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Glenn M. Hackbarth, J.D., Chairman
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May 31, 2001

The Honorable Tommy G. Thompson
Secretary of Health and Human Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Thompson:

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) required the Secretary of Health and Human Services to develop a payment method for beneficiaries with end-stage renal disease (ESRD) who are enrolled in Medicare+Choice (M+C) plans and to begin this payment method effective January 2002. The Medicare Payment Advisory Commission (MedPAC) is pleased to have the opportunity to comment on the method proposed by the Health Care Financing Administration (HCFA).

The BIPA required the Secretary to begin making payments to M+C plans on January 1, 2002 using a new risk adjustment method that accounts for factors such as renal treatment modality, age, and underlying cause of the disease. This requirement was motivated by concerns about the limitations of the current method, which does not adjust payments for factors known to influence costs. Rather, M+C plans in a state are paid 95 percent of the statewide average adjusted per capita cost for caring for ESRD beneficiaries under traditional (fee-for-service) Medicare. In addition, the BIPA required HCFA to increase M+C payment rates for beneficiaries with ESRD to reflect the rates used in the ESRD demonstration project, in which participating plans were paid 100 percent of estimated state per capita expenditures for ESRD beneficiaries in the fee-for-service program—adjusted for age, sex, whether diabetes is the underlying cause of ESRD, and renal treatment modality.

HCFA's proposed method will adjust the base payment rates based on beneficiaries' age and sex using the 10-category age classification currently used for M+C payment for beneficiaries without ESRD. The agency will calculate ESRD payment rates based on 100 percent of estimated actual state per capita costs in 1997 for beneficiaries with ESRD in the traditional Medicare program. To bring the per capita rates forward to calendar year 2002, HCFA will apply the M+C method, whereby the annual state capitation

rate will be the largest of the blended capitation rate, the minimum rate, and last year's rate updated by a minimum percentage.

MedPAC considered several issues in evaluating HCFA's proposal, from the theoretical role of risk adjustment in M+C payment policy to the administrative and operational issues that must be resolved in order to collect accurate data about beneficiaries' clinical courses and treatment. Based on our evaluation and guided by our previous review of these issues in our November 2000 report on risk adjustment,¹ we highlight two conclusions:

- HCFA's approach does not appropriately risk-adjust payments for ESRD beneficiaries in M+C plans because it does not include important variables shown to influence costs of ESRD beneficiaries, including underlying cause of ESRD and renal treatment modality. A payment method that recognizes known differences in the costs of beneficiaries with ESRD should help to assure that payments are fair and accurate and to diminish the incentives of plans to select against beneficiaries or stint on their care. In addition, once an effective risk adjustment method is in place, the bar prohibiting ESRD beneficiaries from enrolling in M+C plans can be lifted by the Congress, ensuring that such beneficiaries have access to care in the M+C program.
- The Secretary should regularly monitor and report on the quality of care for beneficiaries with ESRD enrolled in M+C. During the past decade, HCFA's efforts to monitor the quality of dialysis care have helped to improve health outcomes for dialysis patients. Regularly monitoring and reporting on the quality of care in M+C plans will help ensure that beneficiaries with ESRD have access to high-quality care.

Comment on the proposed risk adjustment methodology

Effective risk adjustment is necessary to pay M+C plans fairly for predictable differences in health care spending among their enrollees. Several groups have proposed alternate ways to risk-adjust capitated payments for patients with ESRD. Under contract to HCFA, RAND developed a capitated payment method designed to reflect the specific treatment options, clinical processes, and differences in costs of care for ESRD.^{2,3} RAND's method created risk-adjusted monthly payments for patients on maintenance dialysis and with functioning kidney grafts, using information on age, sex, underlying cause of ESRD, and Medicare eligibility status to risk-adjust payments. It also provided for lump sum payments for patients undergoing kidney transplantation and experiencing kidney graft failure. In addition to the variables included in RAND's model, the Lewin Group, Inc. (2000) included other variables— such as comorbidities, functional status, nutritional status, hematocrit level, and serum albumin—in a payment

¹Medicare Payment Advisory Commission. Report to the Congress: improving risk adjustment in Medicare. Washington (DC), MedPAC. November 2000.

²Farley DO, Kallich JD, Carter GM, et al. Designing a capitation payment plan for Medicare end stage renal disease services. Santa Monica (CA), RAND. 1994.

³Farley DO, Carter GM, Kallich JD, et al. Modified capitation and treatment incentives for end stage renal disease, Health Care Financing Review. Spring 1996, Vol. 17, No. 3, p. 129–142.

model they developed for hemodialysis patients.⁴ Finally, HCFA developed a risk-adjusted method for its ESRD demonstration project that was similar to the one developed by RAND, accounting for age, sex, underlying cause of ESRD, and renal treatment modality for beneficiaries on maintenance dialysis and with functioning kidney grafts. The method provided for lump-sum payments for beneficiaries undergoing kidney transplantation.

Despite all of the information relating costs to the factors described above, HCFA's proposed M+C payment method only accounts for age and sex, and does not include other variables known to affect beneficiaries' costs significantly, particularly the underlying cause of ESRD and renal treatment modality. HCFA cited several reasons for the different approach, including: 1) the agency's expectation of including beneficiaries with ESRD in the comprehensive risk adjustment model, 2) its evaluation that most of the effect of risk adjustment in the ESRD demonstration project was attributable to adjustment for age, 3) research indicating that increased age is the single best correlate of ESRD mortality, and 4) the administrative difficulties the agency encountered in including data on treatment modality in the payment system of the ESRD demonstration project.

As stated in our November 2000 report on risk adjustment, MedPAC encourages the Secretary to consider including ESRD beneficiaries in the comprehensive risk adjustment payment system. In the interim, the Commission believes that the current payment system for beneficiaries with ESRD must ensure that payments to M+C plans are fair and accurate. Although age and sex are two important predictors of ESRD costs, other variables, including diabetes as the underlying cause of ESRD and renal treatment modality, have also been shown to be important predictors of costs. Farley and colleagues (1996) found that diabetes as the underlying cause of ESRD was the strongest predictor for both Part A and Part B payments for dialysis beneficiaries. Data from the US Renal Data System (2000) show the large differences in annualized Medicare spending for each renal treatment modality—from \$9,849 for beneficiaries with a functioning kidney transplant (graft) to \$49,364 for beneficiaries with a failed kidney graft, \$51,341 for beneficiaries requiring maintenance dialysis, and \$93,148 for beneficiaries undergoing kidney transplantation.

In the proposed notice, HCFA states that using a 10-category age classification will increase the power of the age adjustment compared with the 3-category age classification used in the ESRD demonstration. However, it is difficult to evaluate whether use of a 10-category age classification obviates the need for using other variables (such as underlying cause of ESRD and renal treatment modality) without examining quantitative results from alternate risk adjustment models. In addition, a 10-category age classification (in which payment increases with increasing age) alone may not ensure access to kidney transplantation, particularly for younger (under 65 years of age) beneficiaries, who account for the majority of those undergoing transplantation. Medicare's payment policies should ensure that all beneficiaries with ESRD have access to kidney transplantation, which may be problematic without providing for lump-sum payments to help ensure that providers are not discouraged from choosing this high-cost treatment option. Transplantation is the preferred ESRD treatment modality because it offers

⁴Lewin Group. Capitation models for ESRD: Methodology and results. Falls Church, (VA), the Lewin Group. January 2000.

patients better quality of life and has been found to be more cost-effective than chronic dialysis.⁵ Younger beneficiaries do account for a substantial proportion—31 percent—of ESRD beneficiaries enrolled in M+C plans.⁶

MedPAC recognizes that administrative ease and costs need to be considered when developing new payment methods. In our November report on risk adjustment, we concluded that for administrative simplicity, a smaller set of adjusters might be advisable for implementing risk adjustment for beneficiaries with ESRD compared with a large set of adjusters. Nonetheless, payment systems should include those variables known to affect costs significantly. In particular, the Secretary could use information already collected by HCFA on underlying cause of ESRD and renal treatment modality in the ESRD payment method.

In addition to improving its risk adjustment method, the Commission encourages the Secretary to consider other payment methods, including partial capitation, which bases payment in part on actual services used. Partial capitation may be a useful method to consider when evaluating alternative ESRD payment methods for two reasons. First, partial capitation could be useful to deal with beneficiaries whose costs are high and variable. The USRDS showed that spending for dialysis beneficiaries in the 90th percentile was about 2.5 times higher than for those at the median and that about 12 percent of dialysis beneficiaries had 4 or more hospitalizations during the course of a year.⁷ Farley and colleagues (1996) showed the limited ability of an ESRD risk-adjusted model to predict the costs of very expensive non-transplant ESRD patients. Second, partial capitation may be an effective way to deal with the high costs of kidney transplantation.

A payment method that does not adjust payments appropriately may have a negative effect on ESRD beneficiaries' access to care. Currently, beneficiaries with ESRD requiring maintenance dialysis are the only group of beneficiaries specifically denied enrollment in the M+C program. Although they cannot enroll in M+C, beneficiaries requiring maintenance dialysis who were members of a plan before their ESRD diagnosis can continue to be enrolled in plans with a Medicare contract. Partly because of concern that Medicare does not use an M+C payment method that recognizes known differences in ESRD beneficiaries' costs, the Congress has not removed the bar that prohibits beneficiaries with ESRD from enrolling in M+C. Policymakers' reluctance to lift the bar may continue if the M+C payment system fails to account for factors known to affect beneficiaries' costs significantly.

The advantages of permitting beneficiaries with ESRD to enroll in M+C may outweigh the administrative obstacles associated with including additional variables in the payment system. First, lifting the bar would provide beneficiaries with ESRD the same freedom of choice to enroll in M+C as all other Medicare enrollees. (All other Medicare enrollees, even those with other chronic and long-term

⁵Eggers PW. Comparison of treatment costs between dialysis and transplantation, *Seminars in Nephrology*. May 1992, Vol 12, No. 3, p. 284–289.

⁶Health Care Financing Administration, Department of Health and Human Services. Medicare program; revision of payment rates for end-stage renal disease (ESRD) patients enrolled in Medicare+Choice plans, *Federal Register*. May 1, 2001, Vol. 66, No. 84, p. 21770-21774.

⁷United States Renal Data System. USRDS 1999 annual data report. Bethesda, (MD), National Institute of Diabetes and Digestive and Kidney Diseases. April 1999.

conditions, can enroll in M+C plans.) Second, lifting the bar may benefit beneficiaries with low incomes and those who cannot obtain supplemental insurance. Beneficiaries with ESRD enrolled in the traditional Medicare program have significant out-of-pocket expenses (about \$10,000 per person) and enrolling in private supplemental plans is becoming more difficult because plans are not widely available for patients with ESRD. Third, the potential exists for M+C to benefit beneficiaries with ESRD by providing integrated, coordinated care and by redistributing resources to address patient needs.

Comment on efforts to monitor quality of care

MedPAC is also concerned with the lack of requirements in the proposed notice for monitoring the quality of care for beneficiaries with ESRD enrolled in M+C. Collecting data on quality of care from a sample of in-center hemodialysis and peritoneal dialysis patients has helped improve outcomes for ESRD beneficiaries on dialysis during the past decade. However, data are not stratified based on whether beneficiaries are enrolled in traditional Medicare or M+C, making meaningful monitoring and comparisons difficult. In addition, information on quality in M+C is crucial for lifting the bar prohibiting beneficiaries with ESRD from enrolling in M+C plans. Regularly monitoring and reporting on the quality of ESRD care in M+C will help ensure that beneficiaries who are enrolled in M+C plans get the care they need.

Thank you again for the opportunity to comment on this proposed notice.

Sincerely,

Glenn M. Hackbarth
Chairman