DPC
DIALYSIS PATIENT CITIZENS

Improving Life Through Empowerment

Ensuring Access to Quality Dialysis Care—Stable and Adequate Reimbursement Is Needed

Dialysis is unique among treatments for chronic conditions—a patient with kidney failure needs dialysis on a regular basis to stay alive. In the 1960s, when demand for dialysis exceeded the capacity to provide it, policymakers recognized the need for government action to ensure access to dialysis. The federal government's first initiatives involved direct support for new dialysis facilities. Finally, in 1972, Congress expanded the Medicare program so that any patient with end-stage renal disease (ESRD) can enroll in health insurance coverage for dialysis.

By extending Medicare coverage to dialysis patients, Congress elected to pay dialysis facilities on a fee-for-service basis, the same as other providers such as physicians and hospitals. Medicare's system of "administered prices" is subject to complex formulas, bureaucratic rigidity, and political wrangling. These factors combine, over an exhausting cycle that is repeated every year, to sow instability in payment levels. For patients, this leads to a roller-coaster ride of anxiety about the continuity of their care.

Another unique feature of dialysis is the reliance of providers on Medicare funding. Medicare fees are offered on a take-it-or-leave-it basis to providers. Some doctors and specialty hospitals decline to participate in the Medicare program and instead concentrate on a higher-paying clientele. But physicians and hospitals have many other sources of revenue and mechanisms available for increasing their income. Dialysis clinics can't offer elective procedures or use mergers to increase their leverage over insurers. Unfortunately, the Center for Medicare and Medicaid Services, which sets payments, does not acknowledge any legal duty to keep payment levels for dialysis adequate to cover the costs of providing services.

At present, payments to dialysis facilities are frozen at 2013 levels for two years. Beginning in 2016, payments are scheduled to be reduced by 12 percent—an amount far in excess of the 3.9 percent average Medicare margin for dialysis facilities. This means that clinics' reimbursements were not updated to reflect inflation and that the prospect of a substantial cut looms over decisions to maintain current facilities, nearly one-third of which have negative margins. These negative-margin facilities have lower volumes and are located in areas with lower population densities.

Dialysis Patient Citizens endorses the following principles for dialysis payment policy:

1. **Dialysis reimbursements should be sufficient to permit ready, convenient access to facilities for every patient.** In enacting Medicare coverage for ESRD patients, Congress intended that dialysis facilities be readily available to every American. Prior to 1972, facilities were concentrated in urban areas and regions where academic medical centers had nephrology programs. This meant that to receive dialysis, patients not only had to be judged "worthy" of one of the limited slots in a facility but also might have to uproot from their hometown or quit their jobs. Congress wanted to ensure that dialysis treatment would not require such sacrifices, and that the national kidney care infrastructure would be expansive enough that patients could continue working.

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2. **Dialysis reimbursements should be stable enough to encourage continued investment in facilities and care.** It is of great concern to patients that MedPAC found that dialysis facilities in the two lowest quintiles of volume have negative margins. These facilities are disproportionately located in rural areas where facility closures would cause patients the most disruption in terms of travel times. The financial pressures of operating negative-margin facilities discourage investment in allied health professional staffing, even as CMS' ESRD Seamless Care Organization initiative asks providers to increase such investments.

3. **Dialysis reimbursements should reflect the unique circumstances of ESRD treatment.** CMS should recognize that dialysis facilities are unique and pursue payment policies that reflect this. Dialysis providers cannot decline to participate in the Medicare program—the historic status of Medicare as the primary purchaser of kidney care makes that impossible. If Medicare officials set the price so low that it doesn't cover costs, dialysis organizations would cease to be viable. Further, CMS should acknowledge that the usual worries about paying providers too much don't apply to dialysis. Dialysis is only appropriate for kidney failure, and there is little prospect of suppliers inducing demand for this grueling regimen.