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## Chapter 11: Medicare Expenditures for Persons With ESRD

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- Medicare fee-for-service spending for ESRD beneficiaries rose by 1.6%, from 30.4 billion in 2012 to 30.9 billion in 2013, accounting for 7.1% of the overall Medicare paid claims costs. This marks the third year of modest growth relative to historical trends, and follows the implementation of the bundled payment system.
- In contrast to the increase in global expenditures for ESRD patients, total fee for service spending in the general Medicare population declined by 0.2% in 2013 to \$437.0 billion.
- In 2013, ESRD spending per patient per year (PPPY) declined by 0.7%. Given that ESRD PPPY spending decreased or increased only slightly from 2009 to 2013, the rise in total ESRD costs during these years is almost entirely attributable to growth in the number of covered patients.
- For hemodialysis, both total and PPPY spending were nearly flat between 2012 and 2013. During this period, peritoneal dialysis total spending continued to grow by 9.2% as the share of patients receiving PD has continued to rise. PD growth on a PPPY basis was moderate between 2012 and 2013 (0.8%), however, and PD remains less costly on a per patient basis than HD. Finally, total and PPPY transplant spending has also remained consistent.

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### Introduction

The Medicare program for the elderly was enacted in 1965. Seven years later, in 1972, Medicare eligibility was extended to persons with irreversible kidney failure who required dialysis or transplantation. In 1972, only about 10,000 patients were receiving dialysis (Rettig, 2011), a number that has grown to over 469,950 in 2013. Even though the ESRD population remains at less than 1% of the total Medicare population, it has accounted for about 7% of Medicare fee for service spending in recent years (USRDS, 2014).

On January 1, 2011, The Centers for Medicare and Medicaid Services (CMS) implemented the ESRD Prospective Payment System (PPS). This program bundled Medicare’s payment for renal dialysis services together with separately billable ESRD-related supplies (primarily erythropoiesis stimulating agents (ESAs), vitamin D, and iron) into a single, per treatment payment amount. The bundle payment supports up to three dialysis treatments per individual per week. The reimbursement to facilities is the same regardless of dialysis modality, but is adjusted for dialysis provider case-mix and geographic area health care wages. Early

research linked the PPS with substantial declines in the utilization of expensive injectable medications, and increased use of in-home peritoneal dialysis (PD; Hirth et al., 2013; Civic Impulse, 2013).

Most of the savings from these changes have accrued to dialysis facilities, as CMS initially set the bundled payment rate at 98% of what spending would have been under the costlier utilization patterns observed prior to the PPS. In the American Taxpayer Relief Act of 2012, Congress authorized CMS to “re-base” the PPS bundled payment rate by an inflation-adjusted decrease of 9%. Re-basing the bundled payment rate would transfer the savings from dialysis facilities to Medicare and, ultimately, to taxpayers. Before the bundled payment rate reduction could be fully implemented, however, the Protecting Access to Medicare Act of 2014 required that it be phased in by limiting annual adjustments to the bundled payment rate. That legislation also delayed CMS’s plans to include more oral medications (primarily phosphate binders) in the bundle in 2016, to no sooner than 2024.

This chapter presents recent patterns and longer-term trends in both total Medicare spending and spending

by type of service. Data from 2013 is featured, the third full year under the expanded, bundled PPS.<sup>1</sup>

## Analytical Methods

For this 2015 ADR, reported costs of ESRD include only those ESRD beneficiaries covered by Original Medicare (fee-for-service) for their Medicare Parts A and B benefits. Medicare expenditures can be calculated from the claims submitted for payment for health care provided to these individuals, but not for those enrolled in Medicare Advantage (managed care) plans. The Medicare program pays for services provided through Medicare Advantage plans on a risk-adjusted, per-capita basis, and not by specific claims for services. Methods of estimating Medicare expenditures for Medicare Advantage beneficiaries with ESRD will be explored for future ADRs.

Only a subset of ESRD patients is eligible to participate in a Medicare Advantage plan. If a person becomes eligible for Medicare solely due to ESRD, they are generally not allowed to enroll in a Medicare Advantage plan and must use fee-for-service Medicare. Current Medicare beneficiaries who develop ESRD are allowed to remain in their Medicare Advantage plan, but with a few rare exceptions, cannot switch to a Medicare Advantage plan if they were enrolled in fee-for-service Medicare at the time of ESRD.

Those who are newly entitled to Medicare due to ESRD and require dialysis have a three-month waiting period before Medicare coverage begins; an exception is for those initiating home dialysis training, where coverage may start as early as the first month of dialysis. If the new ESRD patient has private insurance through an employer or union, there are rules governing what Medicare will pay. During the first 30 months after the start of Medicare eligibility due to ESRD, the private insurance will be considered the primary payer of ESRD services. Medicare acts as the secondary payer and may reimburse some services not covered by the private insurance carrier. At month 31 the roles are reversed, and Medicare becomes the primary payer with the private insurance designated the secondary payer.

Additionally, Medicare eligibility based solely on ESRD ends for those ESRD patients who receive a kidney

transplant or discontinue dialysis. Medicare coverage ends 12 months after the last dialysis treatment and 36 months after a successful transplant. However, if a transplant recipient also qualifies for disability or is over the age of 65, then Medicare entitlement will continue. If a transplant fails and the recipient returns to dialysis, Medicare eligibility is re-instated.

In this chapter, both data from the Medicare Enrollment Database (EDB) and 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, such as patients in the initial three-month waiting period.

A more accurate picture of total ESRD-related costs would take into account more than just expenditures by the Medicare program. It would include expenses such as those incurred by private insurance carriers when Medicare is the secondary payer, during the waiting period for initial Medicare coverage, and by insurance carriers of people living with a functioning kidney transplant following the termination of Medicare coverage. It would also include the patients' portion of the cost-sharing with Medicare, including the Parts B and D premiums of those enrolled in Medicare solely due to ESRD, the beneficiary's deductible, and their coinsurance amounts for ESRD services.

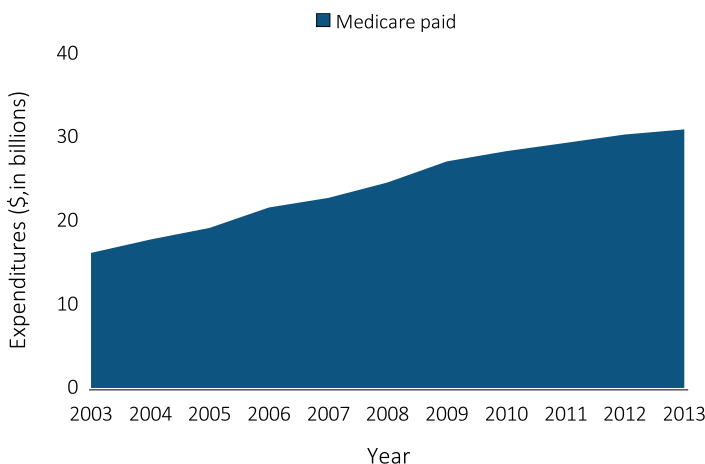
For additional detail see the ESRD Analytical Methods chapter for an explanation of analytical methods used to generate the figures and tables in this chapter.

## Overall & per Person per Year Costs of ESRD

Figure 11.1 displays Medicare's total annual paid claims for period prevalent ESRD patients from 2003-2013. These costs represent about three quarters of all spending for the care of U.S. ESRD patients (USRDS, 2013). Medicare fee for service ESRD spending rose by 1.6% from 2012 to 2013, marking the third year of modest growth relative to historical trends, and following the implementation of the bundled payment system.

<sup>1</sup> The reader may find information on Medicare Health Maintenance Organizations (HMO; managed care), and private insurer spending through 2011 in the 2013 Annual Data Report (USRDS, 2013).

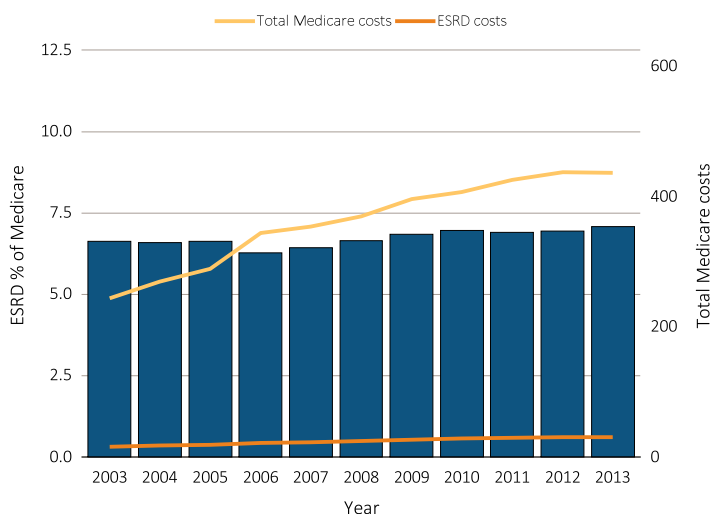
vol 2 Figure 11.1 Trends in ESRD expenditures, 2003-2013



Data Source: USRDS ESRD Database; Reference Table K.1. Abbreviations: ESRD, end-stage renal disease.

As illustrated in Figure 11.2, total Medicare fee for service spending in the general Medicare population declined by 0.2 % in 2013 to \$437.0 billion; spending for ESRD patients increased 1.6 %, to \$30.9 billion, and accounted for 7.1% of the overall Medicare paid claims costs in the fee-for-service system. Note that Medicare Advantage plans (private managed care) represented a larger share of general Medicare spending, while restrictions on new Medicare enrollment by beneficiaries with ESRD limited that growth in the ESRD population. This implies that the increasing fraction of Medicare fee-for-service spending accounted for by ESRD patients reflects both the growth in ESRD spending and the gradual shift away from fee-for-service in the general Medicare population.

vol 2 Figure 11.2 Trends in costs of the Medicare & ESRD programs, 2003-2013

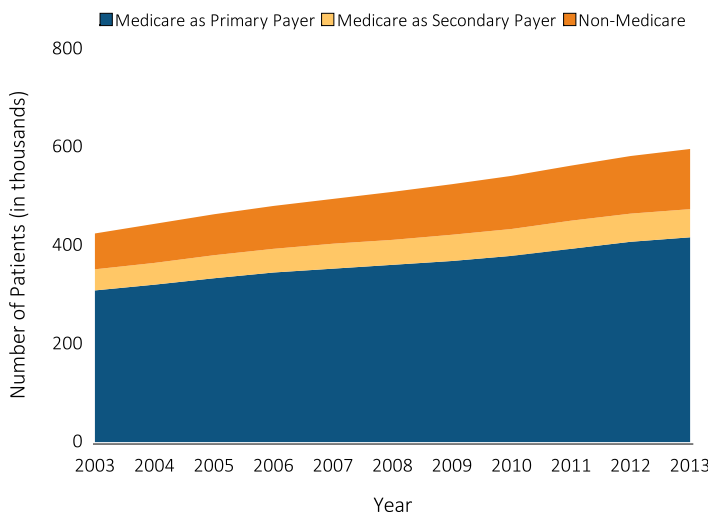


Data Source: Total ESRD costs obtained from USRDS ESRD Database; Reference Table K.1. Total Medicare expenditures obtained from Trustees Report, table B1 <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/TrusteesReports.html>. Abbreviations: ESRD, end-stage renal disease.

## Funding Sources for the ESRD Population

Figure 11.3 illustrates the annual number of prevalent ESRD patients by their Medicare status. Data from the Medicare Enrollment Database (EDB) and dialysis claims information were 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. The number of ESRD patients with MPP grew by 2.3 % from 2012 (407,432) to 2013 (416,808); the MSP ESRD population declined by 0.1% from 2012 (57,730) to 2013 (57,677), while the non-Medicare ESRD population rose 5.0 %, to 122,551.

vol 2 Figure 11.3 Trends in numbers of point prevalent ESRD patients, 2003-2013



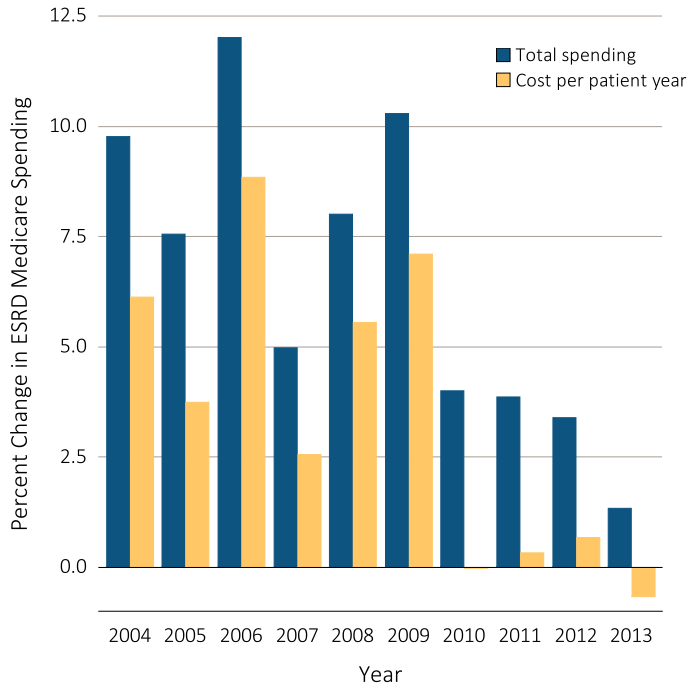
Data Source: USRDS ESRD Database. December 31 point prevalent ESRD patients. Abbreviations: ESRD, end-stage renal disease.

Figure 11.4 displays the annual percent change in Medicare ESRD fee for service spending for all ESRD patients for whom Medicare is the primary payer. Part D costs are included in these measures. However, as Part D is a voluntary component of the Medicare program, some recipients do not participate or have an alternate source of pharmaceutical coverage (e.g., from an employer) and would not have medication claims represented in the Part D records.

For the fourth consecutive year, the annual increase in total Medicare ESRD spending for patients with primary payer status was less than 4%. In 2013, total Medicare paid claims for ESRD services and supplies increased by 1.3% to \$29.7 billion (Figure 11.4; for total and specific values see Reference Table K.4).

In 2013, ESRD PPPY spending declined by 0.7%. Given that these expenditures decreased or increased only minimally from 2009 to 2013, the growth in total ESRD costs during these years is almost entirely attributable to growth in the number of covered patients.

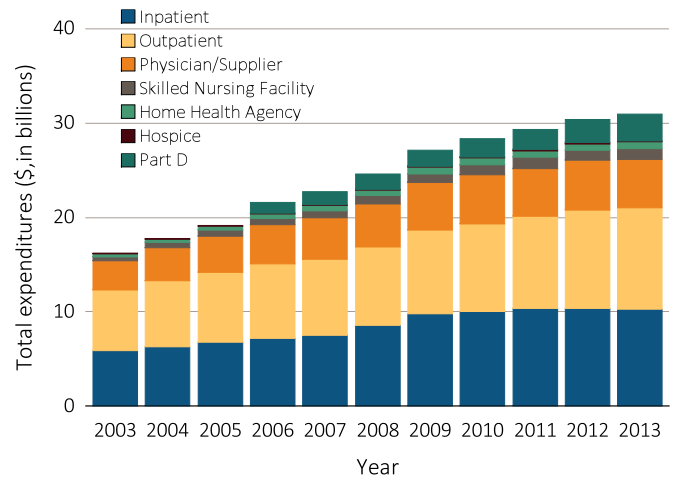
**vol 2 Figure 11.4 Annual percent change in Medicare ESRD spending**



Data Source: USRDS ESRD Database; Reference Table K.4. Total Medicare ESRD costs from claims data; excludes claims with Medicare as secondary payer. Abbreviations: ESRD, end-stage renal disease.

Total Medicare fee for service spending for ESRD patients by type of service is reported in Figure 11.5. Compared to 2012, the costs of Part D coverage and skilled nursing facility care grew at the fastest rates (14.9% and 5.1%, respectively). All other categories of spending rose by less than three percent. The smallest share of Medicare spending for ESRD patients was for hospice care; it should be noted, however, that hospice care had been experiencing the highest rate of growth of any category prior to 2013, when the growth rate decelerated to 0.6%.

**vol 2 Figure 11.5 Trends in total Medicare fee for service spending for ESRD, by type of service, 2003-2013**

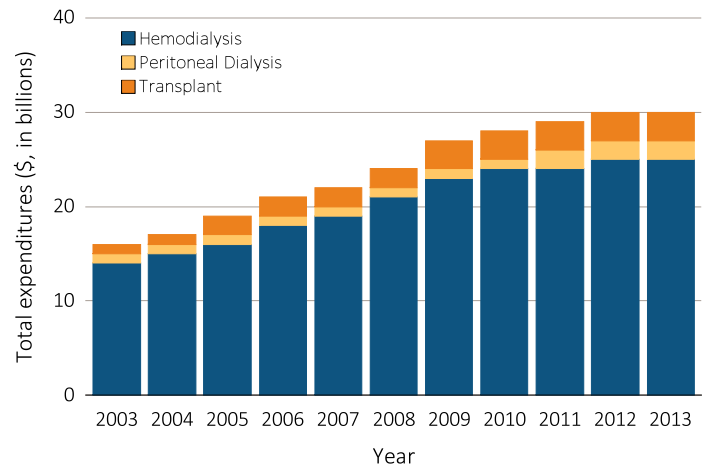


Data Source: USRDS ESRD Database; Reference Table K.1. Total Medicare costs from claims data; includes all claims with Medicare as primary payer. Abbreviations: ESRD, end-stage renal disease.

### ESRD Spending by Modality

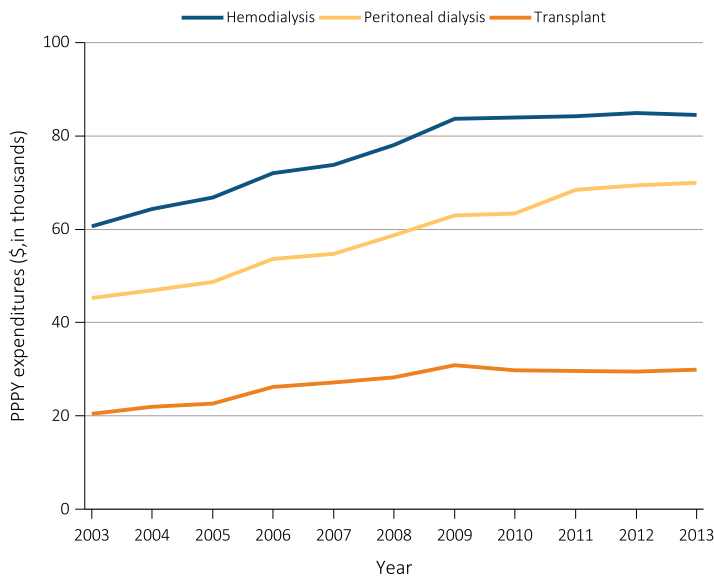
For hemodialysis, both total and PPPY fee for service spending were nearly flat between 2012 and 2013 (Figures 11.6 and 11.7). Peritoneal dialysis total spending continued to grow, by 9.2% between 2012 and 2013 as the share of patients receiving PD has continued to rise. PD growth on a PPPY basis was moderate between 2012 and 2013 (0.8%), however, and PD remains less costly (\$69,919 in 2013) on a per patient basis than HD (\$84,550). Finally, total and PPPY transplant spending has also remained consistent. In 2013 the PPPY cost for transplant patients was \$29,920.

**vol 2 Figure 11.6 Total Medicare ESRD expenditures, by modality**



Data Source: USRDS ESRD Database. Total Medicare costs from claims data for period prevalent ESRD patients. Abbreviations: ESRD, end-stage renal disease.

vol 2 Figure 11.7 Total Medicare ESRD expenditures per person per year, by modality



Data Source: USRDS ESRD Database; Reference Tables K.7, K.8, & K.9. Period prevalent ESRD patients; patients with Medicare as secondary payer are excluded. Abbreviations: ESRD, end-stage renal disease.

## 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>.
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- Rettig RA. Special Treatment—the Story of Medicare's ESRD Entitlement. *New England Journal of Medicine* 2011; 364:596-598.
- U.S. Renal Data System, USRDS 2013 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2013.
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**Notes**