Overview
This paper analyzes the potential impacts of expanding the choice of Medicare Advantage to all End Stage Renal Disease (ESRD) beneficiaries in Medicare. It concludes that the benefits of Medicare Advantage would only be fully realized for these beneficiaries if the Medicare Advantage ESRD payment system is accurate, which is currently not the case. The analysis includes background information on kidney failure and its treatments, including dialysis, as well as a summary of Medicare ESRD payment policies. Finally, the paper includes recommendations on how to improve ESRD care in Medicare. Recommendations include the expansion of more ESRD beneficiaries in Medicare Advantage to ensure high-quality care and prevent negative effects on the Medicare Advantage program, which 1/3 of beneficiaries rely on for their Medicare.

THIS ISSUE PAPER SHOWS:
• ESRD prevalence continues to increase and these patients have complex, high cost treatment needs.
• Medicare Advantage provides a high-value care framework well-suited to vulnerable patients with chronic conditions like ESRD.
• To provide these benefits, Medicare Advantage relies on payment accuracy, and current ESRD payment in Medicare Advantage is inadequate.
• Medicare Advantage ESRD payment is inadequate due to significant discrepancies in the cost of dialysis care in Traditional Fee-For-Service (FFS) Medicare versus Medicare Advantage. This discrepancy is due to an inability to negotiate lower rates closer to Traditional FFS Medicare dialysis costs.
• The Centers for Medicare & Medicaid Services (CMS) must ensure payment for ESRD beneficiaries in Medicare Advantage is adequate, especially if more beneficiaries are given the ability to choose Medicare Advantage.
• Additional, policies should be enacted to improve ESRD care in Medicare by increasing the focus on prevention, encouraging treatment innovations, and removing barriers to care.
ESRD Patients Have Complex, High-Cost Needs

Individuals living with kidney failure, called ESRD, have complex health care needs. These Medicare-eligible individuals require dialysis multiple days per week and must take many medications each day. They are also at high risk of hospital admissions, high out-of-pocket costs and adverse outcomes. Though the number of new ESRD cases has plateaued since 2010, the total number of individuals with ESRD continues to grow as treatments advance and patients live longer.¹

ESRD Continues to Be a Priority for Policymakers

Addressing the cost and delivery of ESRD care has long been a concern for policymakers. Congress has authorized multiple demonstration projects and modifications to the payment methodology for ESRD treatment in Traditional Fee-For-Service (FFS) Medicare, including a move to a bundled payment system tied to performance measures in 2011.² The most recent demonstration is in progress and will be completed in 2020.³
Not All ESRD Individuals Have the Choice of Medicare Advantage

Current law prohibits ESRD Medicare beneficiaries from the choice of receiving their Medicare through Medicare Advantage except for limited situations, including if the individual developed ESRD while already enrolled in Medicare Advantage. Other limited situations include if he/she already received health benefits (e.g. employer-based coverage) through the same health insurance plan that offers the Medicare Advantage plan, or if he/she can join a Special Need Plan (SNP) for people with ESRD in his/her area.4,5

Medicare Advantage Relies on Accurate Capitated Payments to Provide High-Quality, Coordinated Care

The high-quality care under Medicare Advantage is dependent on a capitated payment system that accurately estimates the cost of care for each patient. Accurate payment allows Medicare Advantage to provide preventive, coordinated care that aims to slow disease progression. It can also enable Medicare Advantage to focus on innovation and value-based care, and help address barriers to care.

Current ESRD Payment in Medicare Advantage is Inadequate

Medicare Advantage health plan data indicate that current payment for Medicare Advantage ESRD patients are inadequate. Plan data indicate that current costs for the ESRD enrollees in Medicare Advantage range from just under 100% of payment (approximately 96%) to as high as 137% payment, depending on the geographic area. The average cost is 104% of payment.6 This inaccuracy is compounded by the fact that the average ESRD patient costs over eight times the cost of a non-ESRD patient; on average $7,023 versus $825 per month.7 Also, volatility in the proposed and final Medicare Advantage ESRD rates in recent years indicates potential difficulty in estimating accurate cost.

Medicare Advantage ESRD Payment Inaccuracy Is Due to the High-Cost of Dialysis

Inaccurate payment for ESRD in Medicare Advantage is largely because Medicare Advantage benchmarks are calculated based on Traditional FFS Medicare spending, and data show that the cost of dialysis treatment in Medicare Advantage is not analogous to the Traditional FFS Medicare bundled rate. In fact in many areas the cost of ESRD treatment to private health plans, including Medicare Advantage plans, is significantly higher than Traditional FFS Medicare dialysis costs – often over two times the Traditional FFS Medicare rate.8
Dialysis Market Consolidation Prevents Medicare Advantage Price Negotiations

This cost differential is due to the inability of Medicare Advantage plans to negotiate dialysis prices closer to the Traditional FFS Medicare rates due to the highly concentrated nature of the dialysis provider market. To meet network adequacy rules, Medicare Advantage plans do not have negotiating leverage in most geographic areas across the country. In addition, there is a lack of volume discounting due to the relatively low prevalence of ESRD in Medicare Advantage. The inability of Medicare Advantage plans to negotiate lower dialysis rates is unlikely to change even with more ESRD patients included in Medicare Advantage due to the highly consolidated nature of the dialysis market. This is not the case in most other treatments in Medicare Advantage, where Medicare Advantage plans most often pay rates close to or below Traditional FFS Medicare.9

Inadequate ESRD Payments Impact Beneficiaries and the Medicare Advantage Program

Medicare Advantage rates that are substantially less than the actual cost of treatment could negatively impact beneficiary access to the high-quality care Medicare Advantage provides. If payment accuracy is not corrected, adding more ESRD beneficiaries to Medicare Advantage could not only impact beneficiary care but could also be damaging to the Medicare Advantage program, which is the choice for one out of every three Medicare beneficiaries, almost 18.5 million individuals and growing.10

CMS Must Make Medicare Advantage ESRD Payment Accurate

Before the choice of Medicare Advantage is expanded to more ESRD beneficiaries, CMS must update Medicare Advantage ESRD payment to ensure it accurately reflects the cost of care for ESRD patients in Medicare Advantage. This includes analyzing the accuracy of Medicare Advantage ESRD state benchmarks, the ESRD risk adjustment model, and Star Rating Quality Program.
BMA Recommendations for Improved Care for ESRD Beneficiaries

• CMS must ensure payment for ESRD beneficiaries is accurate in Medicare Advantage:
  ◦ Before ESRD patients are given the choice of Medicare Advantage and more individuals are included in the program, CMS must update the payment system to ensure adequate payments, including ESRD benchmark rates and the ESRD-specific risk adjustment model.

• CMS must evaluate the Star Ratings Quality system as it relates to ESRD beneficiaries:
  ◦ CMS must work with Nephrologists and other ESRD providers to evaluate the Star Ratings Quality system in Medicare Advantage as it relates to individuals with ESRD to ensure it effectively incentivizes improved quality for this complex cohort of patients.

• Place renewed emphasis on preventing ESRD and slowing disease progression:
  ◦ Early detection of Chronic Kidney Disease (CKD) and prevention of ESRD should be emphasized. This should include an evaluation and public reporting of the impact of the recent removal of low acuity renal diagnosis codes in the general Medicare Advantage risk adjustment model.

• Encourage kidney donation and replacement:
  ◦ CMS, other policymakers and stakeholders should work together to increase kidney donation in order to increase access to kidney transplants.

• Share best practices for ESRD care:
  ◦ CMS should work with Nephrologists and other ESRD providers to identify the most effective ESRD care management and community-based programs that should be used to care for patients with ESRD and provide a mechanism for effective dissemination of these best practices.

• Increase access to ESRD education:
  ◦ Ensure all ESRD patients have access to information about all their treatment options, including palliative care.
• **Support advancements and innovations in ESRD treatments:**
  ° CMS should support innovations in care, including the use of telemedicine for routine dialysis-related check-ups, advances in home dialysis, and strides in other modalities of treatment.

• **Allow more flexibility for customized care for vulnerable Medicare Advantage beneficiaries:**
  ° Give Medicare Advantage plans the tools to customize care for ESRD patients to improve outcomes and remove care barriers such as transportation problems. This would include allowing flexibility in benefit design and supplemental benefits.

• **Expand access to Medicare Advantage Special Needs Plans for ESRD beneficiaries:**
  ° Congress should permanently reauthorize the Special Needs Plans (SNPs) with quality improvements, and also encourage expanded access to ESRD SNPs. CMS should also review and publicly report on ESRD SNP access, enrollment, and effective strategies.
End Stage Renal Disease Background

The primary function of the kidneys is to clean the blood of excess fluid and wastes. When the kidneys are damaged, it leads to a condition called Chronic Kidney Disease (CKD) and wastes begin to build up in the blood and complications can occur, such as high blood pressure, anemia, bone weakening, and nerve damage. CKD is divided into five stages based on degree of kidney function, with ESRD being the final stage. When an individual's kidneys are functioning at less than 15%, they have developed ESRD and need a kidney replacement or dialysis.

ESRD Prevalence

According to the most recent United States Renal Data System (USRDS) report, more than 660,000 American are currently being treated for ESRD. Over 70% of these individuals (468,000) are dialysis patients and the remaining 30% have a functioning kidney transplant (193,000). The adjusted incidence rate of new ESRD cases in the U.S. rose sharply in the 1980s and 1990s, peaked in 2006, and has plateaued since 2010. Compared to Caucasians, ESRD prevalence is about 3.7 times greater in African Americans, 1.5 times greater in Asians, and 1.4 times greater in Native Americans.
Chronic Conditions Cause ESRD

Approximately 31 million people are living with CKD. In 2014, 17% of Medicare beneficiaries were living with CKD. CKD can be caused by autoimmune and genetic diseases, but it is most commonly a result of conditions that put stress on the kidneys, namely diabetes and high blood pressure. These two conditions are responsible for up to two-thirds of kidney disease. Since over one in three Americans have high blood pressure, and 9.3% have diabetes (26% of seniors 65+), it is likely the number of individuals with kidney failure will continue to grow. Currently over two-thirds of Medicare beneficiaries have at least two or more chronic conditions.

Preventing ESRD

The earlier CKD is detected and treated the higher the chance disease progression can be slowed or stopped. An increased focus on early CKD detection, treatment, and education is an essential component of decreasing the prevalence of ESRD. Early intervention also ensures kidney patients are connected to a nephrologist as soon as possible to improve patient outcome and long-term quality of life. Simple tests, such as blood pressure, urine and blood analyses, can detect CKD. However, almost 40% of new ESRD cases in 2013 received little or no pre-ESRD nephrology care.
DIALYSIS & OTHER ESRD TREATMENTS

When an individual’s kidneys fail, they must have the help of dialysis to perform the function of the kidneys. During this time, eligible patients are placed on a transplant list and, ideally, are eventually able to receive a kidney transplant. Dialysis keeps the body of ESRD patients in balance by removing waste, salt, extra water and keeping safe levels of potassium, sodium, and bicarbonate in the blood. Dialysis can be performed in a hospital, at a dialysis center that is separate from a hospital, or at home. In addition, prescription drug treatments are crucial to help keep dialysis patients healthier over time.

FIGURE 3

Trends in the Annual Number of ESRD Incident Cases (in Thousands) by Modality, in the U.S. Population, 1996-2013

Source: The United States Renal Data System (USRDS), 2015 USRDS Annual Data Report.
Types of Dialysis

There are two main types of dialysis – hemodialysis and peritoneal dialysis, which are described below. In 2013, 63.7% of all ESRD patients were receiving hemodialysis therapy, 6.8% were being treated with peritoneal dialysis, and 29.2% had a functioning kidney transplant. New ESRD patients are even more likely to receive hemodialysis – 88.2% of all new ESRD cases began dialysis treatment with hemodialysis, 9.0% started with peritoneal dialysis, and 2.6% received a pre-emptive kidney transplant.

Hemodialysis is the most common form of dialysis, and is performed by a doctor creating an access site to large blood vessels, often in the arm or groin. Then, tubes are inserted and blood is transferred to an external machine that cleans the blood and returns it to the body. These vascular access sites must be maintained and can be uncomfortable for patients. Hemodialysis can be done in a hospital, dialysis facility, or at home – the most common setting is one of the over 6,300 dialysis facilities nationwide. Individuals often must receive Hemodialysis three times a week for four hours.

Peritoneal dialysis is the least common type of dialysis and allows blood to be cleaned in the body by placing a catheter into the abdomen. There are two main types of Peritoneal dialysis, Automated Peritoneal Dialysis, and Continuous Ambulatory Peritoneal Dialysis. Each cycle usually lasts 1-1/2 hours and exchanges are done throughout the night while the patient sleeps. Continuous Ambulatory Peritoneal Dialysis can be done manually, without a machine, using a bag that is placed on the catheter and creates an exchange of fluid – each exchange only lasts 15-30 minutes, but exchanges must be performed four or five times each day.

Kidney Transplants

For most patients, the ideal treatment for ESRD is a new, healthy kidney. However, there are long wait lists, and not all candidates are eligible to receive a transplant. In January 2016, there were over 100,000 people waiting for a kidney transplant. The median wait time for an individual’s first kidney transplant is 3.6 years, and the majority of kidneys come from deceased donors. In 2014, 4,761 people died waiting for a transplant, and 3,668 people experienced a decline in their health status that made them too sick to receive a transplant.
After three years, kidney transplant recipients (who are under 65) usually lose their Medicare coverage. Immunosuppression drug coverage gaps often exist for patients after they lose Medicare coverage, creating an incentive for kidney transplant recipients under the age of 65 to maintain a disability status to pay for critical medications.\textsuperscript{36} When patients receive a healthy kidney, they still have complex needs and may need some of the other medicines they took before the transplant in addition to anti-rejection medications.\textsuperscript{37,38}

**Medication**

Almost all patients on dialysis have anemia, which is caused by a low red blood cell count. Injections are often necessary to keep normal red blood cell counts. Oral or intravenous iron may be necessary to stabilize iron levels. Additionally, patients can experience a loss of bone minerals such as calcium and phosphorus, and medicine may be necessary to correct the deficiency with medicine. However, these two minerals can also buildup and become hard in small blood vessels. Vitamin D supplements may be needed to maintain parathyroid hormone levels.
High levels of the hormone can cause inflammation and discomfort for some dialysis patients. In 2013, Medicare Part D spending for ESRD patients per year was $6,673, 2.6 times higher than for general Medicare patients. In 2013, Medicare Part D spending for CKD patients was $3,675, 1.4 times higher for general Medicare patients.

**Different Treatment Options & Palliative Care Education**

In recent years, nephrologists have brought attention to the need for a renewed look at ESRD practice patterns. Some nephrologists feel that more emphasis should be placed on informing patients about the rigorous schedule and side effects of dialysis, especially for frail patients. Nephrologists also recommend that this increased attention to patient education include palliative care options.

**ESRD PAYMENT IN TRADITIONAL FFS MEDICARE**

Since ESRD was included in Medicare in 1972, policymakers have conducted multiple demonstration projects for the ESRD population to test payment and care delivery models, including demos testing managed care. (See below for a legislative timeline.) For example, the CMS ESRD Managed Care Demonstration started in 1998, lasted roughly three years, and despite its limitations, found slight benefits for ESRD patient care and outcomes. However, the demonstration also raised concerns about payment and risk adjustment accuracy.

**ESRD Medicare Eligibility**

For individuals with ESRD who are not otherwise eligible for Medicare, there is a three-month waiting period before the individual can become eligible for Medicare. Once eligible, these individuals are eligible for all covered services in Medicare, not only services directly related to ESRD. If the individual has existing employer- or union-sponsored coverage, the individual can retain their coverage for 30 months after starting dialysis. During this time, if the individual decides to be dually covered by their existing coverage and Medicare, during the 30-month period there is a coordination-of-benefits period during which time their existing private insurance is the primary payer and Medicare as the secondary payer.
High Cost of ESRD Care

Treatment for ESRD is very high cost. For example, in 2013, though ESRD patients comprised less than 1% of the Medicare population, caring for these complex individuals accounted for over 7% of Traditional FFS Medicare spending, totaling over $30.9 billion. This means that caring for ESRD beneficiaries is over eight times costlier than care for the average Medicare beneficiary.

FIGURE 5
ESRD Cost Per Member Per Month in Medicare, 2012 – 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>ESRD*</th>
<th>Non-ESRD</th>
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<tbody>
<tr>
<td>2012</td>
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<td>$752</td>
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<tr>
<td>2013</td>
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<tr>
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<tr>
<td>2017</td>
<td>$7,023</td>
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</table>


FIGURE 6
ESRD FFS Medicare Payment Bundle

<table>
<thead>
<tr>
<th>SERVICES INCLUDED IN THE ESRD FFS MEDICARE PAYMENT BUNDLE</th>
<th>SERVICES EXCLUDED FROM THE BUNDLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Composite Rate Services</td>
<td>• Hospital Services</td>
</tr>
<tr>
<td>• Part B Drugs</td>
<td>• Physician Services</td>
</tr>
<tr>
<td>• Dialysis Related Laboratory Tests</td>
<td>• Blood and Blood Products,</td>
</tr>
<tr>
<td>• Home Dialysis Support Services</td>
<td>Vaccines, TransfusionsHome</td>
</tr>
<tr>
<td>• DME Supplies and Equipment</td>
<td>Dialysis Support Services</td>
</tr>
<tr>
<td>• Supplies and Other Services</td>
<td>• Part D Oral Drugs Without an IV Equivalent</td>
</tr>
<tr>
<td>• Current Part D Dialysis Drugs With an IV Equivalent</td>
<td></td>
</tr>
</tbody>
</table>

Source: CMS
Traditional FFS Medicare ESRD Payment

To address the growing costs of ESRD treatment, policymakers have made multiple changes to the reimbursement method within Medicare since the 1970s. Reimbursement has gone from a cost-based, Fee-for-Service style payment to a composite rate. There was experimentation with capitation in the 90s, and, most recently, adoption of bundled payment tied to performance measures. Starting in 2011, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required CMS to bundle Medicare reimbursement for almost all ESRD treatments into one payment rate, including drugs that were previously billed separately.

The bundled prospective payment system (PPS) for ESRD treatment also included a pay-for-performance program that penalizes providers for not meeting specific quality measures updated by CMS annually. In addition, patient case mix adjustors are now used to adjust payment according to specific patient co-morbid conditions. The American Taxpayer Relief Act of 2012 (ATRA) required recalculation of the annually updated prospective bundled payment rate starting in 2014 to account for changes in use of drugs and biologicals. For payment in 2017, the ESRD Prospective Payment System in the Traditional FFS Medicare base rate will be roughly $232.

ESRD Beneficiary Cost Sharing in Traditional FFS Medicare

Part A covers costs associated with kidney transplant services in hospitals, skilled nursing facilities, and some home health care. Medicare Part A also covers dialysis in a Medicare-approved hospital. Medicare Part B covers the doctor’s services for the transplant, outpatient dialysis, laboratory services and immunosuppression medication for beneficiaries who received a kidney transplant. Under current law, Medicare pays 80% of the Part B costs for Medicare-covered dialysis and other associated physician and ancillary services. In addition to covering the remaining Part B costs, beneficiaries must also pay their Part B premium (the standard 2016 premium is $104.90) as well as Part A and B deductibles – for 2016; the Part A deductible is $1,288 per benefit period and the Part B deductible is $166). Additionally, there are no annual limits on out-of-pocket costs in Traditional FFS Medicare, which is a consumer protection for Medicare Advantage beneficiaries.

Many ESRD beneficiaries are dually eligible for Medicare and Medicaid, and thus receive help with their cost sharing. Others meet the stringent guidelines for programs to help low-income individuals with out-of-pocket costs. However, many ESRD patients in Traditional FFS Medicare rely on Medigap policies to help them with their out-of-pocket costs. Medigap policies will pay for the 20% co-insurance. However, only 29 states require plans to offer at least one kind of Medigap policy for Medicare beneficiaries under the age of 65.
As a result, individuals with ESRD face some of the highest costs associated with any Medicare beneficiary. A 2014 Kaiser Family Foundation report looked at premiums, out-of-pocket spending, supplemental insurance coverage (Medigap), and medical and long-term care services and found ESRD beneficiaries reported they spent on average $6,918 in 2010, much higher than the average $4,734 for all of Traditional FFS Medicare.60

ESRD BENEFICIARIES IN MEDICARE ADVANTAGE

Over 18 million Medicare-eligible beneficiaries have chosen Medicare Advantage over Traditional FFS Medicare and there is increasing provider interest in the more integrated model of care Medicare Advantage provides. However, in 2014, only about 15% of ESRD beneficiaries were enrolled in Medicare Advantage plans; by comparison, about 30% of all Medicare beneficiaries were enrolled in Medicare Advantage plans in 2014.61

The majority of ESRD beneficiaries are enrolled in Traditional FFS Medicare and not Medicare Advantage due to eligibility restrictions, described below. Currently there are likely roughly 95,000 ESRD patients who are currently enrolled in Medicare Advantage, which is approximately 19% of Medicare ESRD beneficiaries.62 This compares to the non-ESRD Medicare Advantage penetration of 36%.63

ESRD Medicare Advantage Eligibility Guidelines

Current law excludes ESRD patients from the choice of enrolling in a Medicare Advantage plan when they become eligible for Medicare, even if they are over 65, except for certain situations. These situations include:

• If you develop ESRD while already enrolled in Medicare Advantage you may be able to stay on your plan or join another plan offered by the same company;
• If you’re already receiving your health benefits (e.g. employer-based coverage) through the same health insurance plan that offers the Medicare Advantage plan;
• You had ESRD, but have had a successful kidney transplant, and you still qualify for Medicare benefits (based on your age or a disability), you can stay in Traditional FFS Medicare, or join a Medicare Advantage Plan;
• If you can join a Special Need Plan (SNP) for people with ESRD in your area;
• If you have ESRD, and are in Medicare Advantage, and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time opportunity to join a new plan immediately.64,65
ESRD Special Needs Plans (SNPs)

A SNP is a type of Medicare Advantage plan that is tailored to the specific diseases or characteristics of a beneficiary, such as chronic conditions (including ESRD) and dual Medicare-Medicaid eligibility. SNPs are allowed to customize their benefits, provider network, and drug formularies (list of covered drugs) to best care for the specific needs of the beneficiaries in the SNP. However, individuals with ESRD can only enroll in a SNP if it is available in their region, and currently ESRD SNPs are only available in six states (AZ, CA, CO, NC, NV, TX). As a result, less than 5,000 individuals with ESRD are enrolled in ESRD SNPs. One barrier to growth of ESRDs is the fact that the SNP program does not have permanent reauthorization.

Potential Benefits for ESRD Patients in Medicare Advantage

Extending the choice of Medicare Advantage to beneficiaries with ESRD would provide these individuals with better-coordinated care, out-of-pocket protections, and potentially better access to more convenient treatments, such as home dialysis. Unlike Traditional FFS Medicare, Medicare Advantage plans are paid a capitated (fixed monthly) amount per to cover all Traditional FFS Medicare services.

To achieve better health outcomes, Medicare Advantage is developing and incentivizing innovative ways to manage Medicare beneficiaries with complex chronic conditions by leveraging the benefits of a capitated payment system. These new care approaches include dynamic value-based contracts with providers, testing telemedicine, the use of care coordinators, and placing greater emphasis on home as an effective site of care. However, these benefits will only be possible if it payment to Medicare Advantage is adequate to care for complex patients. Medicare Advantage plans also have a maximum out-of-pocket that they cannot exceed. Traditional FFS Medicare does not have an analogous protection. For example, in 2016 the out-of-pocket maximum is $6,700.

FIGURE 7

Number of Medicare (Part B) Non-ESRD and ESRD* Enrollees, 2016

<table>
<thead>
<tr>
<th></th>
<th>NON-ESRD TOTAL</th>
<th>NON-ESRD FFS</th>
<th>ESRD TOTAL</th>
<th>ESRD FFS</th>
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</thead>
<tbody>
<tr>
<td>51,567,000</td>
<td>33,193,000</td>
<td>500,000</td>
<td>404,000</td>
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</tbody>
</table>

DIALYSIS PAYMENT IN MEDICARE ADVANTAGE

Unlike Traditional FFS Medicare which has payment for treatments set and updated by the government, Medicare Advantage plans contract individually with providers and other care partners. In many cases, the cost the two parties agree to for a service is similar to the Traditional FFS Medicare rate. In fact, a recent study showed that in many cases Medicare Advantage plans are able to negotiate lower prices and the cost of most Medicare Advantage services is less than that of Traditional FFS Medicare. However, this is not the case with dialysis costs in Medicare Advantage – analyses show that Medicare Advantage pays a much higher rate to dialysis centers than the Traditional FFS Medicare bundle amount.

Dialysis Provider Concentration

The reason for this price discrepancy is that Medicare Advantage plans are unable to negotiate dialysis rates closer to Traditional FFS Medicare rates primarily due to the highly concentrated nature of the dialysis provider market. There are currently over 6,300 dialysis facilities nationwide, and over 93% are freestanding (not hospital-based). In 2014, 71% of all dialysis facilities were owned by two companies. Policymakers and researchers have long predicted and investigated the impact of dialysis provider concentration on access, quality, and cost. In some cases consolidation of the dialysis provider market has demonstrated clinical advantages, especially related to improved compliance, efficiencies, and broad scale quality improvements. However, analyses have also outlined concerns that such a high level of market concentration inhibits price competition. As a result, dialysis providers have been able to set dialysis prices for private insurance significantly higher than the rates they receive for the same care for Traditional FFS Medicare and Medicaid patients. In addition, the relatively small number of Medicare Advantage ESRD beneficiaries in each region prevents the potential use of volume discounts for Medicare Advantage plans. For these reasons, the inability of Medicare Advantage plans to negotiate lower dialysis rates is unlikely to change if more ESRD patients are included in Medicare Advantage.
ESRD PAYMENT METHODOLOGY IN MEDICARE ADVANTAGE

Payment in Medicare Advantage is based on a capitated (fixed) amount the government pays to Medicare Advantage health plans for each beneficiary. Therefore, CMS does not pay for ESRD treatment in Medicare Advantage through the same bundled payment methodology as Traditional FFS Medicare. For non-ESRD Medicare Advantage beneficiaries, capitated payments are calculated based on Traditional FFS Medicare spending at the county level to set a benchmark (and then adjusted for multiple factors), plans then bid against this benchmark, and that base rate is then risk adjusted for each beneficiary.

State-Based Benchmarks

Since the cost of care for ESRD patients is so different than the average Medicare beneficiary, CMS calculates the Medicare Advantage ESRD capitated rates separately and publishes an updated ESRD rate book each year. However, since less than 100,000 ESRD patients are in Medicare Advantage, there is not enough data to calculate at the county level, so ESRD rates are calculated at the state level and there is no bidding – plans are paid based on the set rates by state. These set rates are then risk adjusted by the ESRD risk adjustment model that is also separate from the non-ESRD Medicare Advantage risk adjustment model.

FIGURE 8

Medicare Advantage ESRD Payment Calculation

Source: CMS
MEDICARE ADVANTAGE ESRD PAYMENT ACCURACY

Accurately estimating the cost of care for each beneficiary, especially high-cost patients, is central to the efficacy of a capitated payment system like Medicare Advantage. Each year, CMS releases updates to Medicare Advantage capitated payments for the following year, which are calculated using FFS Medicare data. The proposed growth updates are released in early February, and the finalized rates are released the first Monday of April (60 days later). There is often a change between the proposed and final rate as CMS receives updated data over those 60 days, however, ideally there is only a slight change.

Current Medicare Advantage ESRD Benchmarks Are Inadequate

Medicare Advantage health plan data indicate that current payment for Medicare Advantage ESRD patients is inadequate. Plan data indicate that current costs for the ESRD enrollees in Medicare Advantage range from just under 100% of payment (approximately 96%) to as high as costs 137% of payment, depending on the geographic area. The average is costs that are 104% of payment. This inaccuracy is compounded by the fact that the average ESRD patient costs over 8 times the cost of a non-ESRD patient; on average $7,023 versus $825 per month. Therefore, some ESRD beneficiaries are receiving care from a health plan that could be receiving payments up to $30,000 below what their actual costs of treatment are for that year.

Volatility in Medicare Advantage ESRD Growth Rate Updates

Figure 9 shows that the Medicare Advantage ESRD Growth Rate Updates tend to vary more between the Proposed and Final Rule for ESRD Medicare Advantage as compared to non-ESRD Medicare Advantage. On average, between 2013 to 2017, ESRD growth rates updates varied by 2.26 percentage points from proposed to final, compared to 1.02 percentage points in non-ESRD Medicare Advantage. In 2015, the difference between the initial payment rate estimate and final payment rate was $270 per month, resulting in a total payment difference of $3,240 per member per year. In some years, the proposed and final rules were directionally different, something that has not happened in non-ESRD Medicare Advantage. Also, it is unclear why there is no directional correlation between the updates in ESRD and non-ESRD. Finally, estimates for ESRD tend to be negative, implying that costs for ESRD beneficiaries are decreasing, which is inconsistent with true spending for these beneficiaries (see Figure 5). Unstable payment estimates for ESRD may indicate difficulty estimating costs for these beneficiaries.
Importance of ESRD Medicare Advantage Risk Adjustment

In addition to making sure the ESRD Medicare Advantage rate book is accurate, risk adjustment accuracy is also vital to ensuring Medicare Advantage payment is adequate to care for these patients. Though all ESRD patients have high-cost needs, variability exists between patients and some have many more comorbidities and other risk factors that impact the care they need. Medicare Advantage ESRD has its own Risk Adjustment to Model, separate from the non-ESRD model, and it is important that the model accurately predicts costs for treatment.

In addition to its role with ESRD payment accuracy, risk adjustment plays an important role in preventing ESRD by encouraging diagnosis of the early stages of CKD in order to slow disease progression. In 2013, CMS announced it would phase in a new risk adjustment model (the “2014 Model”) that removed certain diagnosis codes related to early stages of chronic diseases, such as diabetes and chronic kidney disease. The elimination of these codes reduced the resources that were previously available for early treatment of chronic disease. These changes were not based on any public assessment of appropriate clinical practice or quality care, but rather as an additional adjustment for differences in coding patterns between Medicare Advantage and Traditional FFS Medicare. As chronic diseases, including CKD, become more prevalent and if more ESRD patients are included in Medicare Advantage, it is important to evaluate the impact of this policy.
IMPROVING ESRD CARE FOR BENEFICIARIES

In addition to payment policy changes, policymakers remain focused on ways to improve and innovate the care ESRD patients receive.

Addressing Racial Disparities

African American, Hispanics, Pacific Islanders, Native Americans, and seniors are at increased risk of developing kidney failure. In fact, African Americans are more than three times as likely as Caucasians to develop kidney failure and up to 10 times as likely to develop kidney failure due to hypertension. Hispanics and Native Americans are nearly two times as likely as Caucasians to develop kidney failure. The exact cause of this correlation is unknown, though current research aims to better understand the causality. In addition, multiple analyses have shown that Caucasians, high-income, educated individuals, and patients who were under the care of a nephrologist during the pre-ESRD period are more likely to choose home dialysis. Racial and ethnic minorities also have decreased access to treatment. African Americans, Hispanics, and Native Americans wait approximately twice as long as Caucasians to receive a kidney transplant. One study found that in impoverished neighborhoods, African Americans were 57% less likely to get on a transplant list than their Caucasian counterparts. African Americans are 30% less likely and Hispanics 10% less likely to receive the most common type of home dialysis.

Improving Modalities of Care

Improvements in dialysis machines and other treatment advances allow individuals to increasingly bring dialysis into their home, improving independence and convenience. Some Home Hemodialysis and Peritoneal Dialysis patients perform frequent, shorter sessions or perform nocturnal dialysis. Providers have also looked to telemedicine to aid in the care of dialysis patients, and policymakers have called for more flexibility in the use of telemedicine for dialysis in Medicare.

Empowering Patient Decision-Making Through Education

Despite advances in home dialysis care, the majority of dialysis patients still receive dialysis in a dialysis facility. Only approximately 1 in 10 ESRD beneficiaries receive home dialysis. According to a report published by the Government Accountability Office (GAO), “Studies have shown that patients who perform dialysis at home may have increased autonomy and health-related quality of life.” Some of this is due to access issues as well as lack of education on all available options. In one analysis, when provided with a comprehensive pre-dialysis education,
nearly half of the patients opted for home dialysis.87 Proponents of home dialysis blame a lack of patient education and awareness and scarcity of medical experts performing home dialysis therapies for underutilization of home dialysis therapies. Others cite hesitation by dialysis centers to promote home dialysis for fear of lower reimbursement rates. It is important that dialysis patients are aware of all their options to ensure they make the best choice for themselves and their family. Medicare Advantage plans could play an important role in educating ESRD patients about their dialysis options.

Removing Barriers to Treatment

In addition to racial disparities that create barriers for many patients, the three-month waiting period is another barrier to care and delays vital evaluation and treatment for these vulnerable patients. Also, the majority of dialysis patients receive their care at dialysis centers, and often rely on caregivers and family members to drive them there. In addition, many dialysis patients must travel long distances to receive their treatment at a dialysis facility.88 As a result, transportation and access issues can be a large barrier for consistency of treatment.89 Even one missed treatment puts a patient at an increased risk of adverse events, like an intensive care visit, emergency room visit, or even death.90 Increasing access to home dialysis as well as increasing flexibility of supplemental benefits to be used towards transportation costs could help address these barriers.
ESRD CONTINUES TO BE A PRIORITY FOR POLICY MAKERS

Since Medicare coverage was extended to individuals living with ESRD in the early 1970s, Congress has adjusted the policies and payment associated with this population. As mentioned above, Traditional FFS Medicare ESRD payment has changed and is currently a bundled payment system. The U.S. House recently passed the ESRD Choice Act of 2016 (H.R. 5659) in September 2016, which would expand the choice of Medicare Advantage to all beneficiaries with ESRD. The Medicare Payment Advisory Commission (MedPAC) recommended this policy change in 2000 and repeated the recommendation in 2004. However, this change has failed to be enacted, in part due to concerns about payment adequacy. In December 2015, the U.S. Senate Committee on Finance Bipartisan Chronic Care Working Group included this policy in its policy option document, while also asking stakeholders for “...input on how Medicare Advantage benchmarks and bids would need to be adjusted to ensure accurate payment and not increase overall program costs.” In late October, the Chronic Care Working Group also included the change in a legislative discussion draft. Policymakers feel these individuals deserve the choice of Medicare Advantage and are confident Medicare Advantage will provide a better care framework for these high need patients. However, the high-value care Medicare Advantage provides can only be fully realized if the capitated payment is accurate. Currently, this is not the case in Medicare Advantage ESRD payment. CMS must update Medicare Advantage ESRD payment to ensure it is adequate, especially if more ESRD beneficiaries are able to choose the program.

*Does not include all demonstration projects relating to ESRD.
Timeline of Major Changes to ESRD in Medicare

Laws Impacting ESRD:

- **The Social Security Amendments of 1972** extended Medicare coverage to ESRD individuals under the age of 65 starting in 1973. Medicare paid 80% of the allowable rate for outpatient dialysis between 1973 and 1983, which limited the reimbursement to $138 per treatment.

- **The ESRD Program Amendments of 1978** provided immediate Medicare coverage, without a three-month waiting period, for people who received home-dialysis or kidney transplants. The law also called for a prospective reimbursement payment for dialysis and extended transplant benefits from 12 to 36 months.

- **The Omnibus Budget Reconciliation Act of 1981** implemented a prospective “composite rate” payment system that established a per-treatment payment rate, adjusted for geographic wage variations. The average payment per treatment was $123.

- **The Medicare Modernization Act (MMA) of 2003** increased the composite rate by 1.5% in 2005. The bill also based the cost of separately billable dialysis-related drugs based on the Average Sales Price (ASP) plus 6%. The bill also adjusted the composite rate based on beneficiary age, body surface area and low body mass index.

- **The Medicare Improvements for Patients and Providers Act (MIPPA) 2008** required Medicare to establish a prospective payment system for ESRD services, which included composite rates, drugs and laboratory tests, among other things. The law also called for an annual update to prospective payment rates and required ESRD providers to meet certain quality metrics through the Quality Incentive Program (QIP).

- **The American Taxpayer Relief Act of 2012** required Medicare to recalculate dialysis bundled payment rates for 2014 to account for changes in drug use.
Proposals Related to Expanding the Choice of Medicare Advantage to ESRD Beneficiaries:

• The U.S. Senate Committee on Finance Bipartisan Chronic Care Working Group supports policies to allow all ESRD beneficiaries to enroll in Medicare Advantage:
  ° Legislative discussion draft (October 2016): Allows all previously prohibited individuals to enroll in Medicare Advantage starting in 2021 (excluding kidney acquisition costs). The Secretary would also be required to submit a report to Congress on the impact of the provisions of this section related to spending, enrollment and sufficiency of data under the traditional Medicare and Medicare Advantage programs for ESRD beneficiaries.
  ° Policy Options document (December 2015): Solicited feedback on how payment in Medicare Advantage ESRD should be adjusted to ensure accurate payment and not increase overall program costs; requested input on what quality measures are available to ensure that ESRD beneficiaries would have the information to make an informed choice when deciding whether to enroll in a Medicare Advantage plan.

• The Expanding Seniors Receiving Dialysis Choice Act of 2016 (H.R. 5659) proposes allowing ESRD patients to join Medicare Advantage plan. In addition, the bill:
  ° Adds a sense of Congress that “in implementing the policies under this section, [CMS] should provide, in an accurate and transparent manner, for risk adjustment to payment under the [Medicare Advantage] program to account for the increased enrollment in [Medicare Advantage] plans of individuals with [ESRD].”
  ° Excludes the cost for kidney transplants from the Medicare Advantage capitated payment (will remain in Traditional FFS Medicare).
  ° Requires implementation of the changes effective January 1, 2020.
  ° Directs the CMS Administrator to report to Congress on the impact of the bill no later than April 1, 2022.
CONCLUSION AND RECOMMENDATIONS

As the prevalence of chronic disease grows, Medicare Advantage has a large role in improving care for complex patients. This includes helping to slow disease progression towards CKD and ultimately ESRD. Extending the choice of Medicare Advantage to ESRD beneficiaries could enable these individuals to benefit from the quality, coordinated care, and consumer protections Medicare Advantage provides. The emphasis on value and innovation in Medicare Advantage has the potential to improve outcomes and treatments, enhancing the day-to-day life of patients. However, these benefits would only be fully realized if the Medicare Advantage ESRD payment is adequate. Currently this is not the case in Medicare Advantage ESRD payment. CMS must ensure that Medicare Advantage ESRD payment is adjusted and adequate to care for these patients.

If payment is not accurate for Medicare Advantage ESRD patients, the capitated system will struggle to improve outcomes for these high need patients. Individuals with ESRD have health care needs that include continual dialysis treatments, treatments for other chronic conditions they are living with, and numerous medications. These beneficiaries are at high risk for hospital admissions and other adverse events. These complex medical needs lead to high costs for beneficiaries and the health care system.

Medicare beneficiaries are depending on policymakers to get the resources to care for ESRD patients right. This includes accurate benchmarks, risk adjustment, and quality measurement. In the past, policymakers and researchers have conducted many demonstrations and analyses to understand the full impact of changing the payment and delivery of care for ESRD patients. The same care should be taken to ensure payment is accurate in Medicare Advantage for ESRD patients.

When outlining the policy option of giving all ESRD patients access to Medicare Advantage, the U.S. Senate Chronic Care Working group solicited feedback about how, “payment should be adjusted to ensure accurate payment and not increase overall program costs”. Our analysis of those questions has raised concerns that current ESRD rate setting in Medicare Advantage is potentially inaccurate and must be fully evaluated and updated before more ESRD patients are included in Medicare Advantage.
BMA RECOMMENDATIONS FOR IMPROVED CARE FOR ESRD BENEFICIARIES

• CMS must ensure payment for ESRD beneficiaries is accurate in Medicare Advantage
  ◦ Before ESRD patients are given the choice of Medicare Advantage and more individuals are included in the program, CMS must update the payment system to ensure adequate payments, including ESRD benchmark rates and the ESRD-specific risk adjustment model.

• CMS must evaluate the Star Ratings Quality System as it relates to ESRD beneficiaries
  ◦ CMS must work with Nephrologists and other ESRD providers to evaluate the Star Ratings system in Medicare Advantage as it relates to individuals with ESRD to ensure it effectively incentivizes improved quality for this complex cohort of patients.

• Place renewed emphasis on preventing ESRD and slowing disease progression
  ◦ Early detection of CKD and prevention of ESRD should be emphasized. This should include an evaluation and public reporting of the impact of the recent removal of low acuity renal diagnosis codes in the general Medicare Advantage risk adjustment model.

• Encourage kidney donation and replacement
  ◦ CMS and other policymakers and stakeholders should work together to increase kidney donation in order to increase access to kidney transplants.

• Share best practices for ESRD care
  ◦ CMS should work with Nephrologists and other ESRD providers to identify the most effective ESRD care management and community-based programs that should be used to care for patients with ESRD and provide a mechanism for effective dissemination of these best practices.
• **Increase access to ESRD education**
  ° Ensure all ESRD patients have access to information about all their treatment options, including palliative care.

• **Support advancements and innovations in ESRD treatments**
  ° CMS should support innovations in care, including the use of telemedicine for routine dialysis-related check-ups, advances in home dialysis, and strides in other modalities of treatment.

• **Allow more flexibility for customized care for vulnerable Medicare Advantage beneficiaries**
  ° Give Medicare Advantage plans the tools to customize care for ESRD patients to improve outcomes and remove care barriers such as transportation problems. This would include allowing flexibility in benefited design and supplemental benefits.

• **Expand access to Medicare Advantage SNPs for ESRD beneficiaries**
  ° Congress should permanently reauthorize the Special Needs Plans (SNPs) with quality improvements, and also encourage expanded access to ESRD SNPs. CMS should also review and publicly report on ESRD SNP access, enrollment, and effective strategies.
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