MEDPAC | Medicare Payment Advisory Commission

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August 22, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

**Attention: CMS-1805-P**

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, Conditions for Coverage for End-Stage Renal Disease Facilities, End-Stage Renal Disease Quality Incentive Program, and End-Stage Renal Disease Treatment Choices Model," *Federal Register* 89, no. 129, pp. 55760–55843 (July 5, 2024). We appreciate CMS's ongoing efforts to administer and improve the Medicare program, particularly given the many competing demands on the agency's staff.

In this letter, we comment on CMS's proposals to:

- update the ESRD prospective payment system (PPS) base payment rate for calendar year (CY) 2025;
- include oral-only phosphate binders in the ESRD PPS as of January 1, 2025;
- modify the outlier policy;
- update the low-volume payment adjustment (LVPA); and
- modify the wage index methodology.

## Update to the ESRD PPS base payment rate for CY 2025

Per statutory requirements, CMS proposes to update the ESRD PPS base rate for CY 2025 by 1.8 percent. This update is based on the ESRD bundled market basket (ESRDB) increase factor (of 2.3 percent) reduced by a multifactor productivity adjustment (of 0.5 percent).

The proposed CY 2025 ESRD PPS base rate is $273.20, which is an increase of $2.18 to the current base rate of $271.02.[1]

### *Comment*

We support this proposal. In our March 2024 report to the Congress, the Commission's analysis of indicators of payment adequacy for the sector suggests that Medicare's payments to freestanding ESRD facilities in 2022 were adequate. Based on this assessment, the Commission recommended that, for 2025, the Congress should update the CY 2024 ESRD PPS base rate by the amount determined under current law.

## Include oral-only phosphate binders in the ESRD PPS as of January 1, 2025

Per regulatory and statutory requirements, phosphate binders, currently covered under Part D, will be covered under the Part B ESRD PPS bundle as of January 1, 2025. To incorporate phosphate binders into the ESRD PPS, CMS proposes to use the same method that the agency used in 2018 when calcimimetics were moved from Part D to the ESRD PPS. Specifically, CMS will pay for phosphate binders using a transitional drug add-on payment adjustment (TDAPA) until sufficient claims data for a rate-setting analysis are available, but not for less than two years. Per current regulation, pricing of a drug paid under the TDAPA policy is set at 100 percent of the drug's average sales price (ASP)—in other words, ASP + 0 percent.

In response to dialysis organizations' concerns, CMS seeks comment as to whether a TDAPA of ASP + 0 percent is appropriate for phosphate binders and whether there are any costs, such as dispensing fees, associated with including phosphate binders under the ESRD PPS that may not be accounted for by such a payment. Because of stakeholder concerns, CMS is considering a TDAPA payment for phosphate binders of ASP + 6 percent. This payment rate would be similar to that paid for calcimimetics during the first two years of inclusion in the ESRD PPS. (In the third year, CMS lowered the payment for calcimimetics to ASP + 0 percent.) CMS will finalize the TDAPA payment amount for phosphate binders after considering comments.

### *Comment*

The Commission supports paying for oral-only dialysis drugs under the ESRD PPS.[2] Their inclusion in the ESRD PPS payment bundle is intended in part to encourage providers to better manage drug therapy and improve efficiency. Analyses by both the Commission and CMS have shown that bundling certain ESRD-related drugs under the ESRD PPS has resulted in changes in the use of those drugs without sustained negative changes in beneficiary health status.[3,4] Shifting coverage of ESRD-related drugs from Part D to Part B can also improve beneficiaries' access to these medications, since some beneficiaries lack

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[1] The update to the ESRD PPS base rate also reflects a proposed wage index budget-neutrality adjustment factor.
[2] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.
[3] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. *ESRD prospective payment system claims-based monitoring program.* Baltimore, MD: CMS.
[4] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Part D coverage or have coverage less generous than the Part D standard benefit.[5] Indeed, CMS reports that, when coverage of calcimimetics shifted from Part D to Part B, the use of these drugs by Black beneficiaries increased by 10 percentage points over a four-year period.[6] Including phosphate binders in the ESRD PPS bundle might also spur price competition among the six common types of phosphate binders. Prior Commission analysis showed that inclusion in the ESRD PPS bundle increased price competition within the erythropoiesis-stimulating agent and vitamin D therapeutic classes.[7]

To incorporate oral-only phosphate binders into the ESRD PPS, CMS should maintain its existing TDAPA policy, which, per regulation, stipulates a payment rate based on 100 percent of the ASP for each drug. We reiterate our comment on the CY 2019 proposed rule that the ASP + 6 percent policy that is applied to many Part B drugs was developed to reimburse *physicians* for the cost of drugs that they purchase directly and commonly administer in their offices.[10] While the ASP payment policy never stated what cost the "+6 percent" was intended to cover, we note that reimbursing dialysis facilities is considerably different from reimbursing physicians. First, the variation in physicians' purchasing power, whether they practice solo, as part of a group, or in a health system, is likely to result in considerably more variation in the acquisition price for a drug compared to the acquisition prices for dialysis facilities. If the intent of the "+6 percent" was to address acquisition price variation, we believe that rationale is diminished for dialysis facilities. Second, we note that the TDAPA is in addition to the ESRD base rate, which already includes reimbursement for the cost of storage and administration of ESRD-related drugs. Therefore, if the intent of the "+6 percent" was to address storage and administration costs, we believe these costs are already addressed through the ESRD bundle and do not contribute to the rationale for paying ASP plus 6 percent for the TDAPA. As we noted in our comment on the CY 2019 proposed rule, setting the TDAPA at 100 percent of ASP appears to be a well-founded policy. Further, as CMS explained when the agency reduced the TDAPA for calcimimetics in CY 2020 from ASP + 6 percent to ASP + 0 percent, setting the payment level with the average sales price of the drug limits the financial burden on beneficiaries and taxpayers.[12]

The Commission is also concerned that a percentage add-on to ASP may create incentives for use of higher-priced drugs when less-expensive therapeutic alternatives are available.

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[5] The Commission found that, in 2022, about 12 percent of FFS beneficiaries on dialysis had no Part D coverage or had coverage less generous than Part D. See Medicare Payment Advisory Commission. 2024. *Data Book: Health care spending and the Medicare program*. Washington, DC: MedPAC.
[6] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. Medicare program; end-stage renal disease prospective payment system, payment for renal dialysis services furnished to individuals with acute kidney injury, conditions for coverage for end-stage renal disease facilities, End-Stage Renal Disease Quality Incentive Program, and End-Stage Renal Disease Treatment Choices Model. Proposed rule. *Federal Register* 89, no. 129 (July 5): 55760–55843.
[7] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.
[10] Medicare Payment Advisory Commission. 2018. MedPAC comment on CMS's proposed rule on the end-stage renal disease payment system for CY 2019. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/08312018_esrd_cy2019_dme_medpac_comment_v2_sec.pdf.
[12] Centers for Medicare & Medicaid Services. 2019. Medicare program; end-stage renal disease prospective payment system, payment for renal dialysis services furnished to individuals with acute kidney injury, End-Stage Renal Disease Quality Incentive Program, durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) fee schedule amounts, DMEPOS Competitive Bidding Program (CBP) amendments, standard elements for a DMEPOS order, and master list of DMEPOS items potentially subject to a face-to-face encounter and written order prior to delivery and/or prior authorization requirements. Final rule. *Federal Register* 84, no. 217 (November 8): 60648–60809.

As we said in our June 2023 report, since a percentage add-on generates more revenue for the provider when applied to a higher-priced product than a lower-priced product, selection of the higher-priced product could generate more profit for the provider, depending on their acquisition costs for the two products.[13]

The Commission does not support linking a drug's dispensing fee to its ingredient cost (ASP for dialysis drugs paid under a TDAPA) and urges the agency not to set the TDAPA payment rate at ASP + 6 percent to account for dispensing fees. A drug's dispensing fee is intended to cover reasonable costs that are directly related to providing the drug.[14] As we have noted in the prior paragraph, there is no consensus on the original intent of the percentage add-on to ASP.

If CMS elects to include a dispensing fee in the TDAPA for phosphate binders, the agency should examine the dispensing fees for phosphate binders paid under Part D to assess if such data are appropriate to use under the ESRD PPS. We note that, in 2021, the median Part D dispensing fee was $0.50 per claim for the six common types of phosphate binders furnished to beneficiaries on dialysis. The Commission has also found that under Part D, dispensing fees for generic drugs are typically a fixed dollar amount (i.e., not always related to the price of the product), and that similar to dispensing fees paid in the commercial sector, Part D plans typically pay dispensing fees of $1 per claim or less.[15]

## Modify the outlier policy

CMS pays facilities an outlier payment when a beneficiary's payment per treatment for specified outlier services exceeds a threshold, which is the beneficiary's predicted payment amount per treatment for the outlier services plus a fixed dollar loss amount. Per regulation, the policy aims to distribute 1 percent of total payments to the highest-cost months of treatment by reimbursing 80 percent of costs above a specified threshold. Current (CY 2024) outlier services include:

- Dialysis drugs and biologics that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;
- Dialysis laboratory tests that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;

[13] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[14] According to 42 C.F.R. §423.100, dispensing fees are costs incurred at the point of sale in excess of the ingredient cost of a covered Part D drug. Dispensing fees include pharmacy costs such as checking insurance status, performing quality assurance, physical delivery, special packaging, and salaries of pharmacists and other pharmacy workers as well as the costs associated with maintaining the pharmacy facility and acquiring and maintaining technology and equipment.
[15] The Commission's calculation is based on Part D prescription drug event data from CMS. According to our stakeholder interviews, this amount is in line with most commercial insurance. https://www.medpac.gov/wp-content/uploads/2023/10/Generic-prices-Part-D-April-2024-SEC.pdf.

- Dialysis medical/surgical supplies, including syringes, used to administer renal dialysis drugs and biological products that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;

- Dialysis drugs and biologics that were or would have been, prior to January 1, 2011, covered under Medicare Part D; and

- Dialysis equipment and supplies, except for capital-related assets that are home dialysis machines, that receive the transitional add-on payment adjustment (as specified in § 413.236) after the payment period has ended.

CMS proposes to:

- Expand ESRD outlier services to include drugs and biologics that were historically included in the composite rate, as well as newer products that are currently included in the post-TDAPA.

- Modify how it updates its estimate of outlier drug and biologic spending in the upcoming CY. The agency proposes to use a chained Laspeyres price index of the quarterly ASP values for each drug and biologic included as an ESRD outlier service. Currently, the agency uses a blended four-quarter moving average of the ESRDB market basket price proxy for pharmaceuticals to inflate drug prices to the upcoming CY to estimate spending for outlier drugs and biological products in that CY.

## *Comment*

Outlier payments are needed when the PPS's payment adjustments do not capture all of the factors that may affect variation in providers' costs of delivering care. For example, higher costs may be triggered by the occurrence of random events, such as patients who suffer serious complications, and would appropriately trigger an outlier payment.

The Commission supports expanding ESRD outlier services to include drugs and biologics that were or would have been included in the composite rate prior to the ESRD PPS. As we said in our comment letter on the CY 2019 proposed rule, CMS should develop an outlier policy that addresses variation in the total cost of providing the entire ESRD PPS payment bundle, thereby avoiding the potential for misidentifying outliers (e.g., a patient with very high costs for outlier-eligible services may have offsetting, lower costs for outlier-ineligible services). Considering the cost of the full ESRD PPS payment bundle would be more patient-centric and would align the ESRD PPS outlier policy with the policies that Medicare uses for other PPSs.[16]

We also noted in our comment letter on the CY 2019 proposed rule that the overall effectiveness of the outlier policy depends on the accuracy of the ESRD PPS's model

[16] Medicare Payment Advisory Commission. 2018. MedPAC comment on CMS's proposed rule on the end-stage renal disease payment system for CY 2019. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/08312018_esrd_cy2019_dme_medpac_comment_v2_sec.pdf.

specification. The Commission has raised concerns about how CMS estimates the ESRD PPS's case-mix adjustments, including patient-level adjustments, and the accuracy of the adjustments' coefficients.[17, 18] These coefficients are used to calculate the Medicare allowable payment amount, which when combined with the fixed dollar loss amount, determines which treatments will receive an outlier payment. Therefore, to ensure the ability of the outlier policy to account for beneficiaries with high costs, the agency must improve the accuracy of the ESRD PPS's patient- and facility-level payment adjustments.

We support CMS's proposal to modify its method for calculating the increase in future spending of outlier drugs and biologics. The agency's proposal is consistent with the Commission's comment letter on the CY 2024 proposed rule, in which we urged CMS to use a drug price inflation factor based on ASP values to project future spending for outlier services. In that letter, we also noted that the ASP data used by CMS to determine facilities' actual outlier payments might be a more accurate data source for drug prices than the ESRDB market basket pharmaceutical price proxies that are currently used.[20]

## Update the low-volume payment adjustment

The current LVPA, which increases a facility's base rate by 23.9 percent, applies to facilities with fewer than 4,000 total treatments in each of the three years prior to the current payment year. The ESRD PPS also includes a rural payment adjustment, which increases a facility's base rate by 0.8 percent and applies to all facilities located in rural areas, regardless of treatment volume or proximity to other dialysis facilities.

CMS proposes a two-tiered LVPA. Dialysis facilities that furnish fewer than 3,000 treatments would receive a payment adjustment of 28.4 percent. Those that furnish 3,000 or more treatments but fewer than 4,000 treatments would receive a payment adjustment of 18.1 percent.[21] In addition, CMS proposes to determine an ESRD facility's LVPA tier based on the median treatment count of the last three cost-reporting years. The agency does not propose any changes to the rural payment adjustment.

The agency seeks comments on potential changes to LVPA eligibility for new ESRD facilities (i.e., facilities lacking three years of cost-reporting data to determine eligibility

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[17] Medicare Payment Advisory Commission. 2021. MedPAC comment on CMS's proposed rule on the end-stage renal disease payment system for CY 2022. https://www.medpac.gov/wp-content/uploads/2021/10/08302021_ESRD_CY_2022_MedPAC_Comment_SEC.pdf.
[18] Our concerns about CMS's model specification (i.e., using separate facility- and patient-level regressions) include: (1) if services which were separately billable prior to 2011 are included in the dependent variable for both regressions, the weights will not accurately distinguish the relative cost or payment addressed by each regression; and (2) multiplying coefficients from the facility-level and patient-level regressions (with different bases) could diminish the accuracy of the combined coefficients. https://www.medpac.gov/wp-content/uploads/2021/10/08302021_ESRD_CY_2022_MedPAC_Comment_SEC.pdf.
[20] Medicare Payment Advisory Commission. 2023. MedPAC comment on CMS's proposed rule on the end-stage renal disease payment system for CY 2024. https://www.medpac.gov/wp-content/uploads/2023/08/08252023_ESRD_CY2024_MedPAC_COMMENT_v2_SEC.pdf.
[21] The proposed adjusters maintain budget neutrality (i.e., the LVPA payment amount under the existing methodology of $26.7 million based on the expected CY 2025 LVPA payments).

for the current adjustment) that could be included as part of either the proposed tiered structure or a different methodology in the future.

### *Comment*

The agency's two-tier LVPA proposal is an improvement over current policy, as it will better align Medicare payments with facility costs. We support CMS's proposal of a two-tiered LVPA for existing dialysis facilities, as well as the proposal to maintain budget neutrality with respect to the current LVPA policy.

However, CMS's proposal does not ensure that only isolated low-volume facilities receive the LVPA. Neither the LVPA nor the rural adjustment accurately targets facilities that are both critical to beneficiary access and have high costs warranting a payment adjustment. Consistent with the Commission's principles, an adjustment that serves to preserve access to dialysis should focus on isolated and low-volume facilities. In the CY 2025 ESRD PPS proposed rule, CMS asserts that accounting for a facility's low volume and geographic isolation in the LVPA would not adhere to the statute.

The Commission supports a statutory change that would replace the current low-volume and rural payment adjustments in the ESRD PPS with a single adjustment for dialysis facilities that are isolated and consistently have low volume, where low-volume criteria are empirically derived.[22] A single payment adjustment that considers both a facility's distance to the next nearest facility and its treatment volume would eliminate extra payments to low-volume facilities in close proximity to another facility (which may not be needed to preserve access to care) and to high-volume rural facilities (which may achieve economies of scale)[23] and instead would target extra payments to low-volume and isolated facilities. Under current statutory provisions, the Secretary is required to include a low-volume payment adjustment but has the option to include (but is not required to include) a payment adjustment for facilities located in rural areas.

The Commission has three concerns about extending the LVPA to new dialysis facilities. First, extending the LVPA to new facilities without considering whether the facility is isolated risks paying too much to providers that are not critical to ensure beneficiary access to dialysis services. Second, such a policy might incentivize providers to enter markets where demand for additional services is low. CMS has not provided data that demonstrate the need for such an adjustment—in other words, data that show communities in which Medicare beneficiaries lack access to dialysis services. Third, beneficiaries and taxpayers would be at financial risk if a rigorous method of reconciliation is not in place to ensure that new LVPA facilities that ultimately do not meet the policy's eligibility criteria are held fiscally accountable.

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[22] Medicare Payment Advisory Commission 2020. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

[23] Prior analysis by the Commission found that the adjusted cost per treatment is similar between urban and rural facilities with comparable treatment volume. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch7_reporttocongress_sec.pdf.

Thus, CMS should not implement a LVPA for new facilities until the agency can ensure (1) that such facilities are isolated and thus critical to beneficiary access; (2) that there is sufficient demand for additional dialysis services in the community; and (3) that a rigorous reconciliation process is in place to hold providers accountable for meeting the policy's eligibility criteria.

## Update the wage index methodology

Since the beginning of the ESRD PPS, CMS has determined the ESRD PPS wage index using hospital wage data—specifically, the unadjusted acute care hospital inpatient PPS's wage index (referred to as the "pre-floor, pre-reclassification hospital inpatient wage index"). For CY 2025, CMS proposes using a new ESRD PPS-specific wage index that would combine data from the Bureau of Labor Statistics (BLS) Occupation Employment Wage & Statistics (OEWS) and freestanding ESRD facility cost reports to produce an ESRD PPS-specific wage index:

- The BLS OEWS program publishes annual estimates of employment and wages by occupation. Each set of OEWS estimates is based on data from six semiannual survey panels collected over a three-year period. The agency proposes to use mean hourly wage data for all industries combined located at the metropolitan statistical area (MSA) level.[24]

- Freestanding dialysis facilities file cost reports annually. Included in these cost reports is information on the number of full-time equivalent (FTE) positions employed by the facility, by occupation type (RN, LPN, technician, administrative staff, etc.) and total treatment volume.

To derive the ESRD PPS wage index, the agency proposes to use both data sources to determine the core-based statistical area (CBSA)-level treatment-weighted mean hourly wage for each occupation (e.g., RN, technician, dietician), each facility's mean hourly wage in the CBSA, the national treatment-weighted mean hourly wage for each occupation, and the national ESRD facility mean hourly wage. Using these data, the agency then proposes to:

- Calculate the raw wage index level by dividing the ESRD facility mean hourly wage for each CBSA by the national ESRD facility mean hourly wage.

- Calculate the final wage index value by multiplying the raw wage index for each CBSA by a treatment-weighted average of the CY 2025 ESRD PPS legacy wage index constructed using the established ESRD PPS methodology based on hospital data and dividing the product by the treatment-weighted average of the raw wage

[24] Because the publicly available BLS data are available at the MSA, non-MSA and New England City and Town Area levels, and the ESRD PPS wage index is designated at the CBSA level, CMS uses the area definition dataset that accompanies the BLS data to assign wages at the county level and map counties to CBSAs using a crosswalk.

indexes. CMS will apply the 0.6000 floor to the wage index by replacing any final wage index values which fall below 0.6000 with 0.6000.

### *Comment*

The Commission has long been concerned with flaws in the wage indexes that Medicare uses to adjust provider payments to reflect geographic differences in labor costs. In the Commission's June 2023 report to the Congress, we recommended that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new Medicare wage index systems for hospitals and other types of providers, including dialysis facilities, that:

- use all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type;
- reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
- smooth wage index differences across adjacent local areas.[25]

CMS's proposal is generally consistent with the principles underlying the Commission's June 2023 recommendation, and we therefore support the proposal. The use of freestanding dialysis facility cost report data appears reasonable, as BLS does not collect data on occupational shares specific to dialysis facilities. The use of BLS OEWS data for CBSA-level wage estimates also appears to be reasonable; this data source is publicly available, recent, and includes all-employer mean wage data.

CMS's proposal does not include two important elements that we specified in our June 2023 recommendation. First, it would not smooth wage index differences across adjacent local areas. Because proximate providers across adjacent local areas (such as county lines) compete for similar employees, the wage index should smooth wage index differences across adjacent local areas. Second, it would not account for differences in wages within metropolitan statistical areas (for example, by using data from the Census Bureau's American Community Survey). The agency should address the effect of not including these two elements in the design of the ESRD PPS wage index.

CMS should have an ongoing process to determine the validity of freestanding cost report data used in the ESRD PPS, including the wage index. In the current proposed rule, the agency notes "…the importance of accurate cost report data for this proposed policy as well as other current and potential policies under the ESRD PPS, such as facility-level or case-mix adjustment refinement."

The Commission continues to contend that a wage index floor is not appropriate, as wage index floors and related policies (e.g., exceptions and reclassifications) distort area wage

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[25] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

indexes.[26] Regarding the limit on decreases to the wage index values, the Commission supports limiting wage index changes to 5 percent in one year, which serves as a de-facto phase-in policy. However, the Commission contends that the limit should apply to *both* decreases and increases in the wage index. Under such a policy, no provider would have its wage index value increase or decrease by more than 5 percent for CY 2025.[27]

Finally, as stated above, the Commission has repeatedly raised concerns about the accuracy of the ESRD PPS's adjustment factors. When implementing the ESRD PPS in 2011, CMS used the old wage index to calibrate the case-mix adjustment factors.[28] CMS should address the effect of the proposed wage index on the accuracy of the current case-mix adjustment factors.

## Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please contact Paul B. Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair

[26] Medicare Payment Advisory Commission. 2022. MedPAC comment on CMS's proposed rule on the end-stage renal disease payment system for CY 2023. https://www.medpac.gov/wp-content/uploads/2022/08/08192022_ESRD_CY2023_MedPAC_COMMENT_SEC.pdf.
[27] Medicare Payment Advisory Commission. 2020. MedPAC comment on CMS's proposed rule on the end-stage renal disease payment system for CY 2021. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/09022020_esrd_cy_2021_medpac_comment_v2_sec.pdf.
[28] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2010. Medicare program; end-stage renal disease prospective payment system. Final rule. *Federal Register* 75, no. 155 (August 12): 49030–49214.