**Dialysis providers expect ACOs, payment cuts, consolidation**

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When the CMS last year called for kidney-care providers to participate in a new [accountable care](http://www.modernhealthcare.com/section/articles?tagID=694) demonstration for end-stage renal disease, only a few applied. Many small, independent providers said they couldn't afford the investment needed to establish a program that would meet the federal cost savings and quality targets. But others saw the program as a way to prepare for the inevitable future of value-based payment and delivery.  
  
“I know being in a fee-for-service environment is not going to be sustainable,” said Diane Wish, CEO of the not-for-profit Centers for Dialysis Care in Shaker Heights, Ohio, which has 18 facilities and 1,850 patients.  
  
The CMS' accountable care model will be known as an ESRD seamless care organization, or ESCO, and the shared-savings program will begin Jan. 1. Because of the shortage of applications, the CMS postponed the program until 2015, and Wish's not-for-profit center has reapplied.   
  
Wish's center plans to borrow $1.3 million from its charitable foundation to enhance its electronic health-record system to connect with two local hospital systems, so dialysis patients can be tracked in case of hospitalization. It also is adding care managers who will work to keep patients out of the hospital. About 400 of its patients are expected to qualify for the ESCO. Any shared savings the center earns from the ESCO program will be used to pay back the foundation.

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While only about 1% of [Medicare](http://www.modernhealthcare.com/section/articles?tagID=701) patients have end-stage renal disease, the cost of their care represented more than 7% of Medicare spending, or $20 billion in 2010. But the CMS, the largest payer for dialysis services in the U.S., has been moving to cut dialysis costs and pay providers based on outcomes. As a result, the $25 billion dialysis industry now faces a major transformation as it moves from niche providers offering a profitable service to what insurers view as a cost center under the emerging population health-management approach. Insurers and providers increasingly are looking for ways to prevent people from progressing to end-stage renal disease and needing dialysis.  
  
The CMS last year proposed a 9.4% cut in dialysis rates, or about $30 per treatment, based on concerns that it had overestimated the use of an expensive group of drugs known as erythropoietin-stimulating agents. But it opted to phase in the cut over three to four years, keeping payments flat in 2014.   
  
“If CMS were going to have that large of a cut, it would be devastating to providers because the margins are not that big,” said Debbie Cote, president-elect of the National Renal Administrators Association, which represents independent dialysis centers.  
  
As reimbursement is pared back, and economies of scale become increasingly important, the two largest players are likely to roll up the industry even further. “It's going to lead to greater consolidation, that's for sure,” said James Chambers, a professor at the Tufts Medical Center Institute for Clinical Research and Health Policy Studies.  
  
Experts say dialysis providers can realize savings and survive in two ways: they can pursue a consolidation strategy that allows them to spread their fixed costs over a greater number of centers. Or they can find ways to offer the same service more cheaply.   
  
One key question for providers is how soon the [Food and Drug Administration](http://www.modernhealthcare.com/section/articles?tagID=1136) will approve a generic version of erythropoietin-stimulating agents, which are protein-based drugs for which there currently is no generic approval pathway, said J. Mark Stephens, founder of Prima Health Analytics, a health economics consulting firm that focuses mainly on ESRD. The protein-based drugs alone represent $2 billion in annual CMS spending for ESRD patients.

The two largest dialysis providers, [DaVita HealthCare Partners](http://www.modernhealthcare.com/section/articles?tagID=985) and Fresenius Medical Care, control more than 70% of the market. Squeezing payments could threaten the survival of independent providers. Larger providers have the resources to establish partnerships with health systems and insurers, invest in technology and achieve the efficiencies and economies of scale needed to be profitable under value-based payment models.  
  
Indeed, outpatient dialysis centers affiliated with DaVita and Fresenius enjoyed higher profit margins than other free-standing facilities—4.2% compared with 3.5% in 2012, according to a March report from the Medicare Payment Advisory Commission.   
  
Overall, for-profit providers operate 85% of all U.S. dialysis facilities and treat 89% of dialysis patients, according to MedPAC. Hospitals operate 9% of dialysis facilities but treat only 7% of patients.   
  
U.S. demographics and health trends indicate that dialysis will remain a profitable business, at least in the short term, because the incidence of ESRD is increasing. “Some people are using the word 'epidemic,' and that's a little extreme,” Stephens said. “But (ESRD) is growing and people on dialysis are living longer. The financial markets think the demographics are very good and have rewarded (publicly traded dialysis providers).”   
  
The mortality rate for the ESRD population has fallen 19% since 2000, according to the U.S. Renal Data System. The improvement is largely the result of better infection-control measures and a decrease in deaths related to cardiovascular disease.  
  
Larger facilities have higher margins because their costs per treatment are lower. On the other end of the spectrum, Wish said her center loses $50 to $90 per treatment on Medicare patients. Consolidation could accelerate in the coming years, experts say, especially if the CMS goes ahead with proposed rebasing of the bundled payment rate.  
  
Shares of Denver-based DaVita, which has 35% of the dialysis market, are trading at record highs, despite ongoing challenges integrating its acquisition of multispecialty medical group HealthCare Partners. Germany-based Fresenius, which has 37% of the U.S. market, has seen more volatile trading but in April said it expects to double its 2013 revenue by 2020.

On their most recent earnings calls, DaVita and Fresenius Medical Care both reported revenue growth in kidney care. Both companies have grown through higher volume, cost cuts, acquisitions and opening new centers.  
  
DaVita said revenue in its kidney-care division increased 8.2% to $2.3 billion in the second quarter of this year compared with the same period last year. It also raised its expectations for full-year operating income in the kidney care group to a range of $1.55 billion to $1.6 billion, an increase from its earlier projections of $1.52 billion to $1.58 billion. Fresenius similarly saw 7% revenue growth in its North American dialysis business in this year's second quarter compared with the same period last year.   
  
Yet the looming Medicare cuts have nudged even large providers to consider accountable care models that could be the future of dialysis treatment.   
  
In 2012, DaVita purchased HealthCare Partners, which has contracts with thousands of doctors in five states, to gain expertise in capitated and risk-based models. Its VillageHealth division also works on a capitated payment basis with health plans and government agencies to create a disease-management program for kidney-care patients with special needs.   
  
Fresenius followed suit last June, paying $600 million to become the majority owner of Tacoma, Wash.-based Sound Inpatient Physicians, which provides hospitalist services at more than 100 hospitals and post-acute-care facilities. The acquisition allows Fresenius to better coordinate care for its dialysis patients when they're hospitalized. That same month, Fresenius formed a partnership with [Aetna](http://www.modernhealthcare.com/section/articles?tagID=720) to coordinate care for the insurer's Medicare Advantage members with ESRD.  
  
With the CMS proposing penalties for readmissions as part of the ESCO program, partnerships with acute-care providers will be crucial for dialysis centers. Related to that is the need for [health information technology](http://www.modernhealthcare.com/section/articles?tagID=66) interoperability. While even small dialysis providers have electronic health records, those platforms don't always communicate with the EHRs at local health systems. Without that connection, dialysis providers can be left in the dark when their patients are hospitalized.

“That has been a black hole,” said Joyce Jackson, CEO of Northwest Kidney Centers, the 10th largest dialysis provider in the U.S., with a 3% market share. The Seattle-based not-for-profit provider has adopted a technology called the Emergency Department Information Exchange, which delivers immediate notification when a patient is in the emergency room. Most hospitals aren't using EHR systems that are tailored for dialysis patients.  
  
For this reason and others, many dialysis providers have criticized the cost-savings and quality measures that the CMS is planning to use to calculate shared savings in the ESCO program.   
  
“The way (the ESCO program is) constructed is not particularly favorable,” said Dr. Allen Nissenson, chief medical officer for DaVita Kidney Care. “We're going to participate, but there are a lot of problems with it.”  
  
Both DaVita and Fresenius say they have submitted applications for the ESCO program. Applications to participate were due June 23 for large dialysis organizations and Sept. 15 for other dialysis providers.  
  
ESCOs have the same goals as Medicare ACOs—to improve quality of care and reduce costs by giving providers financial incentives to meet cost and quality targets. But they're geared toward the ESRD patient group, which requires particularly expensive care. The per capita cost of dialysis increased 4% from 2011 to 2012, from $27,700 to nearly $29,000, according to MedPAC. Many of these patients have complex physical and behavioral health problems.  
  
ESCOs require collaboration between at least one dialysis facility, a nephrology group and at least one other provider or supplier, and must have at least 500 Medicare ESRD patients under their care.   
  
Providers hope the CMS will grant waivers to ESCO participants so they can incorporate services that wouldn't traditionally be covered under Medicare, such as providing transportation to lower-income patients to get to appointments. Such waivers will be key to helping patients change their behaviors to improve their health, Wish said.   
  
The long-term outlook for the dialysis industry will depend on how quickly providers adapt to the new payment models. “Reimbursement is always going to be a wild card,” said Stephens at Prima Health Analytics.