



What can we learn from the U.S. expanded end-stage renal disease bundle?

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ABSTRACT

Episode-based payment, commonly referred to as bundled payment, has emerged as a key component of U.S. health care payment reform. Bundled payments are appealing as they share the financial risk of treating patients between payers and providers, encouraging the delivery of cost-effective care. A closely watched example is the U.S. End Stage Renal Disease (ESRD) Prospective Payment System, known as the ‘expanded ESRD bundle.’ In this paper we consider the expanded ESRD bundle 2 years after its implementation. First, we discuss emerging lessons, including how implementation has changed dialysis care with respect to the use of erythropoietin stimulating agents, how implementation has led to an increase in the use of home-based peritoneal dialysis, and how it may have contributed to the market consolidation of dialysis providers. Second, we use the expanded ESRD bundle to illustrate the importance of accounting for stakeholder input and staging policy implementation. Third, we highlight the need to consider system-wide consequences of implementing bundled payment policies. Fourth, we suggest how bundled payments may create research opportunities. Bundled payment policies offer opportunities and challenges. Their success will be determined not only by impacts on cost containment, but also to the extent they encourage high quality care.

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1. Introduction

There is virtual unanimity among health policy experts that payment reform is integral to the success of the U.S. health care system. One key policy option under consideration is the episode-based payment, commonly referred to as a “bundled” payment. Bundled payments refer to a single comprehensive “price” for all services involved in an episode of patient care. The appeal of bundled payments stems from the fact that both payers and providers

share the financial risk of treating patients [1]. Under this approach, if the costs of delivering care are less than the bundled payment, providers benefit financially, while, if costs exceed the payment, providers incur the difference. Bundled payments work better when episodes of care occur reliably over a defined timeframe; services contained within the episode of care are predictable; care is provided in a specific care setting; and patients eligible for the bundled payment are easily defined [2–5].

A closely watched example is the U.S. End Stage Renal Disease (ESRD) Prospective Payment System (PPS), known as the ‘expanded ESRD bundle,’ which was implemented by the Centers for Medicare and Medicaid Services (CMS) on January 1, 2011 [6]. In this paper we explain where the expanded ESRD bundle fits in relation to alternative payment systems, highlight some emerging insights from the recently established policy, and discuss implications for

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the design and implementation of future bundled payment policies for other conditions in the U.S. and around the world.

1.1. Medicare's ESRD benefit

Dialysis is an intensive process, with the vast majority of dialysis patients in the U.S. treated with hemodialysis at dialysis centers thrice weekly for approximately 4 h per session. Despite high cost and extensive infrastructure, overall prognosis remains poor, with 20% annual mortality among hemodialysis patients. In order to perform hemodialysis, large volumes of blood are processed through a dialysis filter, with optimal blood flows of approximately 400 ml/min. Dialysis units assess dialysis dose by measuring the clearance of a small filtration marker, called urea nitrogen. Other electrolytes, like calcium and phosphorus are followed, with nutritional interventions, phosphorus binders, vitamin D analogs, and calcimimetic agents used to manage the mineral and bone disorder associated with kidney failure. Other sequelae of kidney disease also traditionally have been managed by dialysis facilities, including anemia through the administration of erythropoietin and iron.

Although hemodialysis has been available in the U.S. for more than 50 years, it became widely used following Congress' inclusion of treatment for kidney failure requiring kidney replacement therapy in the Medicare program in 1972 [7]. To date ESRD remains the only disease-specific condition qualifying an individual for Medicare coverage, regardless of one's age or other disability. At the program's outset, annual costs of the program were projected to be \$250 million over 4 years to serve an annual population of approximately 26,500 patients [8]; in 2009, total Medicare costs for ESRD were \$29 billion, with almost half a million Medicare beneficiaries receiving ESRD coverage (including hemodialysis, peritoneal dialysis and kidney transplant recipients) [9].

Medicare payment for ESRD services has evolved considerably. The first notable shift occurred in 1983 when Medicare implemented a limited bundle that consisted of two components payable to dialysis facilities: a composite rate and a separately billable rate [10]. The composite rate encompassed delivery of all routine services associated with outpatient dialysis care and was set at a relatively

fixed reimbursement level, adjusted only for geographic region, patient size and pediatric patients [11]. The separately billable rate covered aspects of care introduced after 1983, such as drugs (e.g., erythropoiesis-stimulating agents (ESAs), parenteral vitamin D and parenteral iron administration), as well as some laboratory tests and medical supplies [12,13]. Through 2011, Medicare's spending for dialysis had increased steadily, an increase largely attributable to both the growing ESRD population and the separately billable reimbursement component. By 2005, separately billable items accounted for 40% of the total cost of dialysis care [14].

1.2. Path to the expanded ESRD bundle

Other published works, including a September 2012 review by Swaminathan S. et al. in Health Affairs, have provided a thorough historical perspective on ESRD payment policy [15]. In this paper, we briefly review the path to the expanded ESRD bundle to place it into context with alternative payment reform efforts. Fig. 1 illustrates the evolution of the expanded ESRD bundle. The overarching objective of the bundle is to reduce the cost of providing ESRD-related services while maintaining, or ideally improving, patient care. Specifically, Congress mandated a 2% reduction in CMS payments under the expanded bundle compared to the estimated projected total cost of maintaining the existing payment policy [6]. All items in the existing composite rate were included in the 2011 expanded bundle along with dialysis-related laboratory tests and injectable drugs, including ESAs, iron, and vitamin D analogs [6]. Also included were the oral forms of these drugs if available and intravenous antibiotics used to treat dialysis-associated infections.

Congress also required a Quality Incentive Program (QIP), which represents CMS's first non-demonstration pay-for-performance program [16]. Its purpose is to identify poor dialysis facility performance, and its implementation will, according to CMS, "result in payment reductions to providers of dialysis services and dialysis facilities that do not meet or exceed an established total performance score with respect to performance standards established for certain specified measures." [16] Poor performance on the 2012 QIP, as defined by two anemia management metrics (minimizing the number of patients

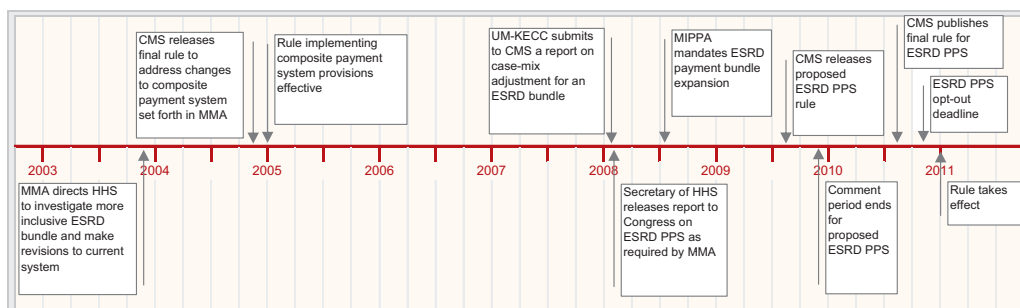


Fig. 1. Evolution of the expanded ESRD bundle. CMS = Centers for Medicare and Medicaid Services; ESRD PPS = End-Stage Renal Disease Prospective Payment System; HHS = United States Department of Health and Human Services; MIPPA = The Medicare Improvements for Patients and Providers Act (MIPPA); MMA = The Medicare Drug, Improvement, and Modernization Act of 2003; UM-KECC = University of Michigan Kidney Epidemiology and Cost Center.

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