

Medicare Coverage for Immunosuppressive Drugs Could Save Money

By Bridget M. Kuehn

Extending Medicare coverage for immunosuppressive drugs through the life of a kidney transplant could reduce the costs of a patient's care by \$3163 while improving their quality of life, according to research presented at Kidney Week 2019.

Using a Markov model and data on posttransplant outcomes from US patients with Medicare and private insurance coverage, Matthew Kadatz, MD, a clinical assistant professor in the Division of Nephrology at the University of British Columbia in Vancouver, and his colleagues analyzed the cost effectiveness of extending Medicare coverage for the life of a kidney transplant. Currently, Medicare only covers immunosuppressive drugs for 36 months after a kidney transplant, which can result in recipients losing access to coverage.

Even when the team reduced the expected transplant survival benefit associated with immunosuppressive drug coverage by 50% of what is seen in privately insured patients, extending coverage remained cost effective at a cost of about \$77,613 per quality adjusted life years, according to the research.

"Extension of the Medicare immunosuppression drug coverage will likely be, if not cost savings, a cost-effective strategy, and that's important for healthcare policy and decision-makers to understand," Kadatz said.

The study is the latest to show that extending Medicare coverage for posttransplant immunosuppressive drugs would likely be cost saving.

"It's a really important addition to a growing body of evidence that current Medicare policies for [immunosup-

pression coverage] don't make sense regardless of whether you look from a financial or patient perspective," said nephrologist Allyson Hart, MD, MS, assistant professor of medicine at the University of Minnesota in Minneapolis. A recent study by Hart and colleagues found very high rates of kidney allograft loss among patients who lose Medicare coverage for immunosuppressive drugs either before or after three years posttransplant.

Hart noted a few limitations of the analysis presented at Kidney Week. First, comparing outcomes to patients on private insurance might not be ideal because Medicare patients may differ in many ways from patients covered by private insurance. Another limitation is that many patients lose access to immunosuppressive medications even with Medicare coverage, possibly because they can't afford co-pays. This could reduce the benefits estimated by the model. Her study, for example, found "an astronomical rate" of allograft loss even among patients less than three years after transplant, who should have access to Medicare coverage.

"We need more information about which patients are losing Medicare coverage for immunosuppressive drugs early and late and why," she said. "Unless we get a better idea of the additional burdens of co-pays we won't see as much benefit as we expect."

Kadatz acknowledged that there are disadvantages to using data on privately insured patients' outcomes because of the socioeconomic and other differences between them and those covered by Medicare. But he noted that he and his colleagues adjusted for as many of those possible differences as they could. In Canada, where patients are guaranteed coverage through public insurance regardless of socioeco-

nom status, transplant graft rates are equivalent among different socioeconomic groups, he noted.

The team also did a threshold analysis that found extending immunosuppression coverage was cost effective even if there was only a 5.5% reduction in the risk of transplant failure at a cost-effectiveness threshold of \$100,000 per quality adjusted life year, which is the typical threshold in the US. Kadatz suspects that the analysis may have even underestimated the potential cost savings of extending coverage. For example, he noted that some kidney transplant patients stay on disability in order to ensure continued coverage for immunosuppression, but if Medicare coverage were extended, they may be able to rejoin the workforce.

Over the past decade, there have been repeated failed attempts in Congress to pass legislation that would extend Medicare coverage for posttransplant immunosuppression, Kadatz noted. He explained that budgetary concerns have been a barrier.

"This really provides support to help get these legislators past the budgetary considerations," he said.

Hart agreed that it is essential to change public policy to ensure patients can access immunosuppressive medications and prevent graft loss. "My hope is with analyses like these we can show this is a case in medicine where patient outcomes and financial incentives are lining up," she said. "We have to have courage to spend money upfront [anticipating savings down the road]." ■

"Economic Evaluation of Lifelong Medicare Immunosuppressive Drug Coverage for Kidney Transplant Recipients" Oral Abstract 128.

Dialysis Industry Consolidation Continues

Monopolies a Growing Concern in Small Markets

Small dialysis chains and independent dialysis facilities continue to disappear, increasing the risk of monopolies, particularly in small markets, according to an abstract presented at Kidney Week 2019.

The dialysis industry has become increasingly consolidated over the past 15 years, with 2 major dialysis chains now controlling 85% of the market, said the abstract's lead author, Caroline Sloan, MD, a general internist and chief resident at Duke University. About 300 small dialysis chains and independent facilities disappeared between 2006 and 2016 either through closure or acquisition by larger firms, according to the analysis. The number of such small or independent facilities decreased from 1353 to 1034, while the number of large dialysis facilities or facilities associated with large chains increased from 3216 to 5419 during that

same period.

"There's about a 1 to 2% rate of acquisition per year and about 1% closure rate per year for these smaller facilities," Sloan said.

Those facilities at greatest risk of acquisition were not-for-profit, smaller in size, or located in markets with fewer hospitals or where there were already few choices for dialysis care. Sloan explained that in markets already dominated by a single large dialysis provider, it may be hard for small facilities to stay open.

Kevin Erickson, MD, MS, assistant professor of medicine at Baylor University, said the findings provide an update on an ongoing trend in the field and suggest there may be a shift in where acquisitions are occurring with small markets becoming a new target.

"These are potentially markets where patients already have limited choice," Erickson said. "The potential effects of an acquisition on the set of choices available to patients and how the providers can change care delivery and pricing is potentially larger when you're already starting with fewer choices."

Additionally, in consolidated markets dialysis providers might offer fewer amenities or reduced quality of care, Erickson noted. There has also been recent evidence that patients who get care at larger, for-profit facilities are less likely to get transplants or may be more likely to be hospitalized, Sloan noted. Although her data didn't look at patient outcomes, Sloan expressed concern about the potential effects of this ongoing consolidation on patient outcomes.



Another potential concern is the effect of consolidation on the cost of care.

"There's a risk of price increases for private insurers," Erickson said. He noted that cost may be offset by potential savings through economies of scale or more bargaining leverage at large facilities, but more study is needed to fully understand the effects of consolidation in the industry. In the meantime, he said policymakers need to consider the potential costs and benefits of policies that may lead to more consolidation.

Sloan suggested policymakers should consider taking steps to maintain patient choice.

"We're urging policymakers to try to maintain competition, especially in the markets that are the most monopolistic," she said. ■

"Consolidation in the Dialysis Industry in the Era of Health Reform, 2006–2013" Oral Abstract 058