

patients. The Medicare Payment Advisory Commission (MedPAC) agreed that the current payment method lacks accountability and quality incentives, and thus encouraged CMS to address these issues. However, MedPAC also expressed concern that without baseline data it was unclear how we could determine and measure the impact of the proposed changes on quality and access. MedPAC further stated that the adjustments to payment should be made subsequent to the collection of information on resource costs and clinical guidelines. Together with these adjustments, further incentives should be added to the monthly payment to reward and improve the quality and access of dialysis-related physician care, which is consistent with MedPAC's June 2003 recommendations. Below are the specific issues raised by commenters:

Disproportionate Payment Differences

Many comments concerned the large variation in proposed payments to

physicians who see a patient only once a month, compared to the proposed payment for seeing a patient either two or three times during the month or four or more times during the month. In addition, commenters stated there is more work involved in managing care of the ESRD patients between visits.

Response: Based on our review of the comments, we agree that a significant amount of physician work for patients with ESRD occurs outside of the face-to-face visit with the patients. Since there may be significant physician work associated with providing physician services to ESRD patients between visits, we agree that there should be less difference in the payment levels than we proposed. By raising the minimum payment level, we are accounting for the extensive patient care coordination and other non-face-to-face management required by ESRD patients. However, we continue to believe that more physician work is associated with more frequent face-to-face visits with the patient, and

any variation in the payment amounts should reflect this difference.

First, we determined the appropriate relative relationship among different codes. For instance, we believe that approximately 25 percent more physician work is involved with providing two to three visits than with a single visit, and 50 percent more physician work is associated with providing four or more visits. By paying a single amount regardless of how often the patient is seen, we believe our current policy pays too much if the patient is seen fewer than four times per month. Thus, we revised our payment to be consistent with different levels of physician work associated with providing monthly management of dialysis patients. We are setting our aggregate revised payments equal to aggregate current payments. Consistent with these assumptions, we determined the following RVUs:

TABLE 3.—RELATIVE VALUES FOR NEW MONTHLY CAPITATION CODES

Age of patient	HCCPS	Number of visits	Work	Practice expense	Malpractice	Total
Patients Other Than Home Dialysis						
<2	G0308	4+	12.69	8.58	0.42	21.69
	G0309	2 to 3	10.57	7.13	0.36	18.06
	G0310	One Visit	8.45	5.72	0.28	14.45
2 to 11	G0311	4+	9.68	4.74	0.34	14.76
	G0312	2 to 3	8.07	3.94	0.29	12.30
	G0313	One visit	6.46	3.16	0.22	9.84
12 to 19	G0314	4+	8.24	4.45	0.26	12.95
	G0315	2 to 3	6.87	3.69	0.23	10.79
	G0316	One visit	5.50	2.96	0.17	8.63
20 +	G0317	4+	5.07	2.88	0.17	8.12
	G0318	2 to 3	4.23	2.39	0.14	6.76
	G0319	One Visit	3.38	1.92	0.11	5.41
Home dialysis patients (entire month)						
<2	G0320	.....	10.57	7.13	0.36	18.06
12 to 19	G0321	.....	6.87	3.69	0.23	10.79
2 to 11	G0322	.....	8.07	3.94	0.29	12.30
20 +	G0323	.....	4.23	2.39	0.14	6.76
Home dialysis patients (partial month only—per day)						
<2	G0324	.....	0.35	0.24	0.01	0.60
12 to 19	G0325	.....	0.23	0.12	0.01	0.36
2 to 11	G0326	.....	0.27	0.13	0.01	0.41
20 +	G0327	.....	0.14	0.08	0.01	0.23

We used the above principles to establish our monthly capitation payments (MCP) for patients 20 or older. For patients younger than 20, we are using the same relationship that exists among the current MCP codes for different age groups for the new codes that we are creating. For example, the current MCP code for a patient under 2

(CPT code 90918) has work RVUs that are approximately 2.5 times the work RVU for a patient 20 or older (CPT code 90921). Thus, Medicare's work RVU for each code for a patient 2 years or younger will be 2.5 times the amount of the corresponding service provided to a patient 20 or older. These values can be considered as interim and we plan to

seek the advice of the RUC in evaluating these codes once the policy has been implemented. There are efforts underway (for example, in their 2004 workplan, the OIG has indicated they will conduct a review of ESRD monthly capitation payments and physician services) which will provide data on the type frequency and content of physician