ONLINE APPENDIXES 6

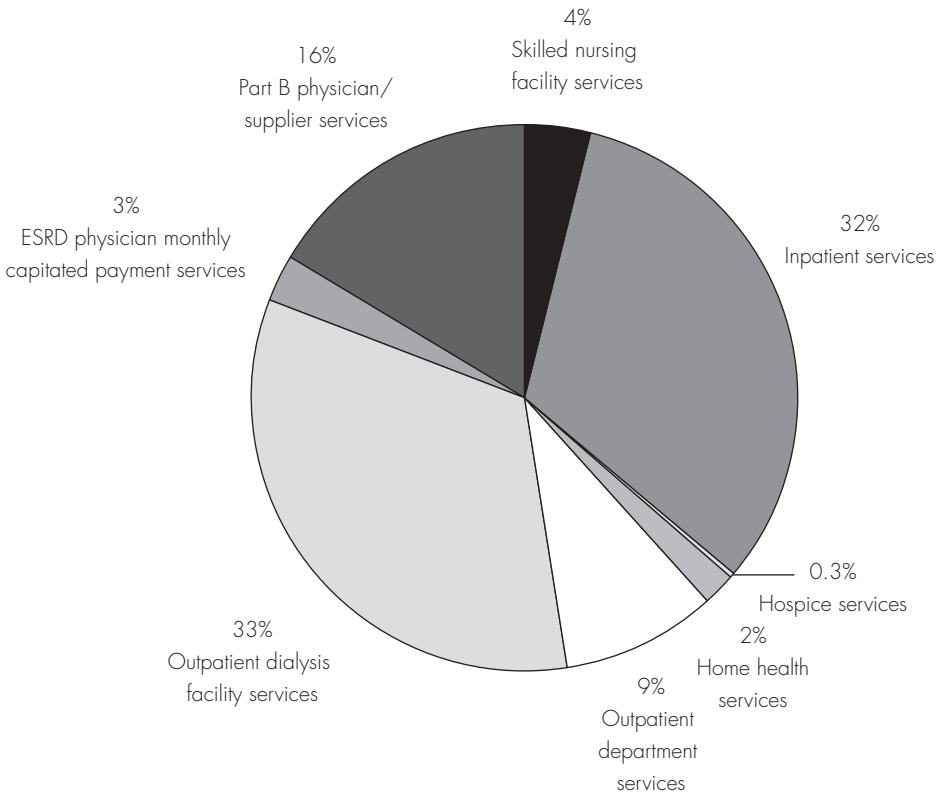
Outpatient dialysis services

ONLINE APPENDIX 6-A

Medicare spending by dialysis beneficiaries is substantial

FIGURE 6–A1

Dialysis beneficiaries' spending for Part A and Part B services, 2013



Note: Spending includes beneficiary deductibles and cost sharing.

Source: MedPAC analysis of the 2013 Master Beneficiary Summary file and 2013 claims submitted to CMS by dialysis facilities.

Program spending on dialysis beneficiaries (including beneficiary out-of-pocket spending) for Part A and Part B services is on average substantially greater than spending for all fee-for-service beneficiaries. According to CMS's Master Beneficiary Summary File, 2013 program spending for Part A and Part B services averaged nearly $85,000 for dialysis beneficiaries, about 8.5 times greater than average program spending for all beneficiaries. Dialysis beneficiaries' high spending is associated with their use of inpatient services (32 percent of Part A and Part B spending) and outpatient dialysis services (33 percent of Part A and Part B spending) (Figure 6-A1).

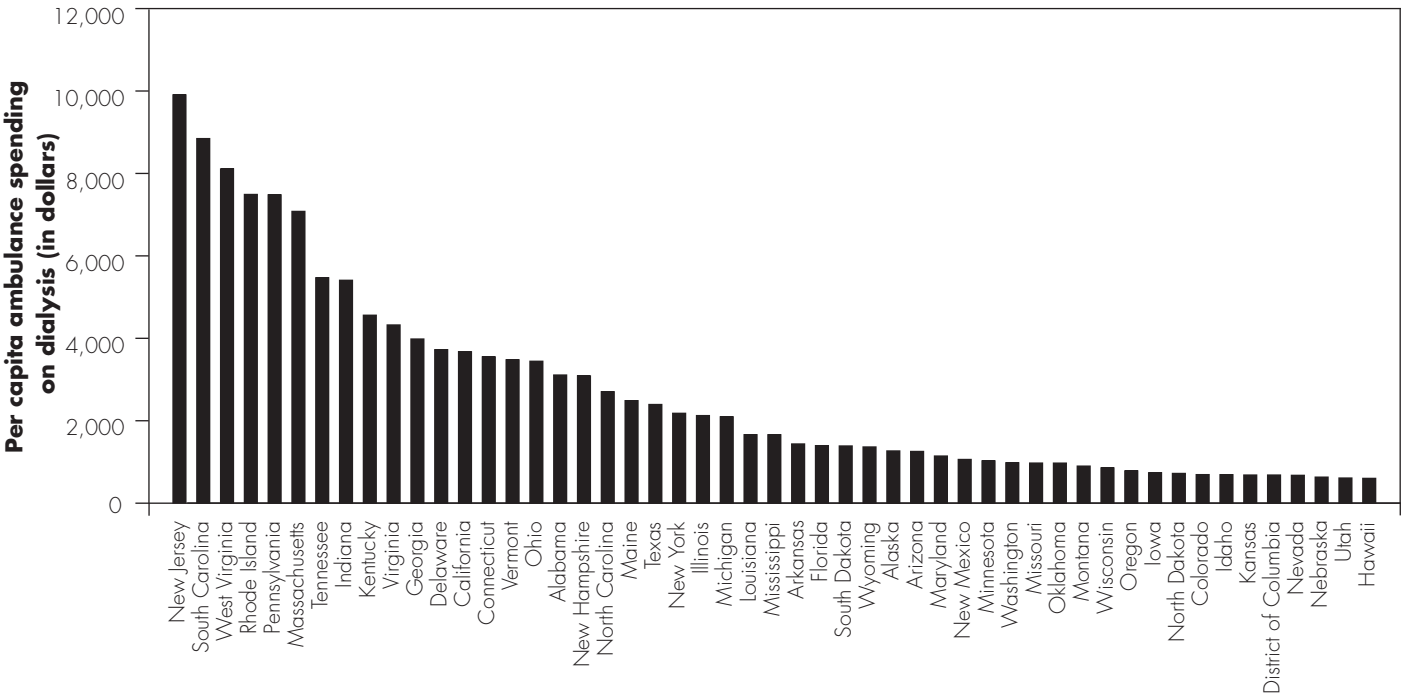
Although hospital admission and 30-day readmission have trended down in recent years, rates remain high. Between 2011 and 2014, mean hospital stays declined from 1.7 per beneficiary to 1.5 per beneficiary, while 30-day readmission rates declined from 23 percent to 21 percent. Emergency department treat-and-release visits increased from about 1.2 visits in 2011 to 1.3 visits in 2013. ■

ONLINE APPENDIX 6-B

Medicare spending for nonemergency ambulance services by dialysis beneficiaries is substantial

FIGURE 6B–1

Medicare ambulance spending for beneficiaries on dialysis, per capita, 2011



Source: United States Renal Data System 2013.

Traveling three times per week to and from a dialysis facility presents a significant challenge by the approximately 90 percent of dialysis beneficiaries who obtain in-center hemodialysis. Researchers have linked transportation-related reasons—along with age, race, ethnicity, personal reasons, and medical reasons—to patients skipping and shortening their in-center hemodialysis treatment schedule (Gordon et al. 2003, Obialo et al. 2012).

The Commission previously raised concerns about the use of nonemergency ambulance services by dialysis beneficiaries (Medicare Payment Advisory Commission 2013). We found pronounced growth in nonemergency ambulance transports to and from dialysis facilities between 2007 and 2011, and tremendous variation across states and territories in per capita spending for those types of transportation. In this appendix, we present updated findings that are consistent with our earlier conclusions.

In 2013, Medicare spending on ambulance services for dialysis beneficiaries continued to be substantial, totaling $1.3 billion (including beneficiary out-of-pocket spending) and increasing between 2011 and 2013 by 3.6 percent per year. Most (about 85 percent) of the ambulance services furnished to dialysis beneficiaries were basic life support (BLS) nonemergency transports rather than more complex service types. In 2013, about half of all dialysis beneficiaries were ambulance users, averaging about 20 ambulance transports. More than 70 percent of dialysis beneficiaries' spending for ambulance services ($920 million) were for transport to and from dialysis. Of dialysis facility transports, nearly all (97 percent) were BLS nonemergency, nearly 55 percent traveled to or from a beneficiary's residence, and about 40 percent traveled to or from a skilled nursing facility to a dialysis facility.

Ambulance use remains concentrated, with 5 percent of ambulance users accounting for over 145 transports per year. This use amounted to approximately $46,000 per user and about 55 percent of ambulance spending, collectively, on dialysis beneficiaries. Ambulance use continues to vary significantly by state; New Jersey,

Pennsylvania, Rhode Island, South Carolina, and West Virginia had the highest ambulance spending per capita in 2011 (United States Renal Data System 2013) (Figure 6-B1).

Beginning December 2014, CMS initiated a prior authorization model for repetitive, scheduled nonemergent ambulance transports in three states (New Jersey, Pennsylvania, and South Carolina), testing whether prior authorization helps reduce expenditures while maintaining or improving quality of care (Centers for Medicare & Medicaid Services 2015). All repetitive, scheduled nonemergent ambulance transports in these states are required to complete the prior authorization process or the claims will be stopped for prepayment review. The Medicare Access and CHIP Reauthorization Act of 2015 expanded to five additional states (Delaware, Maryland, North Carolina, Virginia, West Virginia) and the District of Columbia the prior authorization model for repetitive, scheduled nonemergent ambulance transports by 2016 (Centers for Medicare & Medicaid Services 2015).

In our June 2013 report to the Congress, we said that one way to address concerns about transport to and from dialysis would involve dialysis facilities providing local transportation services to their patients (Medicare Payment Advisory Commission 2013). Currently, the provision of complementary local transportation can implicate the anti-kickback statute (42 U.S.C. Section 1320a-7b(b)) and the civil money penalty law prohibiting inducements to Medicare and Medicaid beneficiaries (42 U.S.C. Section 1320a-7a(a)(5)). If exceptions to these laws were created, facilities might find more efficient and clinically appropriate ways to transport patients to and from dialysis facilities than ambulance transportation services. However, this policy would not increase the Medicare bundled payment for dialysis facilities or require dialysis facilities to provide transportation services. The costs of providing nonemergency medical transportation would not be allowable in calculating the bundled payment under the dialysis prospective payment system. Dialysis facilities may have both a quality-of-care and a financial incentive to provide transportation for their dialyzing patients. For example, one incentive would be to ensure that patients do not experience declines in health status from missing dialysis sessions because of a lack of transportation to and from the dialysis facility. Another incentive would be to ensure that patients arrive on schedule for their dialysis treatments, allowing facilities to be used more efficiently. ■

References

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