS has offered since January 2010, may lead to a greater use of home dialysis, particularly peritoneal dialysis.

Nephrologists and dialysis organizations should allocate resources for monitoring their own patients to detect the effects—positive or negative—of the new system.

Patient financial burden

Beneficiaries receiving Medicare Part B services are typically responsible for a 20 percent coinsurance fee. Implementing bundled payments may increase certain patients' financial responsibility. Separately billable medications have always been subject to patient or secondary insurance copayment; so their inclusion in the bundle will not substantially affect patients' financial responsibility. However, some laboratory tests included in the bundle (e.g., blood cultures for dialysis access-related infections) were not formerly subject to copayment. These will represent a new cost to patients—and one unique to the ESRD program.

Because CMS calculated the base bundled payment amount using the average of current costs, patients who are lower utilizers of resources in the current system likely will see increased copayments, while higher utilizers may actually realize a reduction in costs. CMS estimates that the bundled payment system will result in a net 1.2 percent increase in patient copayments, likely varying widely depending on utilization and secondary insurance.

Conclusion

The unprecedented new bundled payment system for dialysis has the potential to improve the quality, delivery, and cost of dialysis patient care. However, in the absence of a demonstration project prior to implementation of the expanded bundle, facile, timely, and effective monitoring will be critical to assess the effects on dialysis quality and patient access. The implementation of CROWNWeb may allow real-time monitoring of changes in dialysis practices and care. However, CROWNWeb will not be fully implemented until later in 2011, and smaller dialysis providers will be unable to batch data, placing them at a disadvantage.

Accordingly, as we embark on this new era of dialysis in the United States, uncertainty remains about CMS' ability to ascertain the effects of bundled payments on issues such as blood transfusions and bone loss and mineral metabolism parameters, as well as patient access to care, including potential disparities based on race/ethnicity or comorbid conditions (cherry-picking). Tracking data on these issues and other outcomes measures will be necessary to ensure the new system is enabling kidney professionals to provide optimum care for their patients.

ASN and the wider nephrology comunity should be encouraged by CMS' openness to input on the bundled payment system to date, and should continue to advocate for the Agency to allocate resources beyond CROWNWeb and the QIP to monitor the effects of the bundle on practice patterns, patient outcomes, and access to care in as close to real-time as possible. Nephrologists and dialysis organizations, too, should allocate resources for monitoring their own patients to detect the effects—positive or negative—of the new system, as well as conducting larger, population-based studies examining dialysis outcomes and practice patterns nationwide.

Julia Inrig is with the University of Texas-Southwestern, Dallas; Subodh Saggi is with SUNY Downstate Medical Center, Brooklyn, NY, Daniel Weiner is with Tufts Medical Center in Boston; Rachel Shaffer is a policy associate with ASN; and Rajnish Mehrotra is with the Los Angeles Biomedical Research Institute at Harbor-UCLA, Torrance, CA, and David Geffen School of Medicine at UCLA, Los Angeles.