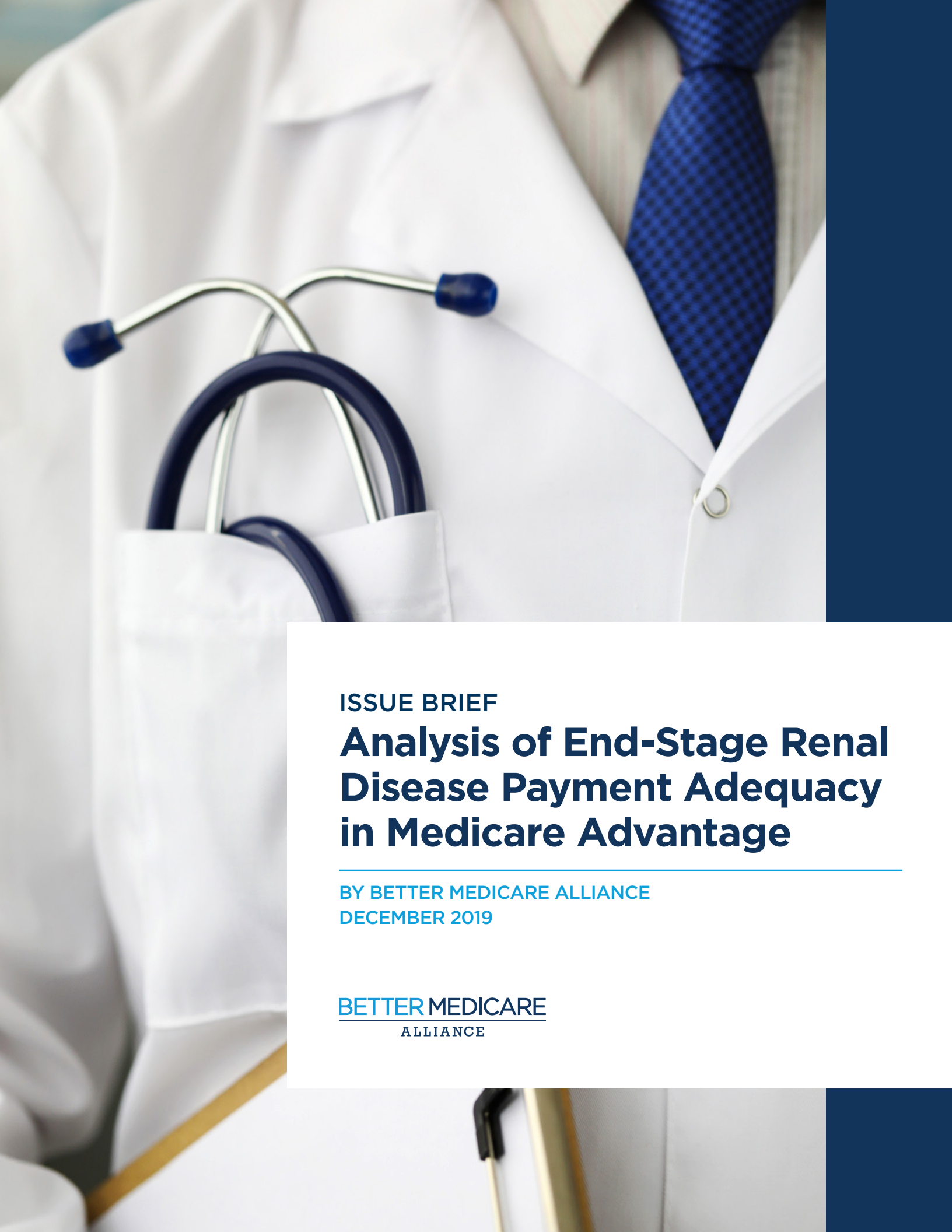

ISSUE BRIEF

Analysis of End-Stage Renal Disease Payment Adequacy in Medicare Advantage

BY BETTER MEDICARE ALLIANCE

DECEMBER 2019

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Better Medicare Alliance commissioned an analysis to assess whether the current End-Stage Renal Disease payment rate for care under Medicare Advantage would be adequate to cover the care of these complex patients, as they will be able to choose Medicare Advantage coverage as of 2021. The analysis was conducted by Avalere Health in October 2019.

I. KEY FACTS

- Most Medicare beneficiaries with End-Stage Renal Disease (ESRD) currently are required to receive coverage through Traditional Fee-for-Service (FFS) Medicare. Medicare spends considerably more on beneficiaries with ESRD compared to other Medicare enrollees.
- Starting in 2021, all Medicare beneficiaries with ESRD will be allowed to enroll in Medicare Advantage.
- A recent analysis finds payment to Medicare Advantage plans for ESRD patients may not be adequate, especially in populous urban areas where many beneficiaries with ESRD reside.
- Policymakers should address payment challenges in the upcoming 2021 Medicare Advantage Rate Notice to ensure ESRD patients receive the highest quality of care in Medicare Advantage.

II. BACKGROUND

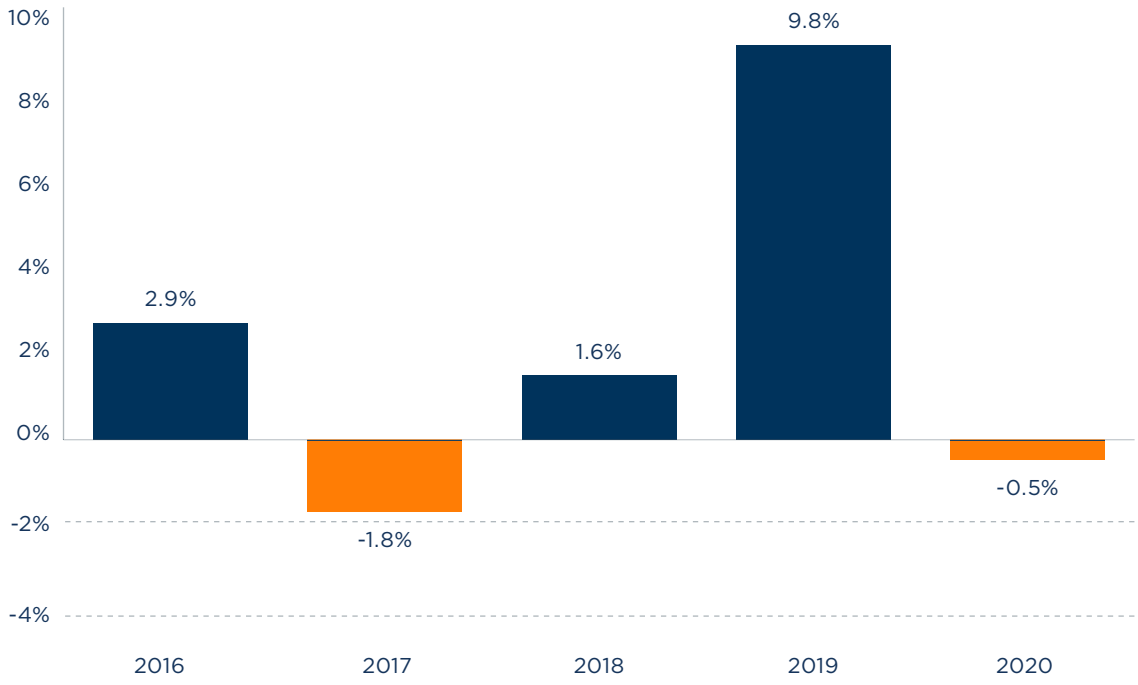
In addition to individuals age 65 and older and people with disabilities, Medicare covers people with ESRD, also known as kidney failure. ESRD occurs when an individual's kidneys permanently and completely stop functioning. Unless they can receive a kidney transplant, people with ESRD undergo dialysis, a process to clean waste, toxins, and other buildup from the blood, typically needed several times a week and is most often done in a facility that specializes in renal dialysis. Overall, more than 500,000 Medicare beneficiaries have ESRD.[1]

Providing care to ESRD beneficiaries, particularly dialysis treatment, is very expensive. In 2016, less than 1% of Medicare beneficiaries had ESRD,[2] but services for these patients accounted for 7.2% of Medicare costs, or $35.9 billion a year.[3] Patients with ESRD often have other health conditions and present complex clinical and social needs. According to the most recent figures, Medicare spends $67,116 annually per ESRD beneficiary.[4] This is four times more than what the spend is on average per disabled beneficiary ($15,437) and six times more than what it spends on average per aged beneficiary ($10,182).[5]

Currently, most beneficiaries with ESRD receive coverage through Traditional FFS Medicare. However, beneficiaries with ESRD can enroll in Medicare Advantage under limited circumstances—namely, through certain Medicare Advantage Special Needs Plans (SNPs) or a plan offered by the same carrier as one's current commercial plan. Additionally, beneficiaries who develop ESRD while enrolled in a Medicare Advantage plan can retain

FIGURE 1

MA ESRD Payment Rate Growth Percentage (Based on FFS Spending)



their coverage in Medicare Advantage. Medicare Advantage plans receive payment for ESRD patients based on a different methodology than non-ESRD enrollees. Specifically, payments to Medicare Advantage for ESRD patients are set at the state level rather than the county level. As a result, ESRD payments do not consider cost variation within a state (i.e., at the local, county, or regional level). Further, ESRD risk adjustment for Medicare Advantage plans is based on a separate model from the one used for other Medicare Advantage enrollees.

As a result of *21st Century Cures Act of 2016*, starting in 2021, all ESRD beneficiaries will have the option to enroll in Medicare Advantage, after they have been diagnosed. Medicare Advantage is well-positioned to provide ESRD beneficiaries with better coverage compared to Traditional FFS Medicare due to its maximum out-of-pocket limit for consumers, supplemental benefits, and ability to coordinate care. However, the costs associated with ESRD have raised serious concerns about what it could mean if payment for these patients is inadequate. Moreover, as Figure 1 illustrates, the Medicare Advantage ESRD payment rate varies significantly from year to year, creating uncertainty over time.

III. ANALYSIS

Avalere Health conducted an analysis to assess whether payment to Medicare Advantage would be adequate based on existing payment rules. Avalere used 2018 FFS claims data to determine the average spending of ESRD patients by metropolitan statistical area (MSA). The analysis then compared these actual costs to the 2018 state-level ESRD benchmarks Medicare Advantage would be paid if these patients were enrolled in Medicare Advantage instead of FFS. The findings show that FFS costs exceed the Medicare Advantage ESRD benchmark and payment is lower for Medicare Advantage beneficiaries in certain geographic areas across the country. Most typically this underpayment occurs in high-density metropolitan areas, likely resulting in payment not being adequate for patients in those specific geographic areas.

Full Analysis from Avalere Health: https://avalere.com/insights/medicare-advantage-plans-may-be-paid-below-actual-esrd-patients-costs-in-large-metropolitan-areas-in-2021.

IV. RESULTS

Of the top 15 MSAs with the most ESRD patients enrolled in FFS, 10 had ESRD FFS costs that exceeded the Medicare Advantage payment rate. In these MSAs, Medicare Advantage payment fell below FFS costs by between 2% and 12%. Five MSAs had a Medicare Advantage benchmark that exceeded FFS costs by 1-9%. Notably, as shown in Figure 2 below, many of these locations are among the most populous in the country and have high overall Medicare Advantage penetration rates. The MSAs with the most ESRD beneficiaries enrolled in FFS—New York, Los Angeles, and Chicago—all had FFS costs that exceeded the Medicare Advantage ESRD benchmark. This was also true in other large, urban MSAs, including Philadelphia, Houston, and Miami. Of the beneficiaries living in MSAs included in this analysis, 45.6% live in MSAs where FFS costs exceed the benchmark payment amount.

FIGURE 2

Top 15 Metropolitan Statistical Areas with Underpayment or Overpayment (FFS Costs Exceeding the Medicare Advantage ESRD Benchmark)

MSA	Number of ESRD Beneficiaries	Payment Relative to Benchmark	Annual Payment Difference Per Beneficiary
New York, NY	24,034	88%	($10,836)
Los Angeles, CA	14,116	98%	($1,980)
Chicago, IL	12,388	96%	($3,624)
Dallas, TX	9,309	105%	$3,972
Atlanta, GA	8,339	101%	$864
Philadelphia, PA	8,167	97%	($2,808)
Houston, TX	7,921	91%	($7,608)
Washington, D.C.	7,449	104%	$3,324
Miami, FL	6,662	94%	($5,328)
Detroit, MI	5,922	92%	($6,528)
Baltimore, MD	4,342	96%	($3,396)
St. Louis, MO	4,225	101%	$1,044
San Francisco, CA	3,937	90%	($9,216)
Boston, MA	3,866	91%	($8,916)
Riverside, CA	3,835	109%	$8,460
The average payment relative to benchmark across the 75 MSAs included in this analysis (225,321 enrollees) was 106%.			

V. POLICY DISCUSSION

ESRD patients have complex and costly needs and Medicare Advantage is well-suited to provide high-value care to this population, because of the coverage and care it offers to chronically ill beneficiaries. Medicare Advantage supports severely ill patients through effective care management, care coordination, and targeted benefit offerings.[6] However, as these findings suggest, Medicare Advantage plans in areas with the most ESRD patients would likely be underpaid in the current payment system. Without adequate payment, Medicare Advantage plans may be forced to raise consumer costs, reduce supplemental benefits, or limit service areas—not just for ESRD patients, but for all enrollees.

VI. RECOMMENDATIONS

In advance of 2021 and the increased enrollment of ESRD beneficiaries into Medicare Advantage, we encourage policymakers to act on the following recommendations to ensure the adequate payment and care for ESRD patients:

- Ensure the Medicare Advantage payment rates cover the actual costs of ESRD patients, with particular attention to underpaid states.
- Update the ESRD payment methodology to provide consistency and predictability and avoid year-to-year fluctuation of the Medicare Advantage ESRD payment rates.
- Consider a transition period given the potential number of new ESRD patients enrolling in Medicare Advantage.
- Expand and incentivize access to innovative forms of care for ESRD patients, including home dialysis.
- Consider changes to Medicare Advantage network adequacy requirements for dialysis providers.
- Encourage access to programs and services to prevent kidney disease and slow disease progression.

Sources

[1] https://www.usrds.org/2019/view/USRDS_2019_ES_final.pdf.

[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2017/Downloads/MDCR_ENROLL_AB/2017_CPS_MDCR_ENROLL_AB_6.pdf. (aged with ESRD + disabled with ESRD & ESRD only / total enrollees)

[3] https://www.usrds.org/2019/view/USRDS_2019_ES_final.pdf - page 53.

[4] http://www.medpac.gov/docs/default-source/data-book/jun19_databook_entirereport_sec.pdf -- page 21.

[5] Ibid.

[6] https://www.bettermedicarealliance.org/sites/default/files/2018-07/BMA_Avalere_MA_vs_FFS_Medicare_Report_0.pdf.