

# Chapter 9: Costs of ESRD

## Introduction

Since the Medicare end-stage renal disease (ESRD) entitlement was enacted by Congress in 1972, the size of the program, both in terms of number of patients served and total spending, has grown substantially. Even though the ESRD population remains less than one percent of the total Medicare population, it has accounted for about six percent of Medicare spending in recent years.

This chapter presents both recent patterns and longer-term trends in total Medicare spending, and spending by type of service. Medicare Part D prescription drug data were not available to the new USRDS Coordinating Center in time for inclusion in this Annual Data Report (ADR). In lieu, the current chapter focuses on Medicare spending for items other than outpatient prescription drugs. Please refer to the 2013 ADR for information on Part D, Medicare Health Maintenance Organizations (HMO; managed care), and private insurer spending through 2011 (USRDS, 2013). Analyses of these topics will be included in the 2015 ADR.

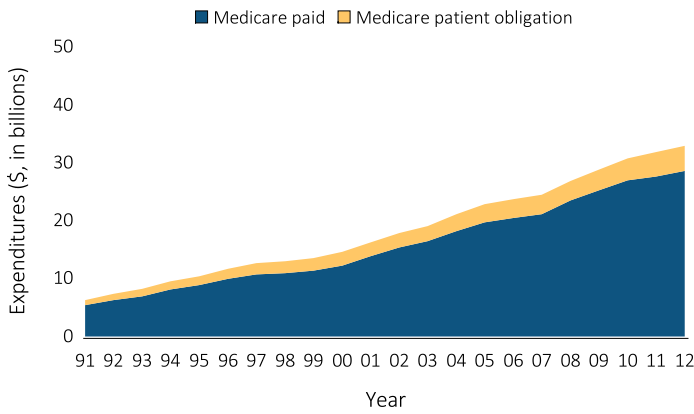
This report features data from 2012, the second full year under the expanded, bundled Prospective Payment System (PPS). Early research on the effects of the PPS showed substantial declines in the utilization of injectable medications and an increase in the use of peritoneal dialysis (Hirth et al., 2013; Civic Impulse, 2013). Savings from these changes, however, are not reflected in Medicare payments. Because the fixed, bundled payment rate was based on the higher utilization rates from 2007, any savings arising from lower utilization accrue to dialysis facilities. In response to these savings, Congress mandated in the American Taxpayer Relief Act of 2012 that CMS “re-base” the bundled payment rate to reflect these reductions in utilization. This action would have had the effect of transferring the savings to Medicare (and, hence, to taxpayers). To meet this mandate,

CMS proposed a 12 percent reduction in the per-dialysis session base rate. After accounting for an inflation adjustment of approximately three percent, net payments in 2014 would have fallen by about nine percent per treatment. Before the reduction could be implemented, however, it was rolled back by subsequent legislation in the Medicare Access to Rehabilitation Services Act of 2013 (Civic Impulse, 2013). That legislation also delayed the inclusion of more oral medications (primarily phosphate binders) into the bundle from the planned 2016 to no sooner than 2024. As a result, the bundled payment rate for 2014 was unchanged from 2013.

## Overall & per Person per Year Costs of ESRD

Total spending per year for Medicare paid claims, Medicare patient obligations, and non-Medicare expenditures for period prevalent patients from 1991-2012 is reported in Figure 9.1 (note that Medicare Part D spending is not included, see Reference Table K.2). Medicare spending and patient obligations represent about three quarters of all spending for the care of U.S. ESRD patients (USRDS, 2013). The non-Medicare share results from beneficiary cost-sharing for services, pre-Medicare coverage periods, legislated provisions for Medicare as Secondary Payer, and post-Medicare entitlement periods for transplant recipients. Medicare spending and patient obligations rose 3.5 percent and 2.8 percent, respectively, in 2012 as compared to 2011, marking the second year of modest growth relative to historical trends following the implementation of the bundled payment system.

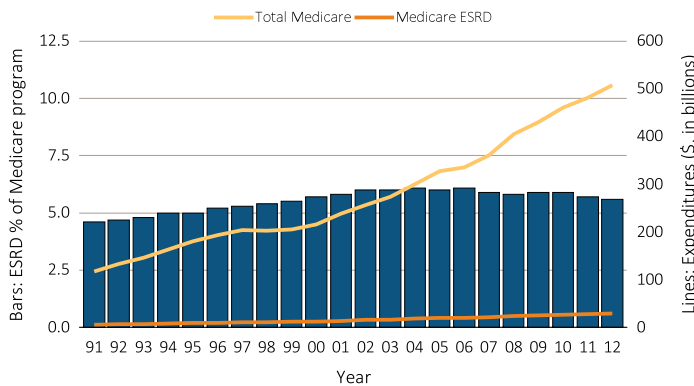
**vol 2 Figure 9.1 Medicare ESRD expenditures, Medicare and patient obligation**



Data Source: USRDS ESRD Database; Reference Table K.2. Abbreviations: ESRD, end-stage renal disease.

As illustrated in Figure 9.2, total Medicare spending (excluding Part D) rose 5.2 percent in 2012, to \$507 billion; spending for ESRD patients increased 3.2 percent, to \$28.6 billion, accounting for 5.6 percent of the Medicare budget costs (inflated by two percent), including estimated costs for HMO & organ acquisition. This continues the downward trend in the fraction of Medicare spending attributable to ESRD patients since that share peaked at 6.1 percent in 2006.

**vol 2 Figure 9.2 Costs of the Medicare & ESRD programs (excluding Part D)**

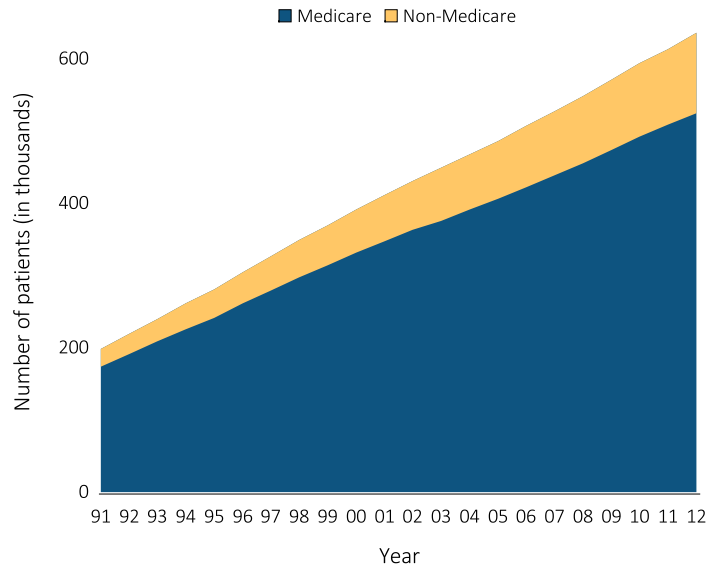


Data Source: USRDS ESRD Database. Total Medicare expenditures obtained from <http://CMS.gov>. Abbreviations: ESRD, end-stage renal disease.

The estimated number of point prevalent Medicare ESRD patients grew by 3.2 percent to 525,481 in 2012, while the non-Medicare ESRD population rose 6.0 percent, to 111,418 (see Figure 9.3). Data from the Medicare Enrollment Database (EDB), as well as dialysis claims information, are used to categorize payer status as Medicare primary payer (MPP), Medicare secondary payer (MSP), or non-Medicare.

Non-Medicare patients in the EDB include those who are pre- or post- Medicare entitlement. Medicare HMO patients are not included in either Medicare or Non-Medicare groups.

**vol 2 Figure 9.3 Estimated numbers of point prevalent ESRD patients**

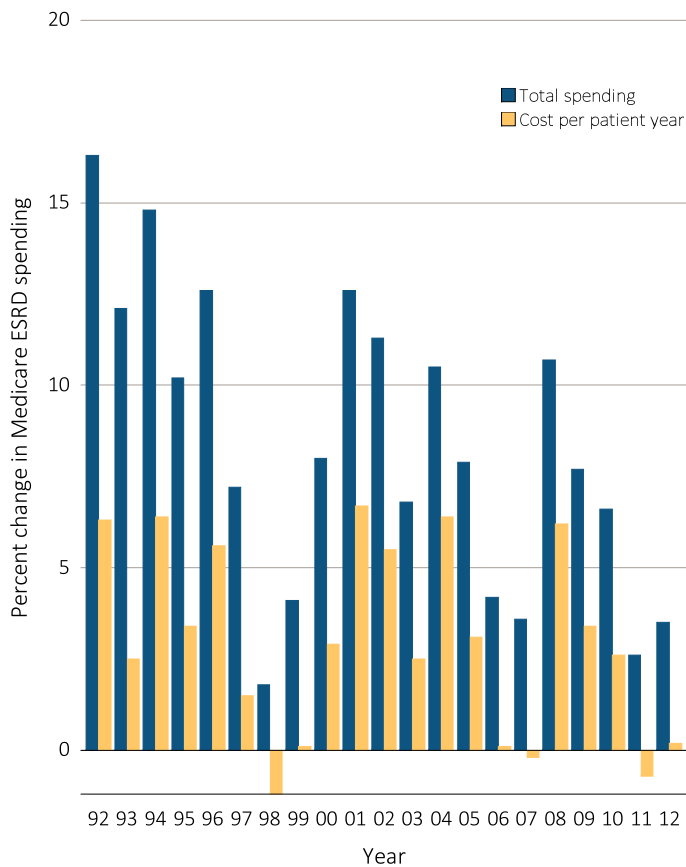


Data Source: USRDS ESRD Database. December 31 point prevalent ESRD patients. Abbreviations: ESRD, end-stage renal disease.

Annual percent change in Medicare ESRD spending for all ESRD patients for whom Medicare is either the primary or secondary payer is reported in Figure 9.4. Because Part D spending is excluded from these measures, total Medicare spending is not captured for years 2006-2012. However, the exclusion of Part D implies that the spending changes reported in Figure 9.4 reflect spending for a consistent set of services.

Total Medicare paid claims in 2012 were 3.5 percent higher than in 2011 (\$28.6 billion versus \$27.7 billion). An increased number of covered patients accounted for almost all of the cost growth, as spending per patient, per year (PPPY) was nearly flat (0.2 percent growth) for the second consecutive year.

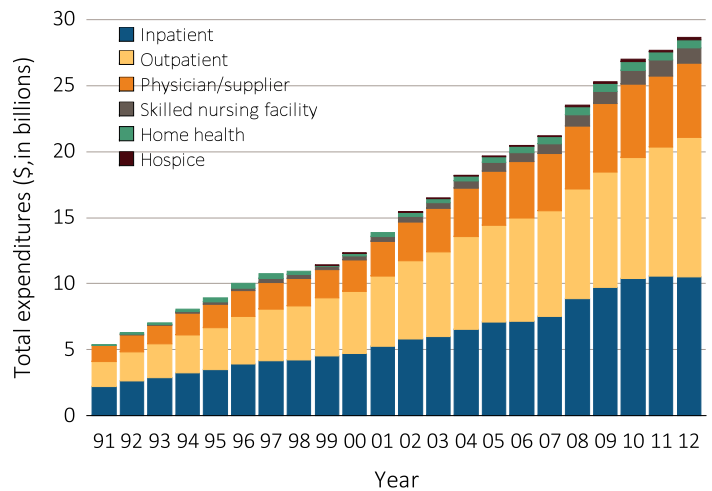
vol 2 Figure 9.4 Annual percent change in Medicare ESRD spending



Data Source: USRDS ESRD Database. Total Medicare ESRD costs from claims data; includes all Medicare as primary payer claims as well as amounts paid by Medicare as secondary payer. Abbreviations: ESRD, end-stage renal disease.

Total Medicare spending for ESRD patients by type of service is reported in Figure 9.5. Compared to 2011, outpatient services, physician/supplier services, and hospice care saw an increase in their shares of non-Part D Medicare spending, while inpatient and skilled nursing care saw decreases in their shares. Notably, inpatient spending has been essentially flat since 2010, consistent with the declines in hospitalization rates and hospital days reported in Chapter 4 of Volume 2, *Hospitalization*. Although hospice spending remains by far the smallest category, it continues to experience the highest rate of growth. Further exploration of end-of-life care for ESRD patients may be worthwhile.

vol 2 Figure 9.5 Total Medicare dollars spent on ESRD, by type of service



Data Source: USRDS ESRD Database. Total Medicare costs from claims data; includes all Medicare as primary payer claims as well as amounts paid by Medicare as secondary payer. Abbreviations: ESRD, end-stage renal disease.

### Conclusion

Medicare spending growth for ESRD patients continued to be moderate in the second year following the implementation of the dialysis bundled payment system. Inpatient spending remained essentially flat for the second consecutive year. The 2015 Annual Data Report will examine additional data for Medicare Part D spending, spending by modality, and spending for a large sample of privately insured patients.

### References

American Taxpayer Relief Act of 2012, Pub. L. No. 112-240 § 632, 2313 Stat. 126.

Civic Impulse. 367;113th Congress, Medicare Access to Rehabilitation Services Act of 2013: A bill to amend title XVIII of the Social Security Act to repeal the Medicare outpatient rehabilitation therapy caps. Retrieved October 24, 2014 from <https://www.govtrack.us/congress/bills/113/s367>.

Hirth RA, Turenne MN, Wheeler JR, Nahra TA, Sleeman KK, Zhang W, Messana JA. The initial impact of Medicare’s new prospective payment system for kidney dialysis. *American Journal of Kidney Diseases* 2013, 62(4): 662-669.

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