

Impact of providers' costs on the quality of dialysis care

ISSUE: Certain freestanding dialysis facilities incur substantially lower Medicare-allowable costs per dialysis treatment than others. Of concern to policymakers is whether this variation in providers' costs influences quality of care. Are higher-cost providers less efficient than lower-cost providers? Or, do higher-cost providers furnish enhanced quality of care or treat a patient population that has more complex needs? Differing results have been reported by investigators examining outcomes of care as a function of dialysis unit size and profit status; however, no recent studies have explicitly assessed the relationship between providers' costs and the quality of dialysis care.

One of the goals of Medicare payment policy is to align payments with the efficient costs of providers and, in so doing, help ensure beneficiaries' access to high-quality health care services. If neither the quality of care nor the patient case-mix differ based on providers' costs, should policymakers consider the costs of higher-cost providers when assessing the adequacy of Medicare's payments for outpatient dialysis services? Alternatively, if higher-cost providers furnish enhanced quality of care, should Medicare's payment rates reflect the increased costs incurred by these providers?

KEY POINTS: The results of an analysis of the relationship between providers' costs and quality of dialysis care are in the attached report authored by Direct Research, LLC. Estimates of the average cost for in-facility hemodialysis were calculated from 2000 cost reports. Quality of care was assessed by measuring: adequacy of dialysis; anemia management; rates of hospitalization, transplantation, and mortality; and number of hospital days.

Providers do not appear to be stinting on furnishing composite rate services, for which Medicare pays a flat rate per dialysis treatment. Measures of adequacy of dialysis, anemia status, and rates of transplantation and mortality do not differ between lower- and higher-cost facilities, even after controlling for other provider and beneficiary characteristics.

Providers do not appear to be stinting on furnishing separately billable drugs to beneficiaries, which is not surprising given that Medicare pays for these drugs on a per-dose basis. Considering costs for both composite rate services and separately billable drugs together, we find that dialysis adequacy and rates of hospitalization and mortality are related to providers' costs, but that anemia status and rate of transplantation are unrelated to providers' costs.

ACTION: Commissioners should comment on the methods, findings, and conclusions set forth in the attached report. The results of this analysis will be included in a chapter in the June 2003 report.

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