ONLINE APPENDIXES 6

Outpatient dialysis services

ONLINE APPENDIX 6-A

The Comprehensive ESRD Care Initiative

On January 31, 2013, CMS announced its plan to test a new delivery model—the Comprehensive End-Stage Renal Disease (ESRD) Care model, or CED care model, for short—that includes financial risk arrangements with the goal of maintaining or improving outcomes and reducing Medicare Part A and Part B spending for dialysis beneficiaries. Under this initiative, ESRD Seamless Care Organizations (ESCOs)—consisting of at least one Medicare-certified dialysis facility and one nephrologist or nephrology practice—will take on the financial risk for a population of ESRD beneficiaries receiving dialysis treatment in a given area. The Center for Medicare & Medicaid Innovation anticipates that it will award between 10 and 15 ESCOs.

ESCOs will be differentiated by those that include participation of at least one dialysis facility owned by one of the two large dialysis organizations (LDOs)—organizations that operate more than 200 dialysis facilities—versus those that include participation of non-LDO facilities only. An ESCO will be required to participate for at least 3 years and have a minimum of 350 beneficiaries matched to it.

CMS will prospectively match eligible dialysis beneficiaries to an ESCO through a claims-based process using a "first touch" approach, meaning that a beneficiary's first visit to a dialysis facility during a particular period will prospectively match that beneficiary to the facility and by extension to the ESCO for the upcoming performance year. Like other accountable care organizations established by CMS, beneficiaries matched to an ESCO can seek care from any health care provider that accepts Medicare.

The method to calculate shared savings or losses (if applicable) is similar to the Medicare Shared Savings Program. For each performance year, the historical expenditure baseline (based on Part A and Part B per capita expenditures) will be risk adjusted, trended, price adjusted, and bundle adjusted to form an updated benchmark reflecting the performance year to compare with the ESCO's per capita expenditure amount for an actual performance year average. For optional performance in years four and five, baseline expenditures will not be rebased using actual performance data from the first three years of the initiative.

The extent to which ESCOs may share in savings or losses will vary based on the size of the organization. ESCOs that include at least one facility owned by an LDO are subject to two-sided payment risk. All other ESCOs that do not include any facility operated by an LDO are subject to one-sided risk.

Similar to the Medicare Shared Savings Program, CMS will use five domains to assess quality: preventive health, chronic disease management, care coordination/patient safety, patient/caregiver experience, and patient quality of life. ESCOs will need to meet a minimum attainment level for each quality-measure domain and will be required to meet a minimum total threshold score to be eligible for shared savings. In addition, ESCOs' participating dialysis facilities must receive a minimum total performance score assigned by the ESRD Quality Incentive Program for the ESCO to be eligible for any shared savings.

Originally, CMS anticipated that this ESRD initiative would begin in the last quarter of 2013. However, the start of the initiative has been delayed several times because of stakeholder feedback about the initiative's design and fewer applicants than expected, which has in turn resulted in CMS modifying the ESCO design. Currently, CMS is evaluating applications that were submitted in June 2014 by ESCOs composed of LDOs and September 2014 by ESCOs composed of non-LDOs.

Finally, CMS has previously tested new delivery models with the goal of improving quality and reducing Medicare spending for dialysis beneficiaries. Most recently, in 2006, CMS tested an approach that permitted dialysis beneficiaries to enroll in Medicare Advantage plans that developed ESRD disease management programs. Based on the first three years of this five-year demonstration, an independent evaluator found that the demonstration has resulted in some clinical benefits (e.g., improved survival), but that capitated payments for participants cost Medicare 13.4 percent more than if participants had remained in Medicare fee-for-service. ■

ONLINE APPENDIX 6-B

Part D dialysis drug spending, 2007–2012

TABLE 6–B1

Trends in Part D drug spending for dialysis beneficiaries, 2007, 2011, and 2012

Outcome measure	Part D spending 2012	Part D spending Aggregate percent change 2007–2012	Part D spending Percent change 2011–2012
Total:			
All Part D drugs	$2.1 billion	71%	12%
All Part D dialysis drugs*	1.0 billion	124	22
Per dialysis treatment:			
All Part D dialysis drugs*	$24	92	18
Calcimimetics for bone and mineral disorders	9	93	22
Phosphate binders for bone and mineral disorders	15	91	16

Note: *Part D dialysis drugs are cinacalcet (a calcimimetic) and calcium acetate, sevelamer, and lanthanum (phosphate binders). Part D spending per dialysis treatment is calculated by dividing total Part D spending for dialysis drugs by the total number of Part B dialysis treatments furnished by dialysis facilities.

Source: MedPAC analysis of 2007, 2011, and 2012 100 percent Part B and Part D files.

Part D spending for dialysis drugs has grown faster than dialysis beneficiaries' spending for all Part D drugs. As shown in Table 6-B1, from 2007 to 2012, Part D spending for dialysis drugs increased by 124 percent, from $462 million to $1 billion, while spending for all Part D drugs provided to dialysis beneficiaries increased by 71 percent, from $1.2 billion to $2.1 billion. In 2012, Part D spending for dialysis drugs accounted for about 50 percent of dialysis beneficiaries' gross Part D spending, an increase from 43 percent in 2007. Dialysis drug spending between 2011 and 2012 also grew more rapidly than total Part D spending for dialysis beneficiaries (22 percent vs. 12 percent, respectively).

The Secretary intended that the ESRD PPS payment bundle, beginning in 2014, include Part D dialysis drugs. The statute has thrice delayed bundling these drugs, first to 2016 and then to 2024 and 2025. Including dialysis drugs covered under Part D in the Part B payment bundle may lead to better management of drug therapy, which may lead to improvements in the efficiency of care. The decision-making process would be based on what is best for the patient. Incentives to use a Part D drug for a service covered under the bundle that might not result in the best care would be eliminated. In addition, giving the Secretary the flexibility to rebase the payment bundle after the drugs are bundled could, if their use declines, lead to savings for beneficiaries and taxpayers. ■