# Discussion with the Office of Management and Budget (OMB) on Proposed Rule 2900-AN37

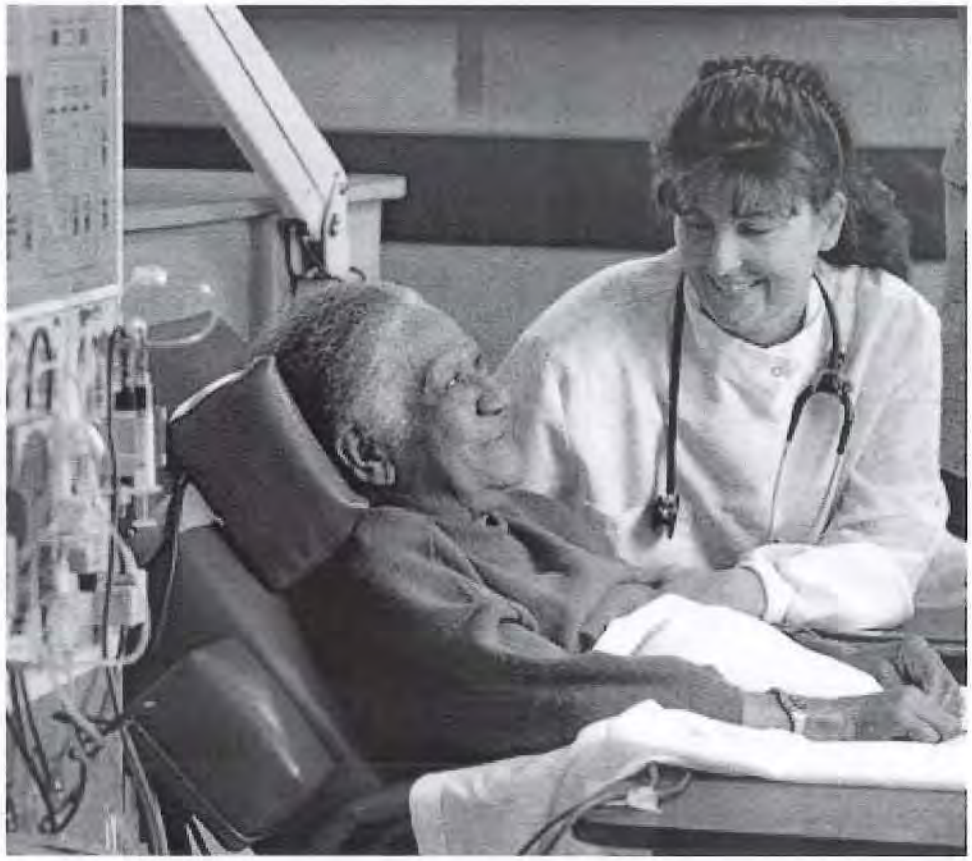
(Payments for Outpatient Care and Health Care Professional Services at Non-Departmental Facilities)

December 9, 2009

# Topics for discussion

- ESRD program is unique – life threatening/life altering
  - -Should be considered separately
  - -Economics specific to dialysis must be taken into account
  - -Disproportionate impact on minority and lower income groups
- Access to care for veterans is at stake
  - -Small shift in payor mix is significant for the ESRD program
  - -Centers at risk of becoming unprofitable and closing
- Important to consider alternative approaches for lowering overall costs of care
- Challenges associated with tying VA rates to the Medicare bundle

# DaVita at a Glance



- 117,000 Patients/week
- DaVita treats almost 1/3 of ESRD patients in the U.S.
- 32,000 Employees
- 43 States + District
- Leader in clinical outcomes

**DaVita translates to**
***"Giving Life"***

# Dialysis care is unique

- Frail patients with multiple co-morbidities
  - -Cannot survive without dialysis or transplant
  - -Access to care is critical
- Three treatments per week each requiring 4 hours of staff assisted care
  - -Specialized, highly skilled workforce needed for care
  - -Dietitian, Social worker, RN
- High tech medical equipment and supplies
- High cost pharmaceuticals

**High quality care can lead to improved outcomes and lower total costs**

# Clinical Outcomes Leader

| Measure | DaVita vs. Other Providers[1] (based on Publicly Reported Data) |
|---|---|
| Kt/V < 1.2[2] (How well we clean out toxins from blood) | 15% Better |
| Alb < 3.5[2] (Nutrition measure affecting mortality) | 18% Better |
| Fistulas Placed[3] (Best Access for patient & taxpayer) | 5%+ Better |
| Mortality[4] | 12% Better |

(1) "Other Providers" defined as National Average less DaVita
(2) DVA data from Sept 2008; Industry data from 2007 CMS Clinical Performance Measures Report (most recently published data, results from 2006)
(3) Fistula data all from Fistula First National Vascular Access Improvement Initiative Website (www.fistulafirst.org), results from September 2008
(4) Industry figure from 2007 USRDS Annual Data Report (Most recently published report, results from 2005); Table J16

# Dialysis center economics are fragile

- Dialysis differs from other payment systems
  - ~80% of beneficiaries are Medicare
  - ~40% of Medicare patients are dual eligible
- Medicare reimbursement does not cover cost of treatment
- Continued operations of unprofitable facilities is not viable

**Changes in reimbursement could compromise industry sustainability**

# Total costs: Most expenses for ESRD patients are outside of dialysis

- Dialysis accounts for only ~1/3 of the total cost for Medicare ESRD patients
- Hospitalizations are the largest cost driver for Medicare ESRD patients
- Savings from 1 fewer hospital admissions are significant

Source: 2005 Data (Trended to 2008) Source: Medicare FFS Sample for ESRD population, Actuarial Analysis;

# Care management

**Complex, vulnerable patients...**

- Medical complexity
  - Multiple co-morbidities
  - Many MDs, medications
  - Frequent hospitalization
- Inadequate care coordination
  - Gaps in preventative care
  - Patients not activated, engaged in care
- Many avoidable complications

**...proven interventions exist**

- Dialysis start with catheter correlated with 15% higher year 1 costs
- Reduced catheter rate correlated with reduced hospitalization
- Activated patients have longer mean time to dialysis
- Compliance correlates with slower kidney disease progression, lower total cost

**Patients achieving care management targets experience lower total cost**

# Part of the solution

**CKD Medicare demonstration**

- 2,000 FFS Medicare CKD patients enrolled in New York
- 5,000 in Control group
- Field + telephonic care model
  - Coordination of care and prevention

**25% reduction in progression to dialysis**

**ESRD demonstration**

- 400+ ESRD patients in California
- Case management nurses and clinical pharmacist drive preventive services/behaviors & coordination of care

**10% reduction in non-dialysis costs**

# Medicare: Major revamping of payment system in 2011

**Additional complexity**

- Expanded services
  - -Labs
  - -Certain oral medications
- Introduction of 17 case mix adjustors
  - -VA would have to supply patient data to providers
- Other facility adjustors (i.e. low volume)

**Sophisticated payment system**

- Outlier payment methodology
  - -Regression-based analysis
- Market basket update system

**High uncertainty, many decisions still to be made**

# Recommendations

- Consider impact of decisions
  - -Total cost of care
  - -Access to care – especially for rural veterans
- Solutions based on industry partnership, not unilateral action
- Integrated care = better care + savings

**Carve out dialysis from Proposed Rule 2900-AN37**