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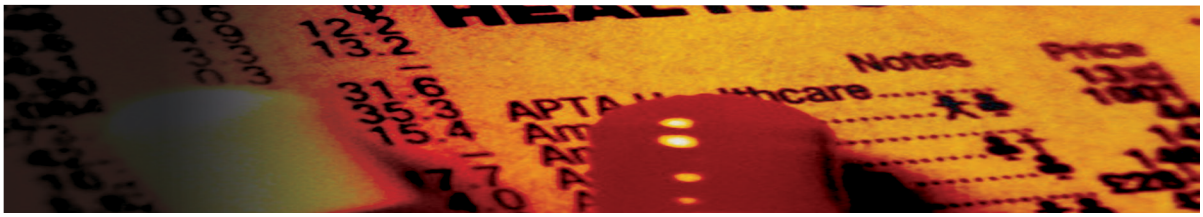
Issue 2



JUNE 2016

IN THIS ISSUE

The papers "Physician visits and 30-day hospital readmissions in patients receiving hemodialysis" and "Provider visit frequency and vascular access interventions in hemodialysis," co-authored by Kevin Erickson, M.D., M.S., appeared in the Journal of the American Society of Nephrology in 2014 and in the Clinical Journal of the American Society of Nephrology in 2015, respectively. Those papers were part of a larger project, "G-Code Reimbursement and Outcomes in Hemodialysis," which was funded by an Agency for Healthcare Research and Quality grant. Erickson is an assistant professor in the Section of Nephrology at Baylor College of Medicine, an investigator at the Houston Veterans Affairs Center for Innovations in Quality, Effectiveness and Safety and a nonresident scholar in health policy at Rice University's Baker Institute for Public Policy.

Baylor College of Medicine

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HEALTH POLICY research

Rice University's Baker Institute for Public Policy-Baylor College of Medicine
Joint Program in Health Policy Research

Should payment reform target certain subgroups?

"Yes," says Kevin Erickson, M.D., M.S., a researcher at Baylor College of Medicine and the Houston Veterans Affairs Center for Innovations in Quality, Effectiveness and Safety. Approximately 650,000 people in the U.S. have end-stage renal disease (ESRD) and require dialysis or a kidney transplant to stay alive. The majority of ESRD patients receive in-center hemodialysis and visit a dialysis center several times per week for treatment. In 2004, the Centers for Medicare & Medicaid Services transformed nephrologist reimbursement rates to encourage more frequent face-to-face physician visits. In several studies, Erickson and colleagues used a national dialysis registry to examine whether the policy improved patient health outcomes and in what circumstances patients benefit from more frequent visits.

A study comparing patient survival and listing for kidney transplant before and after the reimbursement reform found that nephrologist visits increased post-reform, as expected. Yet that did not translate into reduced mortality or an increased likelihood of wait-listing for kidney transplantation. In contrast, two studies of post-reform physician visits found that some in-center hemodialysis patients may benefit from more frequent visits. Hemodialysis patients who see their nephrologist more frequently benefit from a 10 percent reduction in the risk of a 30-day hospital readmission for each additional face-to-face visit in the month following hospital discharge. For patients who start hemodialysis with a central venous catheter as their vascular access, more frequent visits are associated with an increased likelihood of receiving an arteriovenous fistula or graft, which are better for patients. However, more frequent visits may not always be beneficial. A study of patients who were already receiving dialysis through a fistula or graft found that more frequent visits were associated with a greater use of ineffective imaging procedures and radiologic interventions.

Taken together, these findings suggest that more frequent physician visits for hemodialysis patients can improve health outcomes for certain patient subgroups, such as patients who are newly discharged from a hospital or those who recently started dialysis, but may lead to unnecessary interventions in other situations. Considering these benefits, it is interesting that increased nephrologist visits resulting from the reimbursement reform did not lead to overall reductions in mortality. Possible explanations for this discrepancy are that the patient subgroups who could have benefited from more frequent visits weren't actually seen more often as a result of the reform, or that physicians may not have done anything different for their patients.

Last year, President Barack Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015. This will make physician reimbursement in many areas of medicine subject to pay-for-performance initiatives or alternative payment models beginning in 2017. Analyses of Medicare's prior physician reimbursement reforms can help guide future efforts. The studies by Erickson and his colleagues highlight the importance of assessing the effectiveness of future reform efforts and their potential unintended consequences, and of targeting reform incentives toward specific patient subgroups.

HEALTH POLICY research presents a summary of findings on current health policy issues. It is provided by Vivian Ho, Ph.D., James A. Baker III Institute Chair in Health Economics and director of the Center for Health and Biosciences at Rice University's Baker Institute for Public Policy, in collaboration with Laura Petersen, M.D., MPH, chief of the Section of Health Services Research in the Department of Medicine at Baylor College of Medicine.

This publication aims to make research results accessible to regional and national health policymakers. The views expressed herein are those of the study authors and do not necessarily represent those of the Baker Institute or of Baylor College of Medicine.

The Baker Institute and Baylor College of Medicine's Section of Health Services Research work with scholars from across Rice University and Baylor College of Medicine to address issues of health care — access, financing, organization, delivery and outcomes. Special emphasis is given to issues of health care quality and cost.

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Volume 11, Issue 2, June 2016

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