OUTPATIENT DIALYSIS SERVICES PAYMENT SYSTEM

*payment***basics**

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Individuals with end-stage renal disease (ESRD)—irreversible loss of kidney function—require either dialysis or kidney transplantation to survive. In 1972, the Social Security Act extended all Medicare Part A and Part B benefits to individuals with ESRD who are entitled to receive Social Security benefits. This entitlement is nearly universal, covering about 90 percent of all people with ESRD in the United States. Total Part A and Part B Medicare spending for these beneficiaries has exceeded original spending projections—reaching $19 billion in 2005—primarily because of unanticipated growth in the ESRD population. The nearly 440,000 enrolled ESRD beneficiaries in 2005 accounted for about 1 percent of total Medicare enrollment. By contrast, ESRD beneficiaries accounted for only 0.1 percent of enrollment in 1974. This enrollment growth reflects population aging, increased prevalence of diabetes—a major risk factor for ESRD—and improvements in clinical knowledge and techniques that have enabled successful treatment of older patients and those with coexisting illnesses who might not have been treated 30 years ago.

Because of the scarcity of kidneys available for transplantation, most beneficiaries with ESRD (70 percent) receive maintenance dialysis. Medicare spending for outpatient dialysis and injectable drugs administered during dialysis was about $7.9 billion in 2005 and is a predominant share of revenues for dialysis facilities. Medicare pays dialysis facilities a predetermined payment for each dialysis treatment they furnish, using a payment system first implemented in 1983. The prospective payment—called the composite rate—is intended to cover the bundle of services, tests, certain drugs, and supplies routinely required for dialysis treatment and is adjusted to account for differences in case mix and local input prices.

Technological advances have changed the provision of dialysis care since the composite rate was established. Consequently, the composite rate currently excludes several injectable drugs—such as erythropoietin, vitamin D, and iron—that have diffused widely into medical practice over the past decade. Providers are paid separately for these services, and in 2005, drugs comprised about 37 percent of facilities' Medicare payments. Beneficiaries pay a 20 percent copayment for both composite rate services and separately billable drugs.

Defining the care that Medicare buys

Medicare covers two methods of dialysis—hemodialysis and peritoneal dialysis. In hemodialysis, a patient's blood is cycled through a dialysis machine, which filters out body waste. About 90 percent of all dialysis patients undergo hemodialysis three times per week in dialysis facilities. Peritoneal dialysis uses the membrane lining or the peritoneal cavity to filter excess waste products, which are then drained from the abdomen. Patients undergo peritoneal dialysis five to seven times per week in their homes.

The unit of payment is the dialysis treatment. Although different equipment, supplies, and labor are needed for hemodialysis and peritoneal dialysis, the current system does not differentiate payment based on dialysis method.

Providers separately bill Medicare for certain injectable medications, including erythropoietin and vitamin D analogs, and laboratory tests that are not included in the composite rate bundle.

For dialysis drugs, Medicare pays freestanding and hospital-based providers using average sales price. This method uses prices that manufacturers report to

This document does not reflect proposed legislation or regulatory actions.

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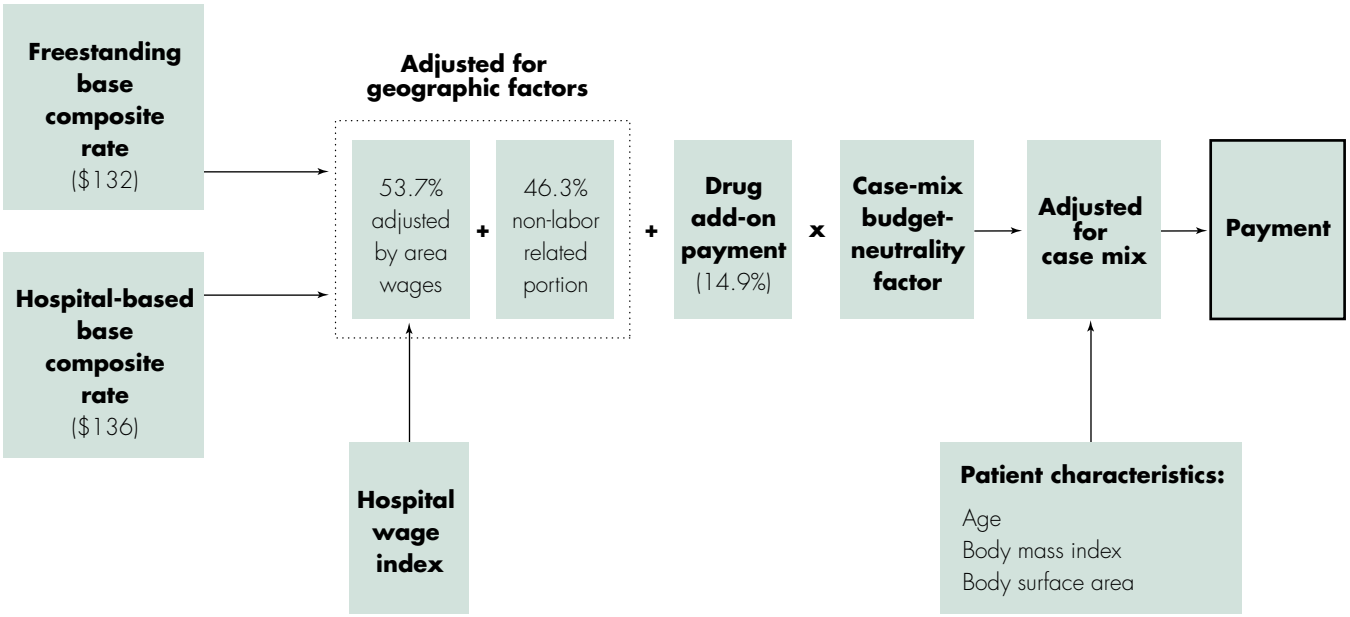
Figure 1 Dialysis prospective payment system in 2007



Note: Dialysis facilities are paid separately for furnishing certain injectable drugs. In 2005, these payments accounted for about 37% of all payments to dialysis facilities. In addition, providers furnishing laboratory tests outside the composite rate bundle are paid separately according to the laboratory fee schedule.

CMS every quarter. CMS set the 2007 rates for these drugs at average sales price (ASP) plus 6 percent.

Finally, providers furnishing laboratory services outside the composite rate bundle are paid according to the laboratory fee schedule.

Setting the composite rate

The composite rate is intended to cover all operating and capital costs that efficient providers would incur in furnishing dialysis treatment episodes in dialysis facilities or in patients' homes. The base payment rate is $132 for freestanding facilities and $136 for hospital-based facilities in 2007 (Figure 1). Medicare caps its payments to facilities at an amount equal to three dialysis sessions per week, although home dialysis may be given more frequently.

An add-on payment supplements the composite rate. It represents some of the profits previously associated with payments for separately billable drugs. CMS annually updates the add-on payment for the growth in expenditures for separately billable drugs furnished by providers. For 2007, CMS calculated an update factor of 0.5 percent and a total add-on payment of 14.9 percent of the composite rate for both hospital-based and freestanding facilities.

CMS adjusts the composite rate and the add-on payment for case mix using the following measures:

- age (<18, 18–44, 45–59, 60–69, 70–79, ≥80 years), and
- two body measurement variables—body surface area and body mass index.

CMS does not apply the body measurement variables when calculating payment for patients under 18.

CMS also adjusts the composite rate for differences in local input prices by using the Office of Management and Budget's Core-Based Statistical Areas. The agency uses the acute care hospital wage and employment data for fiscal year 2003 to calculate the ESRD wage indexes in 2007. The labor-related portion of the composite rate is 53.7 percent for both provider types. ■