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END-STAGE RENAL DISEASE

CMS Should Monitor Access to and Quality of Dialysis Care Promptly after Implementation of New Bundled Payment System

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Highlights

Highlights of GAO-10-295, a report to congressional requesters

Why GAO Did This Study

Medicare covers dialysis for most individuals with end-stage renal disease (ESRD). Beginning in January 2011, the Centers for Medicare & Medicaid Services (CMS) is required to use a single payment to pay for dialysis and related services, which include injectable ESRD drugs. Questions have been raised about this new payment system's effects on the access to and quality of dialysis care for certain groups of beneficiaries, such as those who receive above average doses of injectable ESRD drugs. GAO examined (1) Medicare expenditures for injectable ESRD drugs, by demographic characteristics; (2) factors likely to result in above average doses of these drugs; (3) CMS's approach for addressing beneficiary differences in the cost of dialysis care under the new payment system; and (4) CMS's plans to monitor the new payment system's effects. GAO analyzed 2007 data—the most recent available—on Medicare ESRD expenditures and input from 73 nephrology clinicians and researchers collected using a Web-based data collection instrument. GAO also reviewed reports and CMS's proposed rule on the payment system's design and interviewed CMS officials.

What GAO Recommends

GAO recommends that CMS begin monitoring access to and quality of dialysis care for certain beneficiary groups as soon as possible after implementation of the new payment system. CMS agreed with this recommendation.

View GAO-10-295 or key components.
For more information, contact James C. Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

Certain demographic groups had above average Medicare expenditures for injectable ESRD drugs in 2007. For example, Medicare spent $782 per month on injectable ESRD drugs per African American beneficiary, which was about 13 percent more than the average across all beneficiaries on dialysis and was also higher than for other racial groups. Similarly, monthly Medicare spending per beneficiary with additional coverage through Medicaid was about 6 percent higher than the average across all beneficiaries on dialysis.

Although GAO did not identify the factors that led to the differences described above, it did obtain information from 73 nephrology clinicians and researchers, selected through referrals from dialysis-related professional organizations and a literature review, on the factors that they consider likely to result in above average doses of injectable ESRD drugs. A majority of these experts identified primarily clinical factors as likely to result in above average doses of these drugs. For example, at least 50 percent of the 73 clinicians and researchers from whom GAO obtained information identified 14 factors (including chronic blood loss and low iron stores) as likely to result in above average doses of erythropoiesis stimulating agents, which accounted for about 75 percent of expenditures on injectable ESRD drugs in 2007.

CMS's proposed design for the new payment system for dialysis care includes, as required by law, two payment mechanisms to address differences across beneficiaries in their costs of dialysis care. Under the first payment mechanism—a case-mix adjustment—CMS proposed to adjust payments based on characteristics such as age, sex, and certain clinical conditions that are associated with beneficiaries' costs of dialysis care. The second proposed payment mechanism—an outlier policy—involves making additional payments to providers when they treat patients whose costs of care are substantially higher than would be expected.

CMS's preliminary plans for monitoring the effects of the new payment system build on existing initiatives, but it is unclear whether CMS will monitor the effects on the quality of and access to dialysis care for groups of beneficiaries. In prior work, GAO and others have emphasized the importance of monitoring both the quality of and access to care to ensure that Medicare payment system changes do not result in certain groups of beneficiaries experiencing poor care quality or problems accessing services. CMS intends to monitor the quality of dialysis care under the new payment system, but the extent to which CMS will conduct such monitoring for various groups of beneficiaries is currently unclear because CMS's plans are preliminary. Furthermore, CMS's preliminary plans for monitoring access to dialysis care are limited. However, CMS has stated that it will have a comprehensive monitoring strategy in place by January 2011.

GAO obtained comments on a draft of this report from CMS and from industry groups representing both large and small dialysis providers and nephrologists.