

C H A P T E R

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Updating the Composite Rate for Outpatient Dialysis Services

R E C O M M E N D A T I O N

8A For fiscal year 2000, the composite rate for outpatient dialysis services should be increased by 2.4 to 2.9 percent. To help ensure that payment increases result in improvements in patient care, the Secretary should continue efforts to collect information on patient care and treatment patterns.

Updating the Composite Rate for Outpatient Dialysis Services

Dialysis facilities receive a prospective payment, called the composite rate, for each dialysis treatment they furnish. That rate has remained essentially unchanged since 1983. Even so, freestanding dialysis facilities have prospered because payments have historically been well above costs. In recent years, however, reported costs have risen in relation to the composite rate. The Medicare Payment Advisory Commission continues to be concerned that, without an increase in the payment, the quality of dialysis services may decline. Therefore, an update to the composite rate is recommended.

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Medicare coverage of ESRD

End-stage renal disease (ESRD) is marked by the irreversible loss of kidney function.

Normally, the kidney removes waste products from blood and regulates the amount of water and certain chemicals (especially electrolytes, such as sodium and potassium) in the body. The kidney also activates the vitamin D needed for bone formation and produces erythropoietin, which stimulates red blood cell formation.

The 1972 amendments to the Social Security Act extended all Medicare Part A and Part B benefits to people with ESRD. ESRD patients are eligible if they are fully or currently insured under Social Security or Railroad Retirement programs, entitled to monthly benefits under Social Security or Railroad

Retirement programs, or are the spouse or dependent child of an eligible beneficiary. Medicare covers dialysis and kidney transplantation, as well as immunosuppressive drugs for up to three years after a transplant and the antianemia drug Epogen.

Benefits for dialysis patients generally begin three months after eligibility is established. (Benefits may begin in the first month of coverage if the beneficiary dialyzes at home.) For ESRD enrollees who are covered by employer-sponsored group health plans, all medical claims during the first 30 months of Medicare eligibility are paid first by the employer's plan. If the employer's plan does not pay in full, Medicare makes secondary payments up to its specified limits or the billed amount, whichever is lower.

But providers have faced rising costs in recent years. Although growth in the number of facilities suggests that the dialysis industry is still profitable, the Commission is concerned that facilities can no longer continue to provide dialysis services under the current payment rate without compromising the quality of patient care.

RECOMMENDATION 8A

For fiscal year 2000, the composite rate for outpatient dialysis services should be increased by 2.4 to 2.9 percent. To help ensure that payment increases result in improvements in patient care, the Secretary should continue efforts to collect information on patient care and treatment patterns.

The update framework for dialysis facilities comprises three components: a market basket index that measures input price changes; a performance target; and a scientific and technological advances allowance. The latter two reflect changes in dialysis services and how they are produced. In making its update recommendation, the Commission also considers the adequacy of the current payment rate.

Estimating input price change

The input price component of the composite rate update is based on the projected increase in the market basket index for dialysis facilities. The market basket index is intended to measure the effect of changes in input prices on the cost of producing a dialysis treatment. It is constructed by defining input categories that reflect the full range of goods and services that dialysis providers purchase. Four cost components—capital, labor, other direct costs, and overhead—were used in developing the market basket for fiscal year 2000, along with data from the unaudited 1996 cost reports for independent facilities.

Each component has a weight that represents its cost share or proportion of

Most patients with end-stage renal disease (ESRD) are treated with dialysis, furnished either in hospital-based or freestanding dialysis facilities or at home under the supervision of a local facility. Dialysis facilities receive a fixed, prospective amount for each dialysis treatment, regardless of how it is provided. The prospective payment, called the composite rate, covers the bundle of services, tests, drugs, and supplies routinely required for dialysis treatment. The base composite rate for hospital-based providers is \$126; for freestanding facilities, it is \$122.

Unlike Medicare payments to other types of providers, the composite rate has not been updated annually. Except for a \$2 decrease implemented in 1986 and a \$1 increase in 1991, the composite rate has remained unchanged since 1983.

The Omnibus Budget Reconciliation Act of 1990 required the Prospective Payment Assessment Commission to study the costs of and payments for dialysis services and recommend to the Congress an annual update to the payment rate for dialysis-

related facility services. That responsibility was passed to the Medicare Payment Advisory Commission (MedPAC) in the Balanced Budget Act of 1997. To determine its update recommendation, MedPAC estimates how much costs will increase in the coming year, using a framework similar to that used for the hospital inpatient update recommendations (see Chapter 3). MedPAC also considers other factors, including the adequacy of the composite rate, in making its update recommendations.

Historically, the composite rate was considered to be more than adequate, since Medicare's payments to freestanding providers for dialysis services were considerably higher than reported costs. Freestanding facilities prospered, aided by additional reductions in service costs. Between 1983 and 1987, for example, facilities changed their staffing patterns, increased their use of high flux and high efficiency dialyzers (which led to shortened dialysis sessions), stepped up dialyzer reuse, and successfully sought price discounts from suppliers (Project HOPE 1993).

total expenses. Because data are not available on actual changes in individual prices, the price change for each component is measured by a proxy, derived from the components of the Health Care Financing Administration's (HCFA) input price indexes for PPS hospitals, skilled nursing facilities, and home health agencies. These proxies were used because proxies specific to the dialysis industry are not available. Even if they were available, dialysis-specific price proxies might not be appropriate. Because of the sizable amount of vertical integration in the dialysis industry (that is, the owner of a dialysis facility often owns the laboratory that services the facility or the supplier that equips it), changes in a dialysis-specific price index may be influenced by corporate pricing strategies rather than market forces.

MedPAC's market basket analysis indicates that the prices dialysis facilities pay for their inputs will rise an estimated 2.2 percent between fiscal years 1999 and 2000.

Considering changes in dialysis services and how they are produced

The Commission attempts to reflect the influence of trends in the provision and production of dialysis services in its recommendation. These factors are represented in the performance target and in the scientific and technological advances allowance.

Using data from Medicare Cost Reports, MedPAC examined the trends in a number of performance indicators to estimate what productivity gains dialysis facilities can reasonably be expected to attain in the coming fiscal year. The Commission considered four factors: the number of total treatments (including hemodialysis and peritoneal dialysis) per full-time equivalent employee (FTE);

staff mix measured by the ratio of registered nurses (RNs) to all direct patient care staff (including RNs, licensed practical nurses, nursing assistants, and technicians); the number of in-facility hemodialysis treatments per station; and the average length of a hemodialysis session. Previous analyses indicated that providers had increased their productivity markedly on all of these measures. In recent years, however, productivity improvements have slowed, and 1996 data for freestanding facilities showed a decline in productivity. The reported number of treatments per FTE and per hemodialysis station fell, while the length of dialysis rose (MedPAC 1998). In light of these considerations, the Commission does not expect productivity gains to be realized in fiscal year 2000.

The scientific and technological advances allowance is intended to recognize the costs associated with facilities' adoption of quality-improving technologies. Broad industry trends in the use and cost of new dialysis technologies are examined. The Commission's assessment suggests that, while some relatively new technologies continue to diffuse, there is little evidence that any of these will have a substantial cost-increasing effect in fiscal year 2000. Facilities will, however, face some added costs due to the effect of year 2000 computer problems. MedPAC therefore believes that scientific and technological advances could contribute between 0.2 and 0.7 percentage point to dialysis facility costs in fiscal year 2000.

Considering the adequacy of the composite rate

MedPAC also considered the adequacy of the current payment rate. By some measures that rate would appear to be adequate. For example, there has been no

reduction in the rate of entry into the market. Between 1995 and 1996, the number of freestanding facilities grew by 9.7 percent, as the industry attempted to keep pace with a 10 percent annual increase in the number of dialysis beneficiaries (USRDS 1998). At the same time, however, reported costs have risen in relation to the composite rate. The Medicare payment to cost ratio for these providers, calculated with unaudited cost report data, fell from 1.03 in 1995 to 1.00 in 1996 (MedPAC 1998). Although it is difficult to assess the accuracy of cost report information because it has been many years since these facilities' cost reports have been audited, the Commission is increasingly concerned that the quality of patient care may suffer if the composite rate is not updated.

The Commission believes that any increase in the payment rate for dialysis services should be used to improve the quality of care provided to beneficiaries. To this end, MedPAC supports HCFA's efforts to monitor patient treatment. In 1998, HCFA began to require providers of hemodialysis to report the urea reduction ratio—a measure of dialysis adequacy—on a monthly basis for every patient. These data will enable HCFA to monitor patient care more closely and may allow for future analyses of the relationship between dialysis adequacy and use of health services.

In future reports, MedPAC plans to consider the appropriateness of Medicare's payments for dialysis services. The current payment methods discourage the provision of services that can enhance the quality of dialysis (such as more frequent sessions and dietician services), while at the same time creating incentives for providers to furnish drugs and laboratory tests that are not covered by the composite rate. Improvements in Medicare's payment policies could heighten the quality of care that ESRD patients receive, thereby increasing quality of life for many beneficiaries. ■

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