

Caring for ESRD Beneficiaries in Medicare & Medicare Advantage

WHITE PAPER

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I. Executive Summary

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, including ensuring accurate Medicare Advantage payment for beneficiaries with ESRD to ensure high-quality care and prevent negative effects.

THIS WHITE 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 such as 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 as more beneficiaries are given the ability to choose Medicare Advantage by mobile communication devices such as cell phones.³
- Policies should be enacted to improve ESRD care in Medicare by increasing the focus on prevention, encouraging treatment innovations, and removing barriers to care.

The high-value care under Medicare Advantage depends on the accuracy of the risk adjusted, capitated payment Medicare Advantage plans receive to care for each beneficiary. Payment accuracy is especially crucial for high-risk, high-cost beneficiaries, such as individuals with ESRD. Currently, Medicare Advantage ESRD payment is not adequate and unless the payment is appropriately adjusted to reflect the costs of care for individuals with ESRD, the expectations for quality care in Medicare Advantage will not be realized for increasing numbers of beneficiaries with ESRD.

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 been generally stable 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

Both Congress and the Administration are focused on finding ways to improve care for beneficiaries with ESRD, including recent efforts to increase home dialysis and transplants as well as reduce the incidence of ESRD.²

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.

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 a low of 96% to as high as 137% of payment, depending on the geographic area, with an average cost of 104% of payment.³ Volatility in the proposed and final Medicare Advantage ESRD rates in recent years indicates potential difficulty in estimating accurate costs.

Medicare Advantage 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 many areas the cost of ESRD treatment to private health plans, including Medicare Advantage plans, is significantly higher than Traditional FFS Medicare dialysis – often over two times the Traditional FFS Medicare rate.⁴

Dialysis Market Consolidation Prevents Medicare Advantage Price Negotiations

Medicare Advantage plans are unable 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.

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 all beneficiaries' access to the high-quality care Medicare Advantage provides. If payment accuracy is not corrected, adding more ESRD beneficiaries to Medicare Advantage in 2021 could not only impact beneficiary care but could also be damaging to the Medicare Advantage program, the enrollment choice for nearly 40% of all Medicare beneficiaries.

CMS Must Make Medicare Advantage ESRD Payment Accurate

With the impending expansion of Medicare Advantage options to all 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. CMS should also adjust the bidding process to include ESRD costs, so that plans will not have to cover any losses on ESRD with rebate dollars.

II. BMA Recommendations for Improved ESRD Care

CMS must ensure payment for ESRD beneficiaries is accurate in Medicare Advantage

Given the impending expansion in 2021 for ESRD patients in Medicare Advantage, CMS must update the payment system to ensure adequate payments, including ESRD benchmark rates and the ESRD-specific risk adjustment model. CMS should also modify the Medicare Advantage bidding process to include ESRD costs.

CMS must evaluate the Star Ratings Quality System as it relates to ESRD beneficiaries

Per the 21st Century Cures Act requirement, 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 Chronic Kidney Disease (CKD) and prevention of ESRD should be emphasized.

Encourage kidney donation and replacement

CMS and other policymakers and stakeholders should continue to find ways 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.

III. Chronic Kidney Disease & End Stage Renal Disease Background

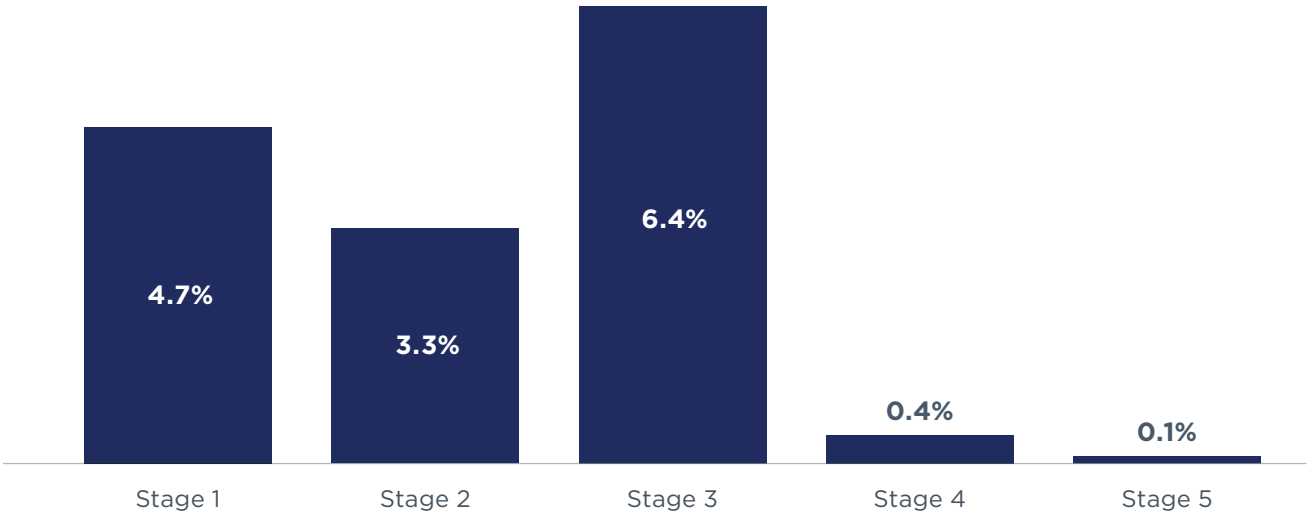
The primary function of the kidneys is to clean the blood of excess fluid and wastes. When the kidneys are damaged, it leads to a condition called Chronic Kidney Disease (CKD). As CKD worsens, wastes begin to build up in the blood and complications can occur, such as high blood pressure, anemia, bone weakening, and nerve damage.⁵ CKD is divided into five stages based on degree of kidney function, with ESRD being the final stage.⁶ When an individual’s kidneys are functioning at less than 15%, they have developed ESRD and need a kidney replacement or dialysis in order to live.⁷

CKD Trends

Approximately 37 million people are living with CKD, including 38% of people over the age of 65.⁸ Some estimates suggest that as many as 90% of people with CKD do not know that they have the condition.⁹ 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.¹⁰ These two conditions are responsible for up to two-thirds of kidney disease.¹¹ Since over one in three Americans have high blood pressure, and 9% have diabetes (26% of seniors 65+), it is likely the number of individuals with CKD will continue to grow.^{12,13,6}

FIGURE 1

Percentage of US Population Age 20+ by Chronic Kidney Disease Stage



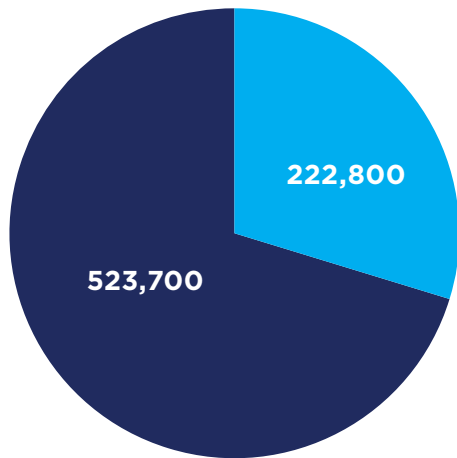
Source: USRDS 2018 Annual Data Report

ESRD Trends

Nearly 750,000 American are currently being treated for ESRD.¹⁴ Over 70% of these individuals (524,000) are receiving dialysis while the remaining 30% have a functioning kidney transplant.¹⁵ The adjusted incidence rate of ESRD in the U.S. rose sharply in the 1980s and 1990s, peaked in 2006, and gradually declined since 2010 to reach an estimated 347 new cases of ESRD per million people in 2017.¹⁶ During the same time period, mortality has improved from over 20% to just under 15% of patients dying each year.¹⁷ Compared to Caucasians, ESRD prevalence is about 3.6 times greater in African Americans, 1.3 times greater in Asians, and 1.9 times greater in Native Americans.¹⁸

FIGURE 2

ESRD Patients by Treatment Modality, 2017

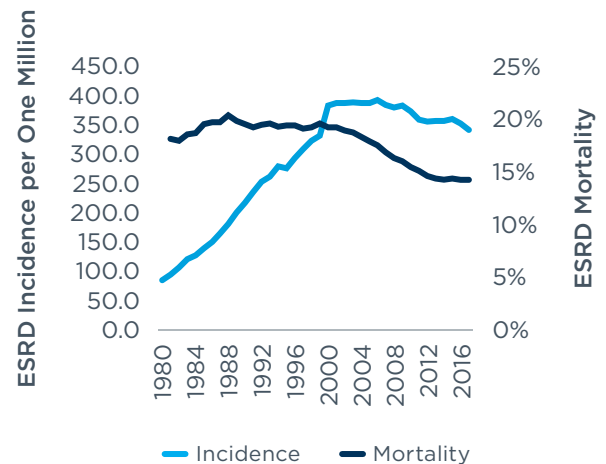


■ On Dialysis ■ Functioning Kidney Transplant

Source: USRDS 2019 Annual Data Report

FIGURE 3

ESRD Incidence and Mortality, 1980-2017

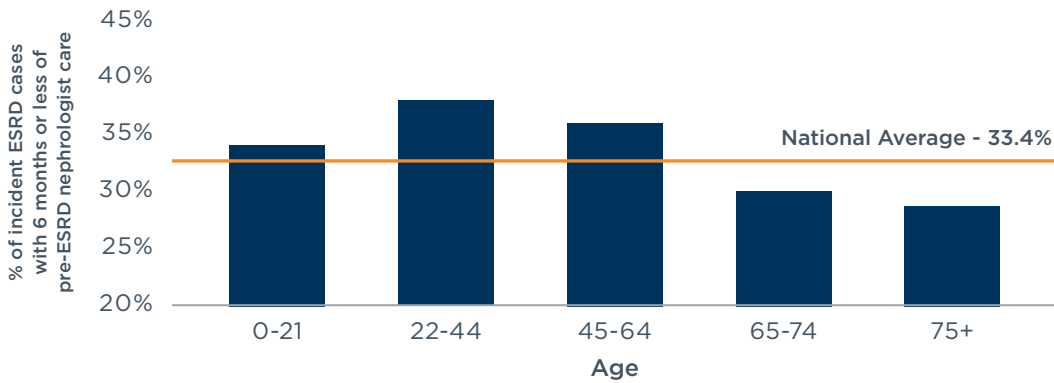


Preventing ESRD

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, one-third of all new ESRD cases in 2017 received less than 6 months of pre-ESRD nephrology care.¹⁹

FIGURE 4

Limited Pre-ESRD Nephrology Care by Age, 2017



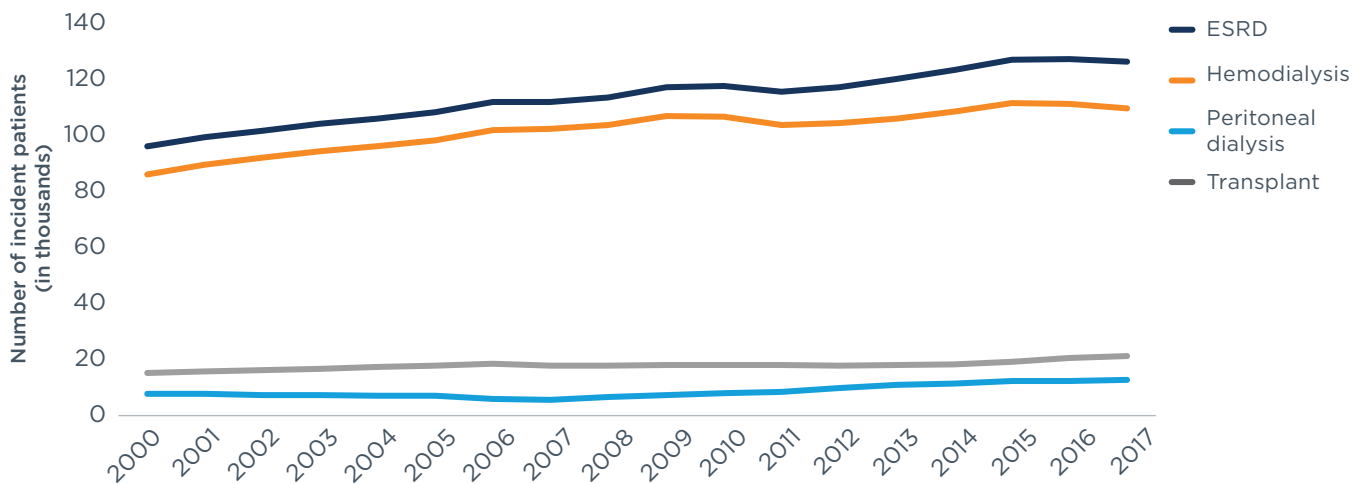
Source: USRDS 2019 Annual Data Report

IV. Dialysis & Other ESRD Treatments

When the kidneys fail, patients 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.²⁰ Dialysis can be performed in a hospital, at a dialysis center that is separate from a hospital, or at home.

FIGURE 5

Incident ESRD Cases in U.S. by Treatment Modality, 2000-2017



Source: USRDS 2019 Annual Data Report

Dialysis

There are two main types of dialysis – hemodialysis and peritoneal dialysis. In 2017, 63% of all ESRD patients were receiving hemodialysis therapy, 7% were being treated with peritoneal dialysis, and 30% had a functioning kidney transplant.²¹ New ESRD patients are even more likely to receive hemodialysis – 87% of all new ESRD cases began dialysis treatment with hemodialysis, 10% started with peritoneal dialysis, and 3% received a pre-emptive kidney transplant.²²

Hemodialysis is the most common form of dialysis. Treatments are usually provided three times per week, with the average treatment time lasting three to four hours.²³ First, a physician creates an access site to large blood vessels, often in the arm or groin. These vascular access sites must be maintained and can be uncomfortable for patients. Tubes are inserted via the access site and blood is transferred to an external machine that cleans the blood and returns it to the body. Hemodialysis can be done in a hospital, dialysis facility, or at home – the most common setting is one of the over 7,000 dialysis facilities nationwide.²⁴

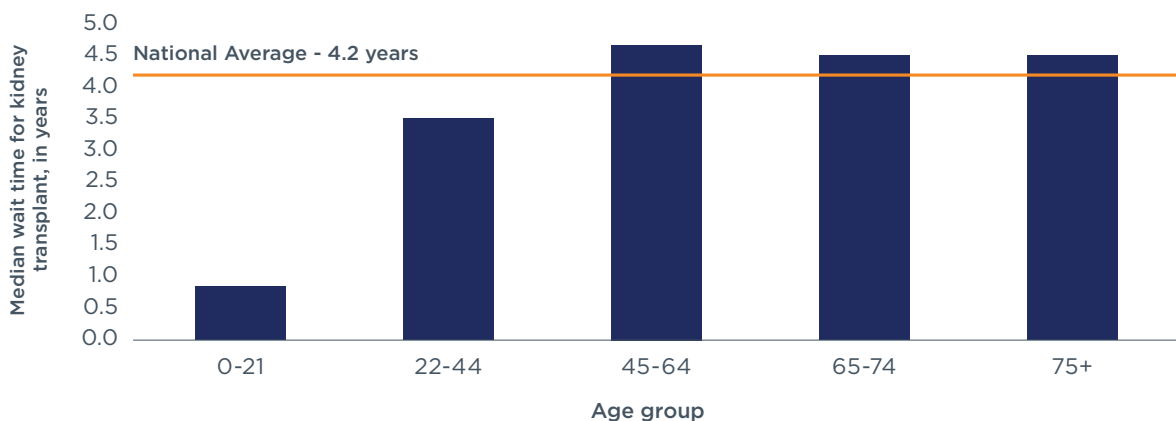
Peritoneal dialysis is a less common type of dialysis that allows blood to be cleaned in the body by surgically implanting a permanent catheter into the abdomen. A sterile dialysis solution is then introduced into the peritoneal or abdominal cavity, and the solution is left in place for several hours while the patient undertakes normal activities. There are two main types of peritoneal dialysis, Continuous Ambulatory Peritoneal Dialysis and Continuous Cycler-assisted Peritoneal Dialysis (CCPD). CAPD is done during the day, with the dialyzing solution manually introduced and removed several times. CCPD uses a cycler machine to introduce and remove the dialyzing solution, and is often done while the patient is sleeping.²⁵

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.²⁶ In November 2019, there were nearly 100,000 people waiting for a kidney transplant.²⁷ The median wait time for a kidney transplant is 4.2 years, and 72% of kidneys come from deceased donors.²⁸ In 2017, nearly 3,000 people died waiting for a transplant, and another 3,600 experienced a decline in their health status that made them too sick to receive a transplant.²⁹

FIGURE 6

Median Wait Time for Kidney Transplant by Age



Source: USRDS 2019 Annual Data Report

Medication

The kidneys are responsible for producing erythropoietin, a hormone that stimulates the bone marrow to produce red blood cells. When kidneys fail, most patients develop anemia due to a low red blood cell count. Injections of an Erythropoietin-Stimulating Agent (ESA) are often necessary to maintain normal red blood cell counts. Oral or intravenous iron may also 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. 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.

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.³⁰ Nephrologists also recommend that this increased attention to patient education include palliative care options.³¹

V. Medicare Coverage of ESRD

The federal government included ESRD as a chronic disability in 1972, extending Medicare benefits to any person with the condition regardless of age. Over the years, coverage and payment for ESRD and dialysis has been modified to address different initiatives and priorities. Most recently, in July 2019 the Trump Administration announced an initiative to reduce the incidence of ESRD as well as make more kidneys available for transplant.³²

Legislative Timeline of ESRD in Medicare

- **The Social Security Amendments of 1972** extended Medicare coverage to individuals under the age of 65 with ESRD starting in 1973. These individuals would need to wait three months after starting dialysis to apply for Medicare coverage. 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 the 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 post-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. Congress also created the Medicare Secondary Payer (MSP) period, requiring employer-based health insurance to continue coverage for individuals with ESRD for 18 months after the start of dialysis care.

- **The Balanced Budget Act (BBA) of 1997** extended the MSP period to 30 months. Medicare reimbursement for dialysis was not adjusted by this legislation.
- **The Medicare Modernization Act (MMA) of 2003** increased the composite rate by 1.5% in 2005. The bill 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 the composite rate, 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 (ATRA) of 2012** required Medicare to recalculate dialysis bundled payment rates for 2014 to account for changes in drug use.
- **The 21st Century Cures Act (CURES) of 2016** removed enrollment restrictions related to individuals with ESRD and Medicare Advantage, required organ acquisition costs for kidney transplants to be excluded from Medicare Advantage benchmarks, and instructed Medicare to evaluate potential modifications to the ESRD risk adjustment model and Medicare Advantage Star Rating system.

ESRD Medicare Eligibility

For individuals diagnosed with ESRD who are not otherwise eligible for Medicare, there is a three-month waiting period before the individual can apply for Medicare.³³ Once enrolled, 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 health insurance, the individual can retain their coverage for 30 months after starting dialysis. During this time, there is a coordination-of-benefits period during which the private insurance is the primary payer and Medicare is the secondary payer.³⁴

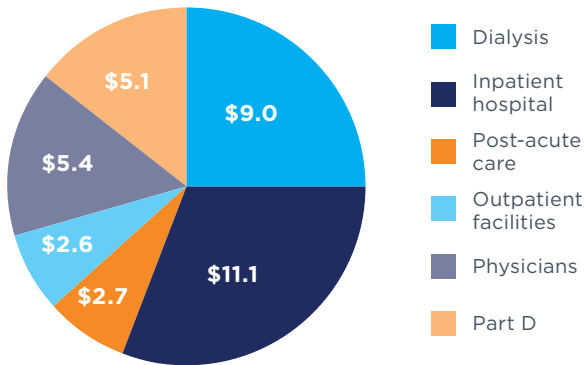
Kidney transplant recipients who are under 65 usually lose their Medicare coverage 36 months after a successful transplant.³⁵ Immunosuppression drug coverage gaps often exist for patients after they lose Medicare coverage, creating an incentive for kidney transplant recipients under the age of 65 to maintain a disability status to pay for critical medications.³⁶ When patients receive a healthy kidney, they still have complex health needs and likely require other medicines in addition to anti-rejection medications.³⁷

High-Cost of ESRD Care

Individuals with ESRD require complex, high-cost care. In 2017, patients with ESRD comprised less than 1% of the total Medicare population but accounted for nearly 4% of total Medicare spending, totaling nearly \$36 billion.³⁸ Inpatient hospital stays accounted for \$11 billion (31%) of total Medicare spending, followed by dialysis costs of \$9 billion (25%).³⁹ According to CMS data, care for an average Medicare enrollee with ESRD is more than eight times costlier than care for an average non-ESRD Medicare beneficiary.⁴⁰

FIGURE 7

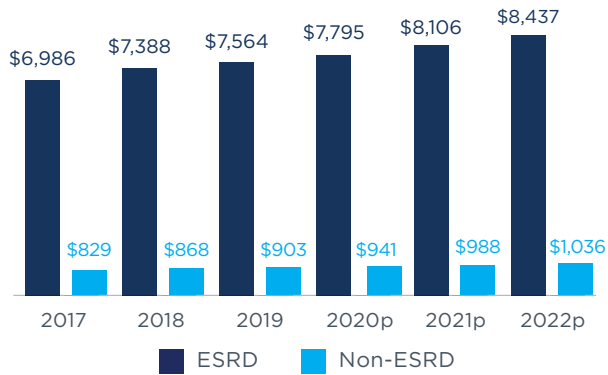
Medicare Spending on ESRD, 2017
(\$ in billions)



Source: USRDS 2019 Annual Data Report

FIGURE 8

ESRD vs Non-ESRD Average Per Member Per Month Medicare Costs, 2016-2022



Source: CMS, 2020 Medicare Advantage Final Rate Announcement, April 1, 2019

Traditional FFS Medicare ESRD Payment

Policymakers have made multiple changes to the Medicare reimbursement method for dialysis since coverage began in the 1970s. Like nearly all Medicare payment systems, dialysis reimbursement started as cost-based, then transitioned to a prospective composite payment in the early 1980s. Starting in 2011, Medicare payment shifted to a bundled prospective payment system (PPS) for dialysis that covered all care provided during one treatment session, including drugs that had previously been billed separately.⁴¹ The bundled PPS is updated each year for inflation and recalculated to account for changes in use of drugs and biologicals.⁴²

Under the bundled PPS, dialysis providers receive a single payment per treatment that is adjusted for the geographic location of the provider via a wage index, certain patient-level co-morbid conditions via a case mix adjustor, and unusually high-cost treatment needs via an outlier payment. The bundled PPS also includes a pay-for-performance program that penalizes providers for not meeting specific quality measures. In 2020, the ESRD Prospective Payment System Medicare base rate will be roughly \$239.⁴³

Physicians receive separate Medicare payment for caring for patients with ESRD. For patients on dialysis, the nephrologist receives a Monthly Capitation Payment (MCP) that varies based on the number of times the nephrologist saw the patient during the month. The MCP covers all of the routine care a dialysis patient requires and is set and updated each year by CMS via the Medicare Physician Fee Schedule annual rules.⁴⁴ In 2020, the MCP will range from \$200 for 1 patient visit per month to nearly \$1,000 for 4 or more visits per month, depending on the age of the patient.⁴⁵

ESRD Beneficiary Cost Sharing in Traditional FFS Medicare

Medicare Part A covers inpatient hospital and post-acute care costs, while Medicare Part B covers physician services and outpatient facilities including dialysis providers. In 2020, ESRD beneficiaries will

be responsible for a \$1,408 inpatient hospital deductible for any inpatient stays, along with 20% of all Part B costs after a \$198 deductible. Beneficiaries must also pay the \$144.60 monthly Part B premium.⁴⁶ There are no annual limits on out-of-pocket costs in Traditional FFS Medicare, which is a consumer protection for Medicare Advantage enrollees.⁴⁷

Nearly 50% of ESRD beneficiaries are dually eligible for Medicare and Medicaid compared to 11% of all Medicare enrollees, and thus receive help with their cost sharing.⁴⁸ Most other ESRD patients in Traditional FFS Medicare rely on Medigap policies to help them with out-of-pocket costs. However, only 32 states require plans to offer at least one kind of Medigap policy for Medicare beneficiaries under the age of 65, although not all of these states have a Medigap option for individuals with ESRD.⁴⁹ An estimated 22% of all ESRD enrollees had no supplemental coverage and were therefore fully responsible for their out-of-pocket costs.⁵⁰

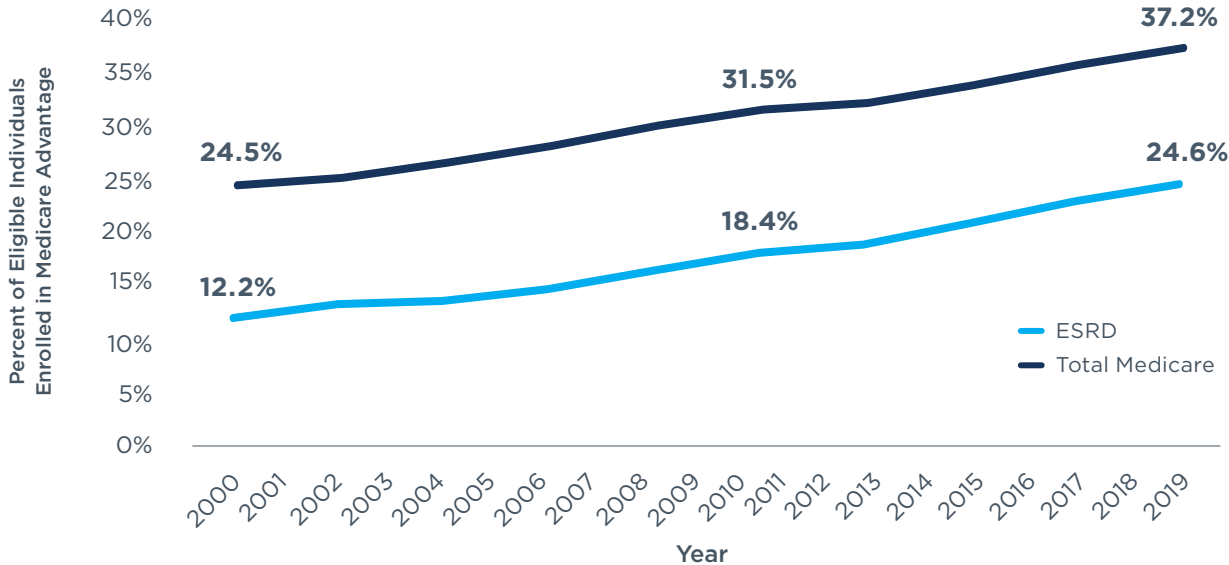
Individuals with ESRD in Traditional FFS Medicare face out-of-pocket costs. A 2014 Kaiser Family Foundation report looked at total costs paid by Medicare enrollees in 2010 and found an average ESRD beneficiary spent \$6,918, much higher than the \$4,734 for the average Traditional FFS Medicare enrollee.⁵¹

VI. ESRD Beneficiaries in Medicare Advantage

As of 2019, over 23 million Medicare-eligible beneficiaries have chosen Medicare Advantage over Traditional Medicare and there is increasing provider interest in the more integrated model of care Medicare Advantage provides. However, in 2019 an estimated 25% of ESRD beneficiaries were enrolled in Medicare Advantage plans versus 37% of all Medicare beneficiaries.⁵²

FIGURE 9

Medicare Advantage Enrollment, 2010-2019



Source: CMS, 2020 Medicare Advantage Final Rate Announcement, April 1, 2019.

ESRD Medicare Advantage Eligibility Guidelines

Historically, ESRD patients were limited when choosing a Medicare Advantage plan to the following situations:

- An individual who developed ESRD while already enrolled in Medicare Advantage could stay on that plan or join another plan offered by the same company;
- An individual receiving non-Medicare health benefits (e.g., employer-based health insurance) could enroll with the same health insurance plan if it offers a Medicare Advantage plan;
- An individual with ESRD and a successful kidney transplant, who still qualifies for Medicare benefits (based on age or a disability), could join a Medicare Advantage plan;
- If a Special Needs Plan (SNP) for people with ESRD was offered in the area;
- An individual with ESRD enrolled in a Medicare Advantage plan that no longer provides coverage in the area had a one-time opportunity to join a new plan immediately;
- An individual with a Medicare Advantage plan offered through an employer or union group.⁵³

In 2016, Congress passed the 21st Century Cures Act, which amongst other things removed the limitation on ESRD enrollment in Medicare Advantage plans. Starting in 2021, all Medicare-eligible individuals with ESRD will be allowed to enroll in any Medicare Advantage plan.⁵⁴

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. 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 covering approximately 5,500 individuals.⁵⁵ Historically the lack of a permanent authorization for the SNP program was seen as a barrier to growth of ESRD SNPs. The CHRONIC Care Act of 2018, which was included in the Bipartisan Budget Act of 2018 and signed into law on February 9 2018, provided permanent authorization of the SNP program.⁵⁶

Potential Benefits for ESRD Patients in Medicare Advantage

To achieve better health outcomes, Medicare Advantage is developing and incenting 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, focus on primary care and care management, use of telemedicine, use of care coordinators, and placing greater emphasis on home as an effective site of care. However, these benefits will only be possible if payment to Medicare Advantage is adequate to care for complex patients. In particular, Medicare Advantage plans must cap enrollees' out-of-pocket costs at \$6,700 in 2020 for in-network care, a significant difference from the un-capped maximum that individuals in Traditional FFS Medicare face.

VII. Dialysis Payment in Medicare Advantage

Unlike Traditional FFS Medicare which has payment rates set and updated by the government, each Medicare Advantage plan contracts 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.⁵⁷ One recent study showed that some 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.⁵⁸ 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.⁵⁹

Dialysis Provider Concentration

One 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 nearly 7,000 dialysis facilities nationwide, and nearly 95% are freestanding (not hospital-based).⁶⁰ As of 2017, 73% of all dialysis facilities were owned by one of two companies.⁶¹

Policymakers and researchers have long predicted and investigated the impact of dialysis provider concentration on access, quality, and cost.^{62,63} In some cases consolidation of the dialysis provider market has demonstrated clinical advantages, especially related to improved compliance, efficiencies, and broad scale quality improvements.⁶⁴

However, analyses have also outlined concerns that such a high level of market concentration inhibits price competition.⁶⁵ 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 even if more ESRD patients are included in Medicare Advantage.

VIII. ESRD Payment Methodology in Medicare Advantage

Payment to Medicare Advantage plans is based on a capitated (fixed) amount the government pays for each beneficiary. 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 a benchmark using Traditional FFS Medicare spending at the county level (adjusted for multiple factors). Plans bid against this benchmark, and receive a rebate representing a portion of the difference between the bid and the benchmark. This rebate, which can vary based on the quality Star rating of the plan, must be used to offer enhanced benefits for enrollees in the health plan. The final rate is adjusted for the risk of each beneficiary.

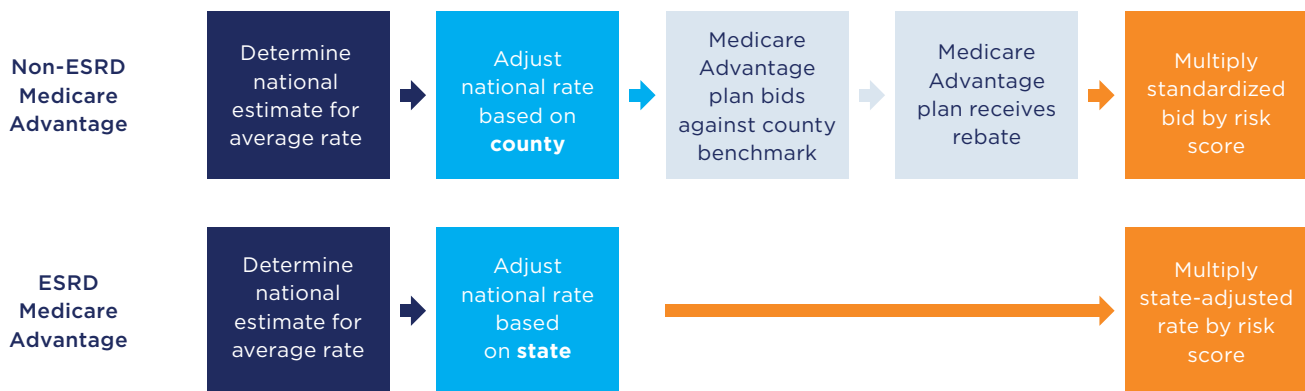
State-Based ESRD Benchmarks

Since the cost of care for ESRD patients is significantly higher than the average Medicare beneficiary, CMS calculates the Medicare Advantage ESRD capitated rates and publishes a separate ESRD rate book each year. However, due to the low number of ESRD beneficiaries, there is not enough data to calculate these benchmarks at the county level. ESRD benchmark rates are instead calculated at the state level and there is no bidding – plans are paid based the state-level benchmark, adjusted for the risk of each ESRD enrollee.

Notably, the ESRD payment is not modified based on the quality Star rating of the health plan. And in lieu of bidding on ESRD, plans must include the expected gains and losses as part of their rebate. In other words, if a plan anticipates that it will lose money on ESRD beneficiaries, it must use a portion of its rebate to offset these losses. Curiously, prior to 2008 CMS repeatedly indicated it was working towards including ESRD costs into Medicare Advantage plans bids, but since 2008 there have been no mentions by CMS of potential modifications to this process.⁶⁶

FIGURE 10

Medicare Advantage Payment Calculation, ESRD vs Non-ESRD



Source: Centers for Medicare & Medicaid Services

IX. Medicare Advantage ESRD Payment Accuracy

Accurately estimating the cost of care for each beneficiary, especially patients with high recurring costs, 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 next payment year, which are calculated using FFS Medicare data. The proposed growth updates are released in early February, and the finalized rates are released 60 days later in early April.

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 costs for ESRD enrollees in Medicare Advantage range from approximately 96% of payment to as high as costs 137% of payment, depending on the geographic area, with an average cost of 104% of payment.⁶⁷ This data suggests that some ESRD beneficiaries are receiving care from a health plan that could be receiving payment nearly \$30,000 below what the actual costs of treatment. In addition to the issues with dialysis provider concentration noted earlier, one of the other likely causes for the inadequate ESRD benchmarks relates to calculations used by Medicare. Current statute requires Medicare Advantage benchmarks to reflect costs paid by the government for Medicare services.⁶⁸ In all cases, this calculation excludes the standard 20% Part B co-insurance that beneficiaries are responsible for paying. In the case of Traditional FFS Medicare, the 20% Part B co-insurance for ESRD beneficiaries can exceed \$10,000 per year due to dialysis and physician utilization.⁶⁹ These amounts are excluded from the ESRD Medicare Advantage benchmarks. Due to the out-of-pocket cap required for all Medicare Advantage plans, beneficiary costs are significantly lower than the assumed amounts in Traditional FFS Medicare, resulting in a discrepancy between the costs paid by the government and the costs paid by the Medicare Advantage health plan.

Volatility in Medicare Advantage ESRD Growth Rate Updates

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 2016 to 2020, the ESRD growth rates updates varied by 1.1 percentage points from proposed to final, compared to 0.7 percentage points in non-ESRD Medicare Advantage. In some years, the updates in the proposed and final rules were directionally different, something that has not happened in non-ESRD Medicare Advantage. It is unclear why there is no directional correlation between the updates in ESRD and non-ESRD. Unstable payment estimates for ESRD reinforces the difficulty estimating costs for these beneficiaries.

FIGURE 11

**Medicare Advantage
ESRD Growth Percentage**

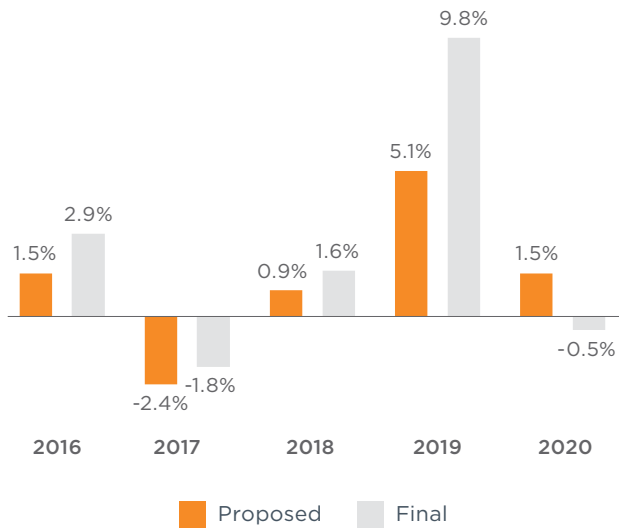
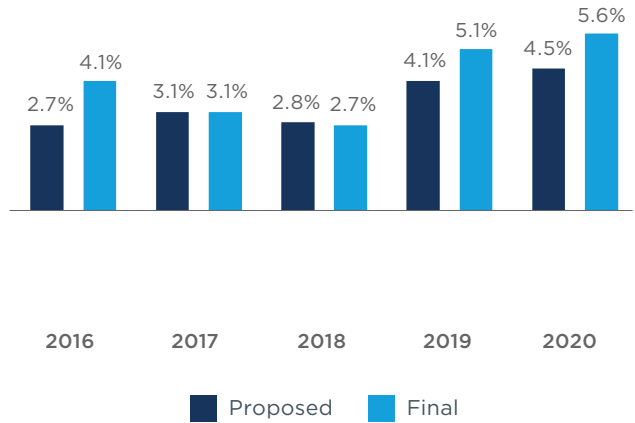


FIGURE 12

**Medicare Advantage
non-ESRD Growth Percentage**



Source: CMS, 2016-2020 Medicare Advantage Final Rate Announcements.

X. 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. 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.⁷⁰ Hispanics and Native Americans are nearly two times as likely as Caucasians to develop kidney failure.⁷¹ The exact cause of this increased risk is unknown, though current research aims to better understand the causality. 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.⁷²

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.⁷³ One study found that in impoverished neighborhoods, African Americans were 57% less likely to get on a transplant list than their Caucasian counterparts.⁷⁴ Another study found African Americans and Hispanics are less likely to receive home dialysis.⁷⁵

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 home peritoneal dialysis patients perform frequent, shorter sessions or nocturnal dialysis. The Trump Administration's 'Advancing American Kidney Health' Initiative seeks by 2025 to have 80% of new ESRD patients either receiving dialysis at home or receiving a transplant.

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."⁷⁷ 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.⁷⁸ Proponents of home dialysis point to 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 due to the fixed costs associated with operating a facility. ESRD patients may also lack family support or have other social risk factors that limit their choices.

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, access to treatment locations can cause issues. The majority of dialysis patients receive their care at dialysis centers, and often rely on caregivers and family members to drive them to and from treatment three times each week. In addition, many dialysis patients must travel long distances to receive their treatment at a dialysis facility.⁷⁹ As a result, transportation and access issues can be a large barrier for consistency of treatment.⁸⁰ Even one missed treatment puts a patient at an increased risk of adverse events, including emergency room visits or even death.⁸¹ Increasing access to home dialysis as well as the flexibility of using Medicare Advantage supplemental benefits for transportation costs could help address these barriers.

XI. ESRD Continues to Be a Priority for Policymakers

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. The last several years has seen a flurry of legislative activity, expanding Medicare Advantage enrollment options to all ESRD beneficiaries,

providing permanent authorization of the Medicare Advantage SNP program, allowing dialysis providers to utilize telemedicine to increase home dialysis adoption, and encouraging Medicare to including the diagnosis of CKD in its risk adjustment model.

In addition to these legislative accomplishments, there has been significant activity within the Administrative branch as well. The Center for Medicare and Medicaid Innovation (CMMI) launched the Comprehensive ESRD Care (CEC) model in September 2015, for five years. Under this model, dialysis clinics, nephrologists, and other providers join to create an ESRD Seamless Care Organization (ESCO) to coordinate care for aligned beneficiaries with ESRD. There are currently 33 ESCOs participating in the CEC.⁸²

In July 2019, CMMI also announced its intention to create the ESRD Treatment Choices (ETC) model. The ETC would adjust payment for selected ESRD facilities and managing clinicians, incenting these providers to encourage home dialysis or transplants for their aligned patients with ESRD.⁸³

The Office of the Chief Technology Officer (CTO) of the U.S. Department of Health and Human Services (HHS) launched the Kidney Innovation Accelerator, called KidneyX. This initiative provides funding for companies developing innovative drugs, devices, biologics and other therapies for kidney care.⁸⁴

XII. 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.

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**

- Given the impending expansion in 2021 for ESRD patients in Medicare Advantage, CMS must update the payment system to ensure adequate payments, including ESRD benchmark rates and the ESRD-specific risk adjustment model. CMS should also modify the Medicare Advantage bidding process to include ESRD costs.

- **CMS must evaluate the Star Ratings Quality System as it relates to ESRD beneficiaries**

- Per the 21st Century Cures Act requirement, 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.

- **Encourage kidney donation and replacement**

- CMS and other policymakers and stakeholders should continue to find ways 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.

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