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Regional Variations in the Interpretation of the End-Stage Renal Disease Thirty-Month Coordination Period: Potential Implications for Patient Care

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Abstract

Chronic kidney disease is a non-communicable disease that is now well recognized as a major source of premature morbidity and mortality. In general, racial/ethnic minorities in the United States are more likely than non-minority groups to develop end-stage renal disease (ESRD), but paradoxically most have a lower mortality risk. Unlike most minorities, dialysis patients in Puerto Rico have a mortality risk nearly 50% higher than the national average. Multiple factors such as medical conditions, socioeconomic, environmental, and health system factors can influence health outcomes for patients with ESRD. We describe one potential health system factor that may contribute to this finding, a unique interpretation and implementation of the ESRD Medicare Secondary Payer provision in the Commonwealth of Puerto Rico. We conducted a search of

regulatory documents and key stakeholder interviews to help envision the potential implications of these differences for dialysis facilities, health care providers, and patients with ESRD.

Keywords

End-stage renal disease; Medicare; insurance; Puerto Rico; U.S. territories; health policy; ESRD Coordination Period

Chronic kidney disease (CKD) is a major source of premature morbidity and mortality affecting more than 10% of adults.¹ In the U.S. over 110,000 people each year develop the advanced stage of CKD or end-stage renal disease (ESRD) requiring renal replacement therapy with either dialysis or renal transplantation.² End-stage renal disease also levies a substantial financial burden as ESRD patients in the U.S. consume nearly 7% of Medicare costs while accounting for less than 1% of the total Medicare population, making their care a national priority.³ Racial/ethnic minorities in the United States are 1.5–3 times more likely than non-Hispanic White patients to develop ESRD, but despite suffering from excess rates of cardiovascular risk factors, minority ESRD patients treated with maintenance dialysis paradoxically have 15–30% lower adjusted rates of mortality.^{5,6} In 2013, the Standardized Mortality Ratio in Puerto Rico was 47% higher than the national rate.⁷ This is in stark contrast to most studies, which report much lower adjusted rates of mortality among Hispanic patients receiving dialysis therapy.^{5,6} This finding is highlighted by a national analysis of mortality risk by race/ethnicity and age by Yan et al. reporting that Hispanic dialysis patients had the lowest adjusted mortality rates followed by Black and then non-Hispanic White dialysis patients. The only exception was Black patients 18–30 years of age who had a slightly higher mortality risk than non-Hispanic White patients.⁵ Multiple factors can influence the quality of life and longevity for patients with ESRD treated with dialysis, including but not limited to underlying medical conditions and biologic, environmental, sociocultural, and health care system factors.

In 1972, to address the growing burden of advanced kidney disease, a special provision of the Social Security Act declared people with ESRD who required renal replacement therapy to be disabled for purposes of Medicare Parts A and B. Medicare was established just seven years earlier in 1965 to support health care for the elderly and subsequently extended to disabled people by Social Security Act amendments.⁸ The ESRD Medicare program has now been in place for over 40 years and is widely recognized as a system of equitable care across the nation.

In the United States, at the level of the individual patient, the ESRD Medicare Secondary Payer provision, or ESRD Coordination Period, provides for a coordination of benefits period between Medicare and private health insurance plans for individuals entitled to Medicare solely on the basis of ESRD. If an individual is entitled to Medicare because of ESRD and is covered by a commercial health plan (CHP), the CHP is the first payer (primary) for the first 30 months.⁹ When first enacted in 1981, the period of CHP coverage was 18 months, but was extended to 30 months in 1997 by the Balanced Budget Act.¹⁰ The regulation stipulates the CHP is primary regardless of the number of employees and/or the Medicare beneficiary's employment status. This regulation should apply to all 50 states, the

District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa as well as the territorial waters adjoining the land areas of the United States for services provided onboard a ship.¹¹ In fact, the 30-month ESRD Coordination Period has been implemented in every region of the United States except the territory of Puerto Rico (C. Hernandez, personal communication, May, 2014).¹² This compounds the problem of low ESRD reimbursement in Puerto Rico compared with the 50 states and even the other territories (Table 1). Given the important role of insurance in access to and quality of care, we undertook the present study to better understand the implications of differences in the interpretation and implementation of the ESRD Benefits Coordination Period policy in Puerto Rico.

Over an eight-month period, we conducted a search of regulatory documents as well as a series of key stakeholder interviews regarding the 30-month ESRD Coordination Period in the territory of Puerto Rico. These included discussions with two former CMS officials, senior members of the CMS Division of Medicare Health Plans Operations, senior members of the CMS Region 2 Puerto Rico Field Office, and 2 CEOs of Medicare intermediary insurance companies in Puerto Rico. A synthesis of findings and implications for the future are presented here.

Interviews and Document Review: Report and Discussion

Although many dialysis patients in Puerto Rico are insured through CHP, Medicare is the primary payer after the third month rather than after the 30th month as CHPs in Puerto Rico cover only the first 90 days of dialysis treatment after the onset of ESRD. Commercial health plans in Puerto Rico interpret Medicare's status as primary payer to be supported by the Medicare regulations 42 CFR §411.161 and §411.162, and by the guidelines at Center for Medicare and Medicaid Services 100–05 (MSP Manual) Chapter 1 §10.2 and §70.3 and Chapter 3 § 10.2.^{13–15} These interpretations have set forth the practice of a 90-day coordination period in Puerto Rico in contrast to the 30-month coordination period practiced elsewhere in the United States. This has important implications for not only dialysis care facilities and nephrologists, but most importantly for patients with ESRD.

Based on the Balanced Budget Act,¹⁰ the CMS claims system has no procedure to allow for Medicare as the primary payer for these beneficiaries prior to the 30th month of the ESRD treatment period. Health plans and health care providers use the Common Working File (CWF) to obtain Medicare health insurance eligibility information. The CWF informs the claim system if the beneficiary is within the coordination period and if the individual has other insurance (e.g., a CHP). The aggregate insurance information and patient demographic data assists Medicare, CHP, and the health care provider in determining whether Medicare is the primary or secondary payer.^{16,17} The CWF does not include a data field that would identify the dialysis treatment as not covered by an active insurer and allow a Medicare primary payment during the first 30 months. From our discussions, it is the position of intermediary insurers in Puerto Rico that dialysis treatments could be categorized as not covered by the insurer and that Medicare would then become the primary payer. They also voiced the perception that CMS has chosen not to invest in a system improvement that would directly address this situation by allowing designation of CHP not covering ESRD.

First Coast Service Options Inc.,¹⁸ the Medicare Administrative Contractor for Puerto Rico, uses a so-called work-around in order to pay the claims for these beneficiaries. The work-around instructs dialysis facilities to enter occurrence code 24 and the “date of receipt of denial by higher priority payer” on the claim form.¹⁹ [page 33] An occurrence code 24 is intended for use when it is believed that another insurer covers a service but the insurer denies payment (CMS-104, Chapter 8, § 50.3).²⁰ It allows the contractor to make a conditional payment, that is, a payment governed by Medicare secondary payer billing procedures. First Coast Service Options Inc. and the Puerto Rico dialysis facilities and nephrologists understand that the payments are actually primary, not conditional payments, as does CMS. This work-around continues monthly for many patients with ESRD receiving dialysis treatments on the island until month 30.

First Coast Service Options Inc. requires dialysis facilities and nephrologists to actually bill the beneficiary’s other insurer as if it were a Medicare secondary payer billing situation and assumes the insurer provides dialysis services as a cost-covered service as practiced in most of the United States. In this situation the dialysis facilities and nephrologists do not submit the insurer denial with the claim. They are to retain it on file as documentation to confirm their entitlement to receive payment in case the claims are audited. This, unfortunately, can lead to the patient encountering additional out-of-pocket deductibles and additional bills related to the imposed insurer denial in this process, as this can lead to the provider or facility billing and pursuing collection from the patient.

Although not intended by FCSO to create an onerous condition for dialysis facilities, nephrologists and patients, the work-around procedure does so, and, as noted above, the additional burden imposed on patients can be quite substantial. It requires dialysis facilities and nephrologists to expend limited resources to bill other insurers for services that they know the insurers do not cover so they can fill in a date for condition code 24 and file the record of denial. The insurers have no incentive to cooperate with the work-around process and may respond late or may not respond until several requests have been filed. At best, dialysis facility and nephrologist reimbursement for this unique designation of Medicare eligible services in Puerto Rico are substantially delayed. At worst, providers’ billing staff may lose track of some of the cases in the confusion, resulting in a loss of revenue, and downstream effects may include reduced patient services in the dialysis facility. If the standard Medicare claims system was revised so that it could recognize the claims at issue as payable by Medicare as primary payer, dialysis facilities and nephrologists would be entitled to bill immediately upon service and would be entitled to receive payment after the claims clear, as early as 14 days and no later than 29 days after claim submission. Claims not processed within that time would be payable with interest. Through no fault of their own, dialysis facilities and nephrologists in Puerto Rico do not receive these benefits.

More importantly, some patients encounter only partial coverage of care through two insurers (CHP and Medicare) adding unnecessary co-payments and confusion around which insurer is the primary provider for the myriad of dialysis and non-dialysis related care for ESRD patients. This can lead to patients overpaying, or even worse unintended missed payments to an insurer, facility, or provider could be forwarded to a collection agency leading to a poor credit rating or even legal proceedings against patients. Presently, CMS

educational materials for ESRD patients cover insurance issues related to the 30-month coordination period, but CMS has no materials or training for patients in Puerto Rico who must figure out on their own insurance issues based on a 90-day coordination period and any differences in apportionment of ESRD-related services. There are no educational materials to address this for providers, either. Yet CMS is aware of and supports the 90-day coordination period and atypical system of reimbursement.

The Way Forward

The territory of Puerto Rico is facing severe health care challenges related in large part to a variety of policies that affect social determinants of health, federal health care reimbursement rates and health care billing processes (Tables 1 and 2).²¹ Thus, addressing the multiple issues that face the care of ESRD patients is critical. One solution to help improve the care and hopefully the outcomes of patients on dialysis would be for the territory of Puerto Rico to adopt the 30-month ESRD coordination period. In lieu of that, one approach to a work-around at the provider level would be to revise how claims are processed in the common working file in a way that appropriately reduces the patient's, dialysis facilities', and nephrologists' administrative burdens as follows. The common working file could incorporate an exception or waiver that allows the billing of ESRD beneficiaries who reside in Puerto Rico to be processed after 90 days, rather than 30 months. That common working file is a system that is usually simple for FCSO to manage, protects the Medicare trust fund against improper payments, and meets CMS's timely and accurate payment objectives. When the Medicare beneficiary begins dialysis treatment, the provider would complete a questionnaire designed to determine whether Medicare is the primary or secondary payer. Puerto Rico beneficiaries typically have other insurance coverage, but not for dialysis services. According to the Medicare secondary payer manual, Chapter 3, § 10.1.5E,²² "If the information obtained does not indicate CHP coverage, the provider annotates the bill to that effect (e.g., CHP coverage lapsed, benefits exhausted)."[p.14] That statement suggests that the Medicare claims system may actually have the flexibility to make primary payments for these claims without a major work-around by merely adding the exception or waiver for Puerto Rico. If so, then the solution to this problem might already exist within standard billing procedures.

At a patient level, this could also help to address the additional insurance coverage gap. Many patients with a Medicare Prescription Drug Plan reach the point where their medication coverage runs out and this is known as the donut hole where Medicare no longer pays for prescription medication.²³ The donut hole is due to a temporary limit on what a medication plan will cover for a given year. Patients in Puerto Rico not only face this issue, but also frequently face having to pay two deductibles for medications and other services due to having two insurers with unclear policies around attribution of coverage for costs of ESRD versus non-ESRD related services, and which insurer is responsible, thereby creating a second donut hole. This may contribute to dialysis patients in Puerto Rico having inadequate health care and worse clinical outcomes such as higher adjusted mortality rates as reported by ESRD Network 3.⁷

Conclusion

In summary, if the adoption of the 30-month ESRD coordination period is not feasible and a work-around is still necessary, we recommend a process in which the provider would not bill the CHP, but would still enter a date with condition code 24 that would be pre-approved by CMS to allow the claim to be processed. If a date is not required in the notation field, a standard comment appropriate to the situation could be entered. Thus, the claim could be submitted without delay and processed without error. Dialysis facilities and nephrologists would still have to obtain and keep adequate documentation of the beneficiary's lack of other insurance coverage for dialysis treatments during the ESRD coordination period. Again, a more complete solution in this situation would be to create a seamless and harmonized ESRD reimbursement system for the United States and all of its territories to optimize the systems that ultimately affect patient care.

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Table 1.**ESTIMATED MEDICARE ADVANTAGE 2017 ESRD RELATIVE REIMBURSEMENT RATES**

STATE/TERRITORY	2017 DIALYSIS RATE
US 50 State Average	Reference
Hawaii	0.96
Northern Mariana	0.84
United States Virgin Islands	0.83
American Samoa	0.72
Guam	0.71
Puerto Rico	0.60

Source: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/calculationdata2017.zip>

Table 2.**UNDER-RECOGNIZED TERRITORIAL POLICIES AFFECTING HEALTH AND KIDNEY CARE**

	Puerto Rico	50 States
Ability of citizens to vote for President of the United States	No *	Yes
Representation in Congress	No *	Yes
Private insurer covers dialysis for the first 30 months of ESRD followed by Medicare (the 30-month ESRD Coordination Period)	No	Yes
CMS fact sheet for ESRD patients accurately captures the insurance issues patients will need to know as they transition to dialysis	No	Yes
Dialysis patient “donut hole” - limit on what a medication plan will cover for a given year leaving the patient to pay	Yes	Yes
Double donut hole due to inconsistent coverage policies for dialysis and non dialysis CKD care during the first 30 months for patients with private insurer often leaving the patient to have two co-pays and two donut holes	Yes	No

* Holds for all U.S. Territories

ESRD – end-stage renal disease; CMS - Centers for Medicare and Medicaid Services; CKD – chronic kidney disease