

Understanding Risk Adjustment in Medicare Advantage

ISSUE BRIEF JUNE 2017

Risk adjustment is an essential mechanism used in health insurance programs to account for the overall health and expected medical costs of each individual enrolled in a health plan. Accurate documentation of diagnoses by clinicians is a critical component of the risk adjustment process.

The Medicare Advantage program relies on risk adjustment to maintain predictable and actuarially sound payments to Medicare Advantage to provide benefits to all enrollees.

A stable risk adjustment system is essential to ensure sustainability in benefits provided to enrollees and to the continued innovation in the delivery of high quality, coordinated, and affordable care to all Medicare Advantage beneficiaries.

Overview of Medicare Advantage

Medicare Advantage, also known as Medicare Part C, is the part of Medicare through which health plans provide health care coverage to people over 65 and individuals with disabilities. These plans are approved and regulated by the Centers for Medicare & Medicaid Services (CMS) and the program undergoes an annual review process that makes policy changes and sets payment rates for the next year.

Medicare Advantage is required to cover all Medicare Part A (hospital) and Medicare Part B (provider) benefits that are covered by Traditional Fee-For-Service (FFS) Medicare. Almost all Medicare Advantage plans also include additional benefits, such as vision, hearing, dental, fitness, and wellness. Unlike FFS Medicare, Medicare Advantage also has an out-of-pocket maximum to protect beneficiaries.

Key Medicare Advantage Facts

- **One third of Medicare beneficiaries — over 18.5 million individuals** have chosen to receive their Medicare coverage through Medicare Advantage.¹
- **Over 36% of MA beneficiaries** have annual incomes of less than \$20,000.²
- **Nearly one third of African American Medicare beneficiaries and 44% of Hispanic Medicare beneficiaries** are enrolled in Medicare Advantage.³
- **Roughly 1 in 4 individuals dually eligible for Medicare and Medicaid** are enrolled in Medicare Advantage.⁴
- **Medicare Advantage beneficiaries are satisfied** — 91% of beneficiaries report they are satisfied with their coverage.⁵
- **99% of Medicare-eligible individuals** have access to a Medicare Advantage plan in their area.⁶
- **Medicare Advantage enrollment is projected to reach 31 million beneficiaries** and 41% of Medicare by 2027.⁷

FIGURE 1

Medicare Population 57 Million⁸

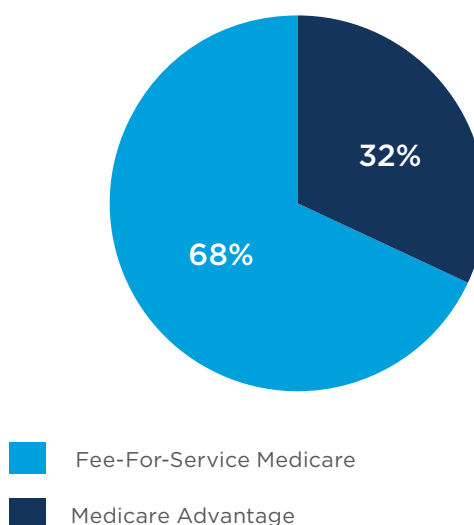
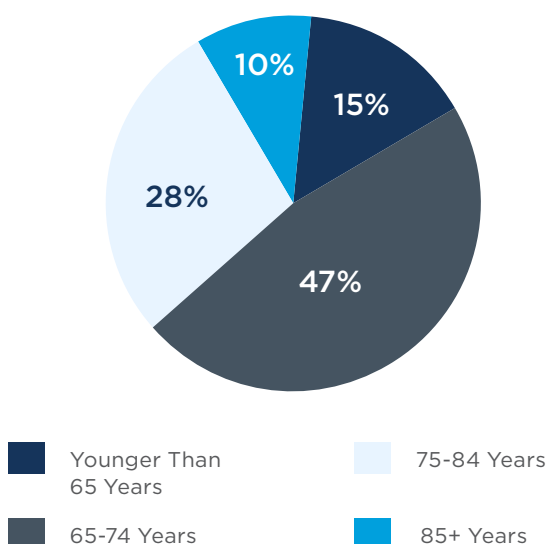


FIGURE 2

Age Demographics⁹



Key Differences Between Medicare Advantage and Fee-For-Service Medicare

It is important to understand the significant differences between Medicare Advantage and Traditional Fee-For-Service (FFS) Medicare.

1. Medicare Advantage is paid a capitated amount per beneficiary

The Federal government pays Medicare Advantage plans a fixed (or capitated) monthly amount per beneficiary to provide health benefits to that individual. Medicare Advantage then contracts with and pays clinicians, hospitals, and other providers to care for beneficiaries. In FFS Medicare, the Federal government reimburses hospitals and other providers directly on a “fee-for-services” basis — in other words — for each discrete service provided to a FFS Medicare beneficiary.

2. Medicare Advantage focuses on preventive care and early intervention

Because Medicare Advantage plans are paid a capitated amount, they are incentivized to provide high-value care to keep beneficiaries healthy and minimize disease progression. Medicare Advantage places an emphasis on identifying and treating early stage chronic disease. Since FFS Medicare is paid by volume (per service), this incentive does not exist.

3. Medicare Advantage incentivizes innovation and care coordination

Medicare Advantage deploys innovative models for delivering and coordinating health care, such as home care by nurse practitioners, dynamic disease management strategies, and specialized care for individuals living with multiple conditions. Such robust activities are absent in FFS Medicare.

4. MA uses risk adjustment to account for beneficiary differences

To ensure capitated payments reflect the expected cost of providing medical care to each beneficiary, Medicare Advantage payments are risk adjusted to reflect the specific characteristics of each enrolled beneficiary - including demographics, Medicaid eligibility, and health status. In Medicare Advantage, it is important that clinicians document clinical diagnoses accurately to ensure that beneficiaries receive the appropriate care management and related services they need based on their condition. In FFS Medicare, payment is not risk adjusted, and thus coding patterns are different.

Focus on Chronic Disease

As millions of Baby Boomers enter Medicare, attention is turning to how to effectively address the high incidence of chronic illness among Medicare beneficiaries. According to the most recent CMS data, over two thirds of Medicare beneficiaries, or 21.4 million beneficiaries are living with two or more chronic conditions.⁸ Active and effective management of these conditions is essential to ensuring that Medicare beneficiaries receive the best possible care and that the Medicare program is sustainable.

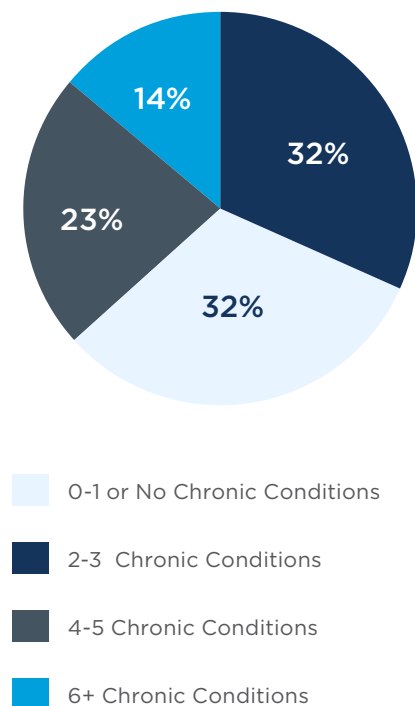
Risk adjustment is critical to ensuring that Medicare Advantage has adequate resources to provide needed, quality care to their beneficiaries.

Medicare Advantage is uniquely positioned to address chronic disease —unlike FFS Medicare, the payment model in Medicare Advantage encourages providers to identify, manage, and treat chronic illness in innovative ways that are cost-effective and produce high-quality outcomes.

- Medicare Advantage plans are actively engaged in identifying and documenting beneficiary health conditions in order to initiate early intervention and slow disease progression.
- Medicare Advantage plans emphasize preventive services and primary care. Primary care teams coordinate care for beneficiaries and work to ensure proper screening and disease management, particularly for those with chronic conditions.
- Medicare Advantage plans offer services specifically designed to help beneficiaries with chronic conditions stay as healthy and active as possible. Through robust health information technology platforms and programs that coordinate care for beneficiaries who see multiple health care providers, MA works to ensure that chronically ill beneficiaries receive the most clinically appropriate care.
- To ensure effective identification and treatment of beneficiaries with chronic illness, Medicare Advantage payments must accurately reflect the health status of Medicare Advantage enrollees.

FIGURE 3

Medicare Populations With Chronic Conditions¹¹



STEP 1

CMS determines the county benchmark payment rate.

STEP 2

CMS determines risk scores to predict cost of care for beneficiary.

STEP 3

County benchmark rate is adjusted for beneficiary risk score.

STEP 4

Payments to Medicare Advantage plans are reduced each year by the coding intensity adjustment. The amount is determined at the discretion of CMS.

Risk Adjustment Methodology

The patient population that chooses Medicare Advantage includes individuals with a wide variation in health and disease status. CMS pays Medicare Advantage plans on a per enrollee capitated basis. Medicare Advantage benchmark base rates are determined for each county and then are risk adjusted for each enrollee by CMS to account for the cost differences associated with various diseases and demographic factors. In other words, CMS modifies the payments to Medicare Advantage plans to reflect the health of each beneficiary.

CMS uses the risk adjustment process to ensure Medicare Advantage functions effectively by paying more for enrollees who are expected to cost more to take care of and paying less for healthier enrollees. **Risk adjustment is critical to ensuring beneficiary health status is fully captured and resources are appropriately allocated to treat and manage beneficiary care.**

Health conditions and diseases are assigned diagnosis codes. CMS groups individual diagnosis codes into broader diagnosis groups, which are then refined into Hierarchical Condition Categories (HCCs). HCCs, together with demographic factors such as age and Medicaid eligibility, are used to predict beneficiaries' total care costs. The system is prospective, which means it uses beneficiary diagnoses from one year to calculate a risk adjustment factor used to establish a payment for the following year.

Despite the inefficiencies in FFS Medicare and inherent differences between Medicare Advantage and FFS Medicare, Medicare Advantage risk adjustment and payment is primarily based on coding patterns and costs in FFS Medicare.

BENCHMARK RATE

X

RISK SCORE

=

MONTHLY CAPITATED
PAYMENT TO
MEDICARE
ADVANTAGE

Clinical Coding Patterns

Accurately identifying illness is key to the comprehensive approach to care in Medicare Advantage. FFS Medicare reimburses providers separately for each episode of care. In contrast, Medicare Advantage is structured to encourage early identification of illness, coordinated care, and improved beneficiary health outcomes.

Medicare Advantage encourages clinicians to identify and treat illness in early stages to enable early intervention, coordinate care for those seeing multiple providers, and provide disease management programs to slow disease progression. These approaches often include care coordination teams focused on beneficiaries with multiple conditions, case managers who support beneficiaries to better ensure compliance with appointment schedules and prescription protocols, exercise and nutrition counseling, and in-home care and evaluation.

Diagnoses in FFS are less reflective of the early identification of chronic illnesses compared to Medicare Advantage.

Medicare Advantage initiatives to identify and treat chronic disease are demonstrating evidence of fewer hospital admissions and readmissions, improved use of preventive and primary care services, and higher rates of screening and outcome metrics for chronic diseases.

- Medicare Advantage enrollees experience a more clinically appropriate use of health care services than beneficiaries in FFS Medicare. For example, Medicare Advantage beneficiaries experience lower incidence of emergency services and receive fewer hip and knee replacements.¹²
- Medicare Advantage beneficiaries are 20% more likely to have an annual preventive care visit than their FFS Medicare counterparts.¹³

Recent Changes to Risk Adjustment

Coding Intensity Adjustment

Since 2010, Congress has required CMS to apply a coding intensity adjustment to Medicare Advantage payments that is an across the board cut to Medicare Advantage risk scores. The purpose of the adjustment is to account for differences in coding patterns between Medicare Advantage and FFS Medicare — differences that are a function of the differences between the structural payment and care models in the Medicare Advantage and FFS Medicare programs. Per statute, the coding intensity adjustment has increased from a 3.41% reduction in 2010 to a 5.91% reduction for payment year 2018. The coding intensity adjustment must remain no less than a 5.91% reduction to risk scores for all subsequent years. CMS has the authority to determine the amount above the statutory minimum. To date, CMS has applied the minimum coding intensity adjustment required by law.

Payments to Medicare Advantage plans are reduced each year by the coding intensity adjustment.

Coding Intensity Adjustment	
2010 to 2013	-3.41%
2013	-4.91%
2014	-5.16%
2015	-5.41%
2016	-5.66%
2017	-5.91%
2018+	At Least -5.91%

Changes to the Risk Adjustment Model

- In 2013, CMS announced it would phase in a new CMS-HCC 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, meaning plans would no longer get payment for those diagnoses. The elimination of these codes reduced the resources that were previously available for early intervention of chronic disease.
- In 2017, CMS adopted a change to the CMS-HCC risk adjustment model to address concerns that the model didn’t accurately predict the full cost of treating high-risk beneficiaries who are dually eligible for Medicare and Medicaid. Under the new methodology, CMS divides beneficiaries into six groups:
 1. Full benefit dual aged
 2. Full benefit dual disabled
 3. Partial benefit dual aged
 4. Partial benefit dual disabled
 5. Non-dual aged; and
 6. Non-dual disabled.
- Evidence shows that the risk adjustment model still does not adequately account for the cost of treating beneficiaries with multiple chronic conditions.

An Example of Medicare Advantage Payments in 2018

\$790.52*

Average Monthly Cost or
Benchmark of a Medicare
Beneficiary in Erie County,
New York

*NOTE: Setting of benchmark rates includes variation by county and adjustments for demographic characteristics, which are not represented here. Assuming the plan's bid has been set to the benchmark their monthly "Capitation Rate" is the benchmark.

Risk scores assigned to each **individual** beneficiary based on health and demographics.*



LOWER RISK

HIGHER RISK

*These examples do not represent any individual and are intended to be illustrative examples.

EXAMPLE ONE



Maria is 65 years old and has rheumatoid arthritis, but is otherwise healthy. Maria is not low income.

FEMALE AGED 65-69 = 0.312

RHEUMATOID ARTHRITIS (HCC40) = 0.423

0.735

Total Unadjusted Risk Score

Sum of risk score factors before coding intensity adjustment

\$790.52

Capitation Rate*

\$581.03

Unadjusted monthly payment to plan

-\$33.99

Reduction to payment due to 2018 coding intensity adjustment of -5.91% that reduces Risk Score to 0.692

\$547.04

Final Monthly Plan

EXAMPLE TWO



Philip is 88 years old, has lung cancer, diabetes, macular degeneration, is depressed, and is low income and is dual eligible for Medicare and Medicaid.

MALE/85-89 YEARS OLD = 1.009

DIABETES WITH CHRONIC COMPLICATIONS (HCC18) = 0.346

LUNG CANCER (HCC9) = 0.973

MAJOR DEPRESSIVE DISORDER (HCC58) = 0.444

EXUDATIVE MACULAR DEGENERATION (HCC124) = 0.0.278

3.050

Total Unadjusted Risk Score

Sum of risk score factors before coding intensity adjustment

\$790.52

Capitation Rate*

\$2,411.09

Unadjusted monthly payment to plan

-\$142.30

Reduction to payment due to 2018 coding intensity adjustment of -5.91% that reduces Risk Score to 2.870

\$2,268.79

Final Monthly Plan

Risk Adjustment Data Validation (RADV) audits are conducted to ensure the accuracy of diagnoses codes

*NOTE: This simplified example uses the 2017 CMS-HCC model and does not include several additional adjustments to Medicare Advantage payments, including for normalization and quality bonus payments. It assumes the plan bid is set to the benchmark and therefore there is no rebate payment.

Conclusion

Risk adjustment is critical to ensuring that Medicare Advantage plans have the resources necessary to provide innovative, affordable, high quality care to all Medicare eligible beneficiaries who choose Medicare Advantage. One third of Medicare eligible beneficiaries — 18.5 million seniors and people with disabilities depend on Medicare Advantage.

Medicare Advantage relies on an accurate and stable risk adjustment that ensures plans are able to provide high value care to all beneficiaries, including those with complex health needs. Medicare Advantage's approach depends on the accurate clinical identification of health status to reflect the needs of beneficiaries. It is this process that allows Medicare Advantage plans to provide the high quality care that works to identify illness early, coordinate care, and slow disease progression.

It is essential that risk adjustment in Medicare Advantage is accurate, stable, and predictable. This enables Medicare Advantage plans to offer innovative, effective, quality care that is highly valued by millions of beneficiaries, their families, and providers.

Risk adjustment that is stable and accurate is critical to ensuring that Medicare Advantage plans have the resources to provide quality, innovative, and effective care for all their beneficiaries.

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Medicare Advantage Special Needs Plans

ISSUE BRIEF JULY 2017

Overview

Special Needs Plans (SNPs) are a specialized type of Medicare Advantage plan designed to serve the health care system's fastest growing population – frail, disabled, and chronically-ill individuals.¹ Over 4 million Traditional Fee-For-Service (FFS) Medicare beneficiaries in 2014 had six or more chronic conditions, representing 51% of FFS Medicare spending.² SNPs enable Medicare Advantage plans to target care to high risk beneficiaries. SNP Medicare Advantage plans tailor care to the needs of a targeted population with complex conditions. SNPs are designed to manage and treat beneficiaries through approved Models of Care. The program aligns incentives and contains costs by emphasizing primary care, chronic care management, and integrated health care services.

Over 18.5 million Medicare eligible beneficiaries have chosen Medicare Advantage, and over 2.4 million of those beneficiaries are in SNPs.³ SNPs are required to offer all Medicare Part A and B benefits and serve beneficiaries who are dually eligible for Medicare and Medicaid, have certain chronic conditions, or receive long-term care in an institutional setting such as a Skilled Nursing Facility. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the SNP program through December 31, 2018.

Policy Recommendations

- 1. Permanently Authorize the SNP Program:** Congress should permanently authorize SNPs before expiration in 2018. Long-term authorization recognizes SNPs as a valuable care delivery model for high risk beneficiaries and offers continuity and stability for SNPs and the beneficiaries they serve.
- 2. Provide SNPs with More Flexibility in Benefits:** Increasing flexibility in benefit design and supplemental benefits would help plans tailor services to specific populations to improve health outcomes for beneficiaries. SNPs must adhere to Medicare Advantage design regulations that limit plan ability to tailor networks, cost sharing, and supplemental benefits.
- 3. Provide Beneficiaries with More Information About SNPs:** CMS should provide more information on SNPs to beneficiaries by more clearly identifying options in the “Medicare & You 2018 Handbook” and on the Medicare.gov Plan Finder.
- 4. Ensure Effective Implementation of the Model of Care:** Establish accountability mechanisms to ensure the Model of Care that SNPs are required to submit is being implemented consistent with the approved plan.
- 5. Strengthen the CMS Medicare-Medicaid Coordination Office (MMCO):** Modifying the eligibility requirements for dual eligible beneficiaries should capture all variations of models achieving improved integration. The MMCO should be strengthened to act as the dedicated point of contact to assist states and plans in addressing contract, alignment, and service integration.
- 6. Ensure Accurate Payment and Quality Measurement for SNPs:** Conduct a transparent evaluation of the Medicare Advantage Risk Adjustment system and Star Rating system to ensure payment accuracy for dually enrolled and chronically ill beneficiaries. Ensure the systems are accurately recalibrated to obtain accurate risk adjustment for high risk beneficiaries.
- 7. Utilize Demonstration Authority to Test Community-Based Institutional SNPs (I-SNPs):** Establish a Community-Based I-SNPs demonstration program to target home and community-based services to eligible Medicare beneficiaries.
- 8. Update Report to Congress Evaluating SNPs Impact on Cost and Quality of Beneficiary Care:** Congress should require CMS to conduct an assessment of the impact of SNPs on the cost and quality of services to beneficiaries by updating the 2003 report released in 2008 that evaluated the SNP program.
- 9. Utilize Demonstration Authority to Simplify Criteria for Institutional Equivalent SNPs (IE-SNPs):** A demonstration could help develop appropriate criteria for IE-SNPs that is consistent across states.
- 10. Reinstate Seamless Conversion with Appropriate Protections:** CMS should work with consumer advocates and health plans to reinstate and update the seamless conversion program to ensure continuity of care for these beneficiaries with appropriate consumer protections.

Background

Legislative History

The Medicare Modernization Act of 2003 established the SNP program and since then Congress has continued to reauthorize the program while creating more sub-types of SNPs and adding requirements to the three core types of SNPs. The Act granted the Secretary of Health and Human Services (HHS) authority to define the conditions that could be served by C-SNPs. CMS also defined D-SNPs to help facilitate the development of fully integrated Medicare and Medicaid managed care contracts.⁴

The State Children's Health Insurance Program (CHIP) Extension Act of 2007 extended SNP authorization until January 1, 2010.⁵ In 2007, the National Committee for Quality Assurance (NCQA) released proposed SNP-specific evaluation measures. In 2008, CMS required SNPs to provide a more detailed Model of Care that clearly identified process and outcome measures to determine if structures were in place to care for the targeted population.⁶

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended the SNP program to December 31, 2010. The Act added new requirements that I-SNPs use a state assessment tool and an independent entity to determine SNP eligibility to provide care to a beneficiary living in the community. D-SNPs were required to have a state contract that provided benefits under Medicaid consistent with state policy. CMS was also required to convene a panel to approve clinical conditions for C-SNPs, and ensure plans had evidence-based Models of Care and annual beneficiary assessments in place.⁷

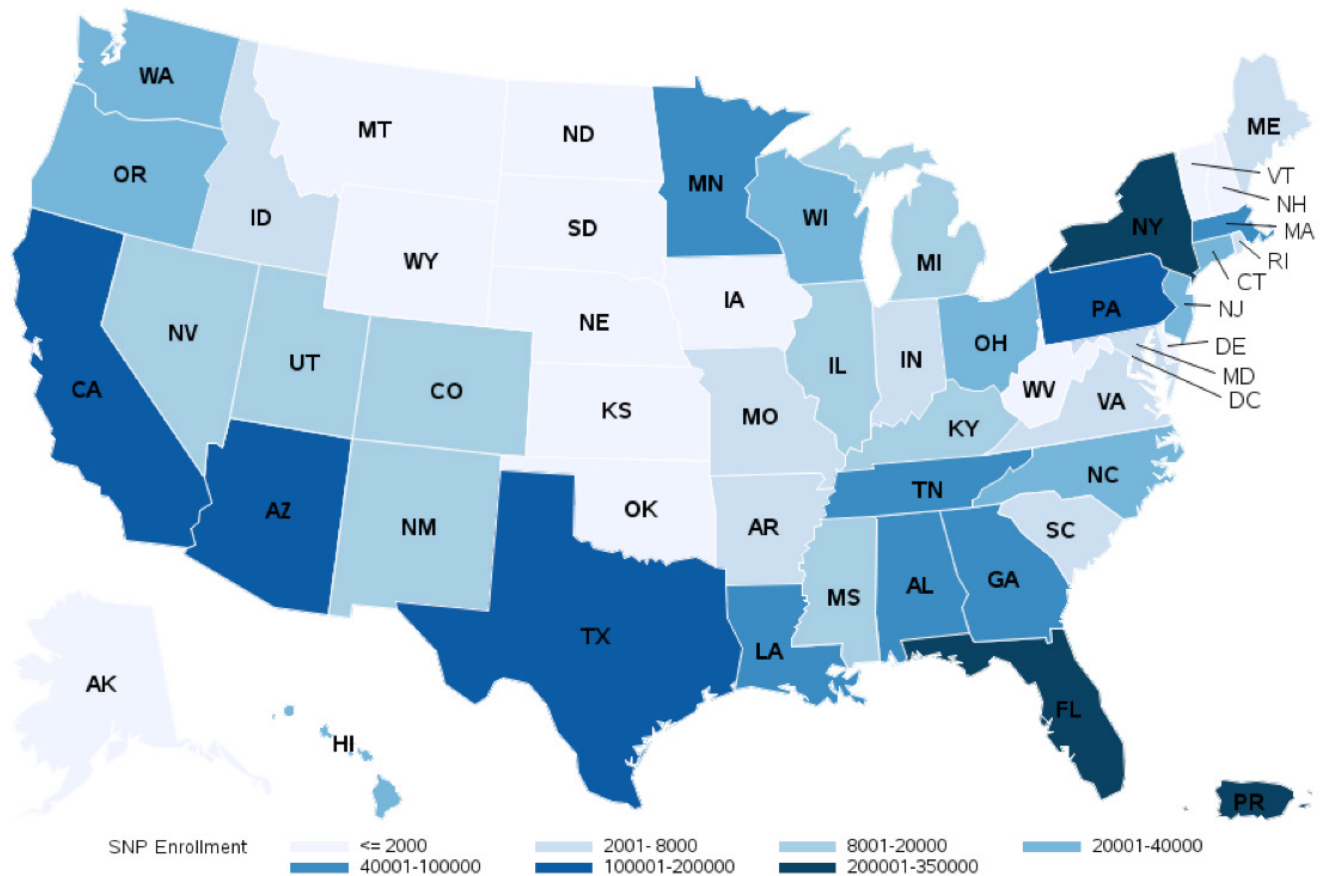
The Affordable Care Act of 2010 extended SNP authorization through December 31, 2013. The Act enabled SNPs that did not have a contract with state Medicaid programs to continue operating. The Act also formalized NCQA's role with SNPs by requiring NCQA-approval Models of Care.⁸ The American Taxpayer Relief Act of 2012 extended the SNP authorization through December 31, 2014.⁹ The Bipartisan Budget Act of 2013 extended the SNP authorization through December 31, 2015.¹⁰ The Protecting Access to Medicare Act of 2014 extended SNP authorization through December 31, 2016.^{11 12}

Most recently, in April 2016, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the SNP program through December 31, 2018.¹³ In April 2017, Senator Hatch re-introduced the CHRONIC Care Act, which would permanently authorize all types of SNPs. In May 2017, this bill passed unanimously out of the Senate Finance Committee.¹⁴ In July 2017, Congressman Tiberi introduced a bill to permanently authorize I-SNPs and provide for 5-year reauthorizations for D-SNPs and C-SNPs. Congressional action is necessary to reauthorize SNPs.^{15 16}

Enrollment

Since SNPs were established in 2003, an increasing number of beneficiaries have enrolled in these specialized plans. Over the last five years, SNP enrollment has grown by over 60% and SNPs now represent about 12.5% of Medicare Advantage. In total, SNP enrollment has grown from 900,000 beneficiaries in June 2007, to over 2.4 million beneficiaries in June 2017 (see *Figure 1 and Appendix I*). Currently, beneficiaries have the choice of enrollment in nearly 600 SNPs nationwide.¹⁷

Figure 1: Medicare Advantage Special Needs Plan (SNP) Enrollment, 2017



Source: CMS. "Special Needs Plan Comprehensive Report." CMS.gov. June 2017. [Web](#).

There are three types of SNPs: Dual Eligible SNPs (D-SNPs), Chronic Condition SNPs (C-SNPs), and Institutional SNPs (I-SNPs). Approximately 87% of SNP beneficiaries are in D-SNPs, 10% are in C-SNPs, and 3% are in I-SNPs.¹⁸ SNP enrollment varies by state (see *Figure 2 and Appendix I*). Some states have 20% or more of their in-state Medicare Advantage beneficiaries enrolled in a SNP; these are Arizona, Hawaii, Minnesota, Mississippi, New York, and Tennessee.¹⁹

[illegible]

Issue Brief: Medicare Advantage Special Needs Plans

Payment

SNPs are paid in the same manner as other Medicare Advantage plans. The federal government pays Medicare Advantage plans a capitated monthly amount per beneficiary to provide health benefits to that individual. Medicare Advantage plans then contract with and pay practitioners, hospitals, and other providers to care for beneficiaries. To ensure capitated payments reflect the expected cost of providing medical care to each beneficiary, payments to Medicare Advantage are risk adjusted to reflect the specific characteristics of each enrolled beneficiary, including demographics, Medicaid eligibility, and health status. To effectively risk adjust payment in Medicare Advantage, CMS determines a unique risk score for each beneficiary. The CMS-Hierarchical Condition Category (CMS-HCC) risk adjustment model is used to create a risk score by using the health of each patient to predict how much that patient may cost in the following year.

Dual Eligible Beneficiaries

Approximately 25% of Medicare beneficiaries are dually eligible for Medicare and Medicaid, amounting to over 11.4 beneficiaries in 2015.²⁰ According to the Medicare Payment Advisory Commission (MedPAC), 75% of dual eligible beneficiaries are in FFS Medicare and 20% are in Medicare Advantage (with the remaining 5% in both, likely due to changing coverage during the year).²¹ In 2011, dual eligible beneficiaries' health costs were four times greater than nondual eligible Medicare beneficiaries.²²

SNP beneficiaries are generally more expensive because they are more likely to be in poorer health than the general Medicare population.²³ In 2012, over 90% of dual eligible beneficiaries lived below 200% of the poverty line.²⁴ In the U.S. there is an estimated 20-year gap in life expectancy between the most and least advantaged populations.²⁵ Duals often have more complex care needs that require additional care and social services as well as long-term care benefits. The 27% of dual eligible enrollees who receive institutional long-term services account for 52% of total Medicare-Medicaid enrollee expenditures.²⁶ In 2016, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) released a report showing dual enrollment to be a strong predictor of increased hospital readmissions and lower performance on quality measures.²⁷ Social determinants of health like lack of social support, food, and transportation have been shown to have a significant impact on health outcomes.

CMS responded to concerns that the CMS-HCC risk adjustment model was not sensitive enough to fully predict costs associated with duals by changing the model for 2017. The change sub-segmented individuals based on Medicaid status and age. Under the new methodology, CMS divides beneficiaries into six groups: 1) Full benefit dual aged; 2) Full benefit dual disabled; 3) Partial benefit dual aged; 4) Partial benefit dual disabled; 5) Non-

dual aged; and 6) Non-dual disabled.²⁸ CMS continues to monitor and evaluate the effect of this change in payment structure.

Interaction Between Medicare and Medicaid

“Dual eligible beneficiaries” is the general term used to describe individuals who are enrolled in both Medicare and Medicaid, but it includes multiple different categories of Medicaid eligibility. Subcategorizations include: fully Medicaid eligible and “Medicare Savings Program” (MSP) categories like Qualified Medicare Beneficiary (QMB) Program. Eligibility for these Medicaid benefit categories is based on federally-defined income and resource standards for full Medicaid and MSP categories. States have the discretion to increase the income and resource thresholds, but they cannot drop them below the federally-set minimums.

Eligibility, by type of dual eligible category, indicates the level of Medicaid services the beneficiary will receive. For example, a fully Medicaid eligible beneficiary is eligible for Medicaid to pay for premiums for Part A (if any) and Part B, cost sharing for Medicare services, as well as other Medicaid-covered services in a given state not already provided by Medicare.²⁹ Other duals subcategories are not eligible for the same cost sharing and other benefits as full dual eligible beneficiaries.³⁰

In addition to required premium and cost sharing support, states are also required to provide nursing home coverage and certain home health services for dual eligible beneficiaries.³¹ Most states go beyond these minimum required benefits to include services such as personal care services related to assistance with activities of daily living (e.g. bathing, dressing, preparing meals), more comprehensive care management, full dental coverage, and other essential services for complex, low-income beneficiaries.³²

For dual eligible beneficiaries, Medicare is the primary payer and Medicare-covered services that are also covered by Medicaid are first paid by Medicare. This includes Part A (inpatient hospital care, Skilled Nursing Facility care, some home health services), Part B (physician services, outpatient care, some durable medical equipment, some home health services, preventive services), Part D (prescription drug coverage), and additional supplemental benefits such as dental and visions (if the dual eligible beneficiary is enrolled in Part C, Medicare Advantage). Medicaid is secondary payer for services partially covered by Medicare, such as nursing home health care, durable medical equipment, personal care, and home- and community-based services.³³ Medicaid is the primary payer for all services solely provided by Medicaid, such as nursing home care, and other home- and community-based services covered by state Medicaid program.

The federal government has several initiatives focused on integrating Medicare and Medicaid benefits for dual eligible beneficiaries. Since 2013, CMS has been testing models in states to better coordinate care for beneficiaries with Medicare and Medicaid through the alignment of financing, primary, acute, behavioral health, and long-term services

and supports. States have the option to enter into a capitated or FFS financial alignment model.³⁴ In June 2017, there were 12 states enrolled in the CMS-approved Financial Alignment (FA) demonstration program for dual eligible beneficiaries. A March 2017 analysis reported care coordination is one of the main components of the capitated demonstration, and it is hypothesized to be a key element of utilization reduction and quality improvement. The demonstration continues to proceed with upcoming monitoring and evaluation expected.³⁵

Quality Measures

Like all Medicare Advantage plans, SNPs are held accountable for meeting quality measurements within the system. High quality plans may receive bonus payments based on a Star Rating system that rates plans from 1 to 5-Stars. Plans with a 4-Star Rating or higher are awarded a Quality Bonus Payment (QBP). The entire QBP must go to beneficiaries through reduced cost sharing or increased benefits. The Star Rating system has been effective at driving quality. In 2015, almost 70% of MA enrollees were in QBP-eligible plans, up from less than 20% in 2009.³⁶ SNPs and other Medicare Advantage plans are measured on nearly the same quality measures in the Star Rating system.³⁷ However, there are four additional measures in the 2018 Star Ratings specific to SNPs:

1. Ratings are Special Needs Plan Care Management
2. Care for Older Adults – Medication Review
3. Care for Older Adults – Functional Status Assessment
4. Care for Older Adults – Pain Assessment.³⁸

There are concerns that the Star Ratings methodology disadvantages plans serving a high percentage of low income beneficiaries. A 2016 report from ASPE showed low income beneficiaries had poorer outcomes on quality metrics in Star Ratings. CMS addressed these concerns by implementing a Categorical Adjustment Index (CAI) adjustment. The adjustment is calculated based on each plan's proportion of duals, and/or enrollees receiving the low-income subsidy, and individuals with disabilities. This change is an interim adjustment to the Star Rating system while CMS continues to design more comprehensive methodological changes.³⁹

Despite the actions taken by CMS, questions remain regarding the accuracy of Medicare Advantage quality payments accounting for social risk factors for low income beneficiaries. SNPs have a higher number of dual beneficiaries who have poorer outcomes on process measures.⁴⁰ The CHRONIC Care Act of 2017 would require the HHS Secretary to determine the feasibility of implementing a separate Star Rating system for SNPs.⁴¹

Benefits

The Medicare Advantage framework aims to align payment and care delivery to incentivize innovative ways to prevent, diagnose, and treat complex chronic conditions to achieve better outcomes and work effectively for beneficiaries. The capitated, or fixed, dollar amount per member, per month system in Medicare Advantage is designed to promote the use of the most appropriate level of care and better care management, particularly for individuals with chronic conditions. Data show that by emphasizing early intervention and better care management, Medicare Advantage can direct beneficiaries with chronic conditions, such as diabetes, to the most appropriate site of care and help prevent adverse, high cost events such as avoidable hospitalizations and emergency room visits.⁴² Research also shows that the positive impact Medicare Advantage is having on care delivery is spilling over to FFS Medicare, resulting in reduced hospitalizations and costs to the system.^{43 44 45}

Payment methodology, quality standards, and oversight for SNPs are the same as for other Medicare Advantage plans, but SNPs must meet additional regulatory and statutory requirements.⁴⁶ SNPs are administered by CMS and enrollment is limited to those beneficiaries who meet disease-specific eligibility criteria.⁴⁷ SNPs have the authority to provide specialized care to serve beneficiaries who are duals, have certain chronic conditions, or receive long-term care in an institutional setting such as a Skilled Nursing Facility.⁴⁸ A beneficiary in a SNP is still in the Medicare Advantage program with all of the same rights and protections. SNP beneficiaries get complete Medicare Part A and Part B coverage as well as Part D prescription drug coverage. Non-SNP Medicare Advantage plans are not required to include Part D coverage, and in those cases beneficiaries may consider buying separate standalone Part D coverage. However, the majority of Medicare Advantage plans include Part D and roughly 90% of Medicare Advantage enrollment is in plans that include Part D (Medicare Advantage Prescription Drug plans, MA-PDs).⁴⁹

The main difference between a Medicare Advantage plan and a SNP are the tailored benefits and care delivery models that are provided to the specific populations SNPs serve. Because enrollment in SNPs is targeted, benefits and interventions can be customized to specific populations. For example, many D-SNPs provide programs to address the social determinants of health most impactful on the health of low-income individuals. Since SNPs have the same statutory limitations in plan design and supplemental benefits as other Medicare Advantage plans, the ability to fully tailor benefits and services to individuals with chronic conditions is limited.

Chart 1: Key Differences Between Medicare Advantage Plans and Medicare Advantage Special Need Plans

	Medicare Advantage Plans	Medicare Advantage Special Need Plans
Benefits	Must offer Medicare Parts A and B benefits. SNPs must provide Part D prescription drug coverage in the plan whereas other Medicare Advantage plans can offer a plan that does not include Part D.	
Payment Method	Capitated monthly amount per beneficiary risk adjusted to each enrolled beneficiary.	
Stars Rating System	Quality is measured through the Star Rating system which rates plans on a 1 to 5-Star scale. In addition, SNPs must report on four additional measures related to care management, medication review, functional status, and pain assessment.	
Supplemental Benefits	Supplemental benefits must be primarily health related	
Flexibility	Must have uniform benefits and plans are largely unable to customize benefit design to specific chronic conditions. *	
Eligibility	Any Medicare-eligible beneficiary residing in a plan service area.	Eligibility limited to beneficiaries who meet criteria of targeted populations in each type of SNP.
Certified Model of Care	Not required.	SNPs must meet NCQA standards and receive approval from CMS for the Model of Care. This includes a description of the SNP population, care coordination plan, a specialized provider network, and a specific, measurable quality measurement plan.

* Unless they are part of a Value-Based Insurance Design (VBID) demonstration project under the Center for Medicare & Medicaid Innovation.

Models of Care Differentiate SNPs

SNPs are required to develop evidence-based Models of Care designed to address the needs of the target population.⁵⁰ The Model of Care is designed to achieve better outcomes for beneficiaries. The NCQA is tasked with approving SNPs that have a robust model of care in place. Key elements that must be included in the Model of Care include a description of the SNP population, care coordination and care transition protocols, the provider network, and quality measurement and performance improvements.⁵¹

4 Key Elements in SNP Models of Care

1. **Description of SNP Population:** The description contains eligibility requirements, social, cognitive and environmental factors, living conditions, and co-morbidities associated with the population, and the ways benefits will be tailored to the highest need beneficiaries.
2. **Care Coordination:** The description contains the staff structure, the health risk assessment tool, an individualized care plan, the interdisciplinary care team, and care transition protocols.
3. **Provider Network:** The description contains the specialized expertise in the network, the use of clinical practice guidelines, and training for network providers.
4. **Quality Measurement and Performance Improvement:** The description contains a quality improvement plan that describes specific data sources and performance outcome measures, measurable goals and health outcomes, patient satisfaction measurements, and ongoing performance improvement evaluations.

SNP Models of Care provide the description of the care delivery design to be implemented to ensure beneficiary needs are identified and addressed. The elements of the Models of Care are scored by NCQA, and the score determines the number of years the Model of Care is approved. The SNP score is based on a percentage of points. SNPs with an 85% or above receive a 3-year approval, SNPs with between 84% and 75% receive a 2-year approval, SNPs with between 70% and 74% receive a 1-year approval, and SNPs with 70% or below receive an opportunity to resubmit their Models of Care.⁵²

Types of Special Needs Plans

Dual Eligible SNPs (D-SNPs)

D-SNPs serve beneficiaries who are eligible for coverage under both Medicare and Medicaid, known as dual eligible beneficiaries. Dual eligible beneficiaries are also able to enroll in C-SNPs and I-SNPs. As described above, dual eligible beneficiaries receive both Medicare-covered benefits as well as Medicaid-covered benefits, such as cost sharing support, nursing home care, and varying degrees of home health, durable medical equipment, personal care, and home- and community-based services. D-SNPs are required to contract with states to cover Medicaid benefits, cost sharing, and additional services such as behavioral health.⁵³

States have different requirements for how D-SNPs must integrate with the state Medicaid program. States that have successfully integrated services for beneficiaries in D-SNPs have done so by engaging stakeholders, achieving data sharing, developing a program design, and obtaining necessary CMS approvals.⁵⁴ Evidence shows that integrated managed care can provide beneficiaries with better care coordination and achieve better outcomes. A 2016 report published by HHS studied the delivery of Medicare and Medicaid services to dually eligible beneficiaries over age 65 in Minnesota. The study compared health care delivery between dually eligible beneficiaries in Minnesota Senior Care Plus (MSC+) and the Minnesota Senior Health Option (MSHO). MSC+ was a Medicaid-only program, and MSHO was a fully integrated Medicare-Medicaid program. The study found fully-integrated managed care plans were more effective than fragmented delivery systems. The integrated plans had higher consumer satisfaction, more service use, and lower emergency department utilization.⁵⁵

Fully-Integrated Dual Eligible SNPs (FIDE-SNPs)

A subset of D-SNPs are known as Fully-Integrated Dual Eligible SNPs (FIDE-SNPs). FIDE-SNPs must have a risk-based Medicaid contract, coordinate care and long-term services with states, create a specialized provider network, and coordinate beneficiary communications.⁵⁶ In June 2017, there were 377 D-SNP plans serving almost 2 million beneficiaries. Of these D-SNPs, 39 were FIDE-SNP plans and they were operating in eight states serving 144,207 beneficiaries.^{57 58} Therefore, less than 8% of D-SNP beneficiaries are in FIDE-SNPs nationwide. About 75% of FIDE-SNP enrollment is in Massachusetts, New Jersey, and Minnesota.⁵⁹ States have the discretion to decide whether or not they want to engage in FIDE-SNP arrangements, and many have not yet decided to do so.

Some states have decided to create capitated arrangements to provide Managed Long-Term Services and Supports (LTSS) through Medicaid. These programs vary widely state to state. As of June 2017, 19 states had a Managed LTSS program.⁶⁰ Some states require a

Medicare Advantage plan to also have a Managed LTSS contract in the state and varying degrees of integration to be able to operate a SNP.⁶¹

Chronic Condition SNPs (C-SNPs)

C-SNPs serve beneficiaries with a disabling chronic condition, as specified by CMS. C-SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations, and helping beneficiaries move from high risk to lower risk on the care continuum.⁶² For example, a C-SNP for a beneficiary with congestive heart failure (CHF) would include a network of providers who specialize in treating this chronic condition, care management programs with expertise in serving people with the chronic condition, and a drug formulary designed around treating congestive heart failure. In June 2017, there were 123 C-SNPs serving over 339,000 beneficiaries.⁶³

Eligibility for C-SNPs:

In the fall of 2008, CMS convened the SNP Chronic Condition Panel. The panel included six clinical experts on chronic condition management from the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), and CMS. Public comment was solicited on the chronic conditions meeting. After discussing public comments, the panel recommended, and CMS approved, 15 SNP-specific chronic conditions.⁶⁴

Beneficiaries may be eligible for a C-SNP with one or more of the following severe chronic conditions:

- Chronic alcohol and other drug dependence
- Autoimmune disorders
- Cancer (excluding pre-cancer conditions)
- Cardiovascular disorders
- Chronic heart failure
- Dementia
- Diabetes mellitus
- End-stage liver disease
- End-Stage Renal Disease (ESRD) requiring any mode of dialysis
- Severe hematologic disorders
- HIV/AIDS
- Chronic lung disorders
- Chronic and disabling mental health conditions
- Neurologic disorders
- Stroke ⁶⁵

Evidence shows C-SNPs are providing high-value care. A 2017 study authored by the RAND Corporation found home visits for beneficiaries in C-SNPs to be a promising avenue to meet beneficiaries' needs.⁶⁶ A 2012 study found beneficiaries in a C-SNP had lower rates of hospitalizations and readmissions than their peers in FFS Medicare. Risk-adjusted hospital days per beneficiary were 19% lower than FFS Medicare and per beneficiary readmission rates were nearly 30% lower than FFS Medicare.⁶⁷ A 2015 Commonwealth Fund case study found that the Medicare Advantage Plan CareMore, which includes SNPs, had 20% fewer hospitalizations than FFS Medicare, while delivering Medicare benefits more efficiently.⁶⁸

Institutional SNPs (I-SNPs)

Institutional SNPs (I-SNPs) serve institutionalized beneficiaries who, for 90 days or longer, have resided or expect to reside in a long-term care facility, such as a Skilled Nursing Facility. A subset of I-SNPs are IE-SNPs for institutional equivalent beneficiaries living in their own homes, but requiring an institutional level of care. I-SNPs contract with nursing facilities to care for beneficiaries.⁶⁹ In June 2017, there were 83 I-SNPs serving over 65,000 beneficiaries.⁷⁰

Evidence shows I-SNPs have higher rates of advance care planning, medication review, functional status assessment, and pain screening.⁷¹ UnitedHealthcare's Nursing Home Plan I-SNP is the largest in the country and delivers coordinated, individualized, and carefully monitored care to roughly 50,000 Medicare Advantage beneficiaries. The UnitedHealthcare Nursing Home Plan has been highlighted by MedPAC as a model for reducing unnecessary hospitalizations. The UnitedHealthcare Nursing Home Plan provides nurse-practitioners (NPs) on site care at Skilled Nursing Facilities to manage the beneficiary's care. The use of NPs onsite support was noted by MedPAC as an important component of the model to provide support and education to residents and facility staff, which improves communication, training, and care. The model was also highlighted for engagement in palliative care and advanced care planning with beneficiaries.⁷²

Policy Recommendations

To build on the successes of SNPs across the country and ensure the continuity of this specialized care for Medicare Advantage beneficiaries, the following recommendations aim to continue and strengthen the program:

1. Permanent Authorization of SNP Program

Without Congressional action, SNP authority will expire in 2018. Congress has continued to reauthorize the program since 2003 because SNPs have been recognized as a valuable care delivery option for high risk beneficiaries. Congress should ensure SNP authority does not expire in 2018. Permanent authorization will provide certainty for states and plans to invest in the program, improve integration, and foster long-term partnerships in SNPs. It will also provide stability, and improve continuity of care for Medicare beneficiaries.

There is broad consensus in Congress, MedPAC, and among stakeholders that SNPs should be permanently authorized. The Senate Finance Committee Chronic Care Working Group recommended permanently authorizing SNPs.⁷³ In 2016, MedPAC recommended Congress permanently authorizing all I-SNPs, certain D-SNPs and certain C-SNPs.⁷⁴ Greater certainty will unlock the potential of these innovative, successful models that are meeting the needs of high cost, high need beneficiaries under Medicare Advantage across the country.⁷⁵

2. Provide SNPs with More Flexibility in Benefits

Increasing flexibility in benefit design and supplemental benefits would help SNPs tailor care and services to specific populations to improve health outcomes for beneficiaries. Currently, Medicare Advantage supplemental benefits are limited to health-related services, which can prevent investments in services such as home delivered healthy meals and transportation to medical appointments. These restrictions limit plans' ability to target benefits, lower cost-sharing, and forge innovative partnerships with community-based organizations. Broadening the definition of health-related services to include all benefits that have a reasonable expectation of improving or maintaining health or overall function would give Medicare Advantage plans more flexibility to offer additional benefits to chronically ill beneficiaries and would better enable plans to address social determinants of health.

Certain high performing D-SNPs receive additional flexibility from CMS to design benefits such as in-home food delivery, support for caregivers, and home modifications. Plans must get approval from CMS to offer the benefit and the benefit must come at zero cost to the beneficiary, must not be duplicative, and must be offered to all beneficiaries uniformly.⁷⁶ CMS has acknowledged the need for flexibility by removing regulatory barriers that could help ensure beneficiaries have access to the most high-value care.

In the Medicare Advantage Final 2018 Rate Notice and Call Letter, CMS decided to develop

SNP-specific network adequacy evaluations. Currently, SNP network adequacy is evaluated based on Medicare Advantage network adequacy standards. More flexibility in networks could enable SNPs to more appropriately tailor care to beneficiaries with special needs.⁷⁷

3. Provide Beneficiaries with More Information About SNPs

According to MedPAC, D-SNPs are limited in their ability to describe to beneficiaries the combination of Medicare and Medicaid benefits available in SNPs in marketing materials.⁷⁸ States have different requirements associated with D-SNP marketing materials, further complicating the information a beneficiary is provided to help determine whether a SNP is a good option.⁷⁹ CMS should provide more information to beneficiaries by more clearly identifying SNPs as an option in the “Medicare & You 2018 Handbook.” State-specific handbooks should also be available for download on the Medicare.gov site so people who choose to receive the Medicare & You Handbook online will also have access to the SNP information that is available in the printed books.

The Medicare.gov Plan Finder is currently not an effective resource for beneficiaries to identify SNP options. The Plan Finder should be improved by including more comparison tools and sorting functionalities. In a BMA survey of Medicare Advantage beneficiaries, over 60% of beneficiaries said Medicare.gov’s Plan Finder was not helpful in finding the right Medicare Advantage plan.⁸⁰ CMS should invest the necessary resources to make effective updates to the Plan Finder. Improvements should include incorporating better comparison tools, especially related to out-of-pocket costs, comparison of Medicare Advantage plan options to FFS Medicare and the additional cost of supplemental, private policies such as Medigap, as well as user-friendly sorting capabilities. Plan Finder should better enable beneficiaries to make informed decisions about cost and quality.⁸¹

4. Ensure Effective Implementation of the Model of Care

The SNP Model of Care process is based on Structure & Process measures previously developed by NCQA.⁸² The Structure & Process measures were developed to ensure SNP beneficiaries received comprehensive, coordinated care in the design. NCQA developed the Structure & Process measures through field testing, public comment and the NCQA Geriatric Measurement Advisory Panel.⁸³ The 2012 Structure & Process measures included requirements around complex case management, member satisfaction, clinical quality improvement, and care transitions. While the Healthcare Effectiveness Data and Information Set (HEDIS) measures included in the Medicare Advantage Star Rating system focus on performance on specific clinical issues, Structure & Process measures were designed to assess the systems SNPs had in place.⁸⁴

However, according to the SNP Alliance, the Structure & Process measures and Model of Care domains were developed independently, and failed to align.⁸⁵ Policymakers should consider putting in place mechanisms to ensure the Models of Care are being implemented in a manner consistent with the approved plan.

5. Strengthen the CMS Medicare-Medicaid Coordination Office (MMCO)

The MMCO should act as the point of contact for states and plans in regards to SNPs to help establish best practices for contract information, questions, and integration of services for dual eligible beneficiaries.⁸⁶ The MMCO currently helps facilitate alignment between Medicare and Medicaid in SNPs.⁸⁷ The office was established by the Affordable Care Act in 2010 to integrate the Medicare and Medicaid programs more effectively for duals and work with states to test integration models.⁸⁸ The Integrated Care Resource Center reported a key component of successful D-SNP contracts is federal agency leadership and staff knowledgeable about Medicaid and Medicare Managed Care.⁸⁹

SNP integration requirements should include definitions that appropriately capture all variations of delivery models achieving improved integration. Specific consideration should be given to ensuring states and plans have multiple pathways to tailor integration. The goal of more integrated care can be accomplished through better data sharing, aligned incentives, and more fully integrated services.⁹⁰ The integration and alignment of services financed by Medicare and Medicaid is important to achieving effective care for dual eligible beneficiaries.

6. Ensure Accurate Payment and Quality Measurement for SNPs

Despite the CMS move to a Risk Adjustment system sub-segmented by dual status to improve accuracy, analyses indicate inaccuracies remain for beneficiaries with multiple chronic conditions.⁹¹ Duals have more complex health care needs and a higher prevalence of multiple chronic conditions such as diabetes, Alzheimer's disease and mental illness.⁹² CMS should conduct a transparent evaluation of the Risk Adjustment system and the Star Rating system to ensure payment accuracy and effective quality measurement for all beneficiaries, including those with the compounding impact of multiple chronic conditions, as well as the effect of social factors and cognitive impairments on risk and cost.

For example, when CMS recently updated the Medicare Advantage risk adjustment model it resulted in a 10% drop in I-SNP payment rates due to a recalibration of the institutional segment of the model.⁹³ CMS stated the update was to improve the predictive power of the model and the cut reflected utilization decreases, but specifics were unclear and there were no impact assessments for the large reduction in payment.⁹⁴ Greater transparency with stakeholders regarding rationale for proposed changes and impact analyses would improve feedback and input from stakeholders and capacity to comply with changes. It would also mitigate adverse impacts on beneficiaries, especially vulnerable individuals like those enrolled in I-SNPs.

7. Utilize Demonstration Authority to Test Community-Based Institutional SNPs (I-SNPs)

In February 2017, Senator Grassley (R-IA) introduced S. 309, the Community-Based Independence for Seniors Act.⁹⁵ The bill would establish a Community-Based I-SNP demonstration program to target home and community-based services to eligible Medicare beneficiaries. The bill would enable HHS to enter into agreements with Medicare Advantage plans to enroll low-income Medicare beneficiaries in a plan to provide long-term care services and supports and benefits such as home delivered meals, transportation services, and respite care. In 2013, the Senate Finance Committee passed legislation to create a Community-Based I-SNPs as a demonstration in five states for three years to target community-based long-term services and supports for low-income beneficiaries who are functionally impaired, however, the bill was never enacted into law.⁹⁶ Action to implement such a demonstration would provide valuable services and evaluation of the impact of these services.

8. Update Report to Congress Evaluating SNPs Impact on Cost and Quality of Beneficiary Care

When SNPs were created in 2003, a report to Congress was required from HHS to assess the impact of SNPs on the cost and quality of services to beneficiaries. CMS contracted with Mathematica Policy Research to evaluate SNPs. The analysis found SNPs had grown steadily and reported that the majority of state Medicaid officials appeared to feel other issues took priority over Medicare/Medicaid integration.⁹⁷ The report concluded that not enough time had passed to do an analysis of quality, and found no evidence that Medicare payments to SNPs differed as compared to other Medicare Advantage plans. Since the last report was released in 2008, an update should be conducted to evaluate SNP impact on quality and cost.

9. Utilize Demonstration Authority to Simplify Criteria for Institutional Equivalent SNPs (IE-SNPs)

IE-SNPs provide care for beneficiaries who need institutional-level care and are living at home. In order to determine eligibility for an IE-SNP, beneficiaries must undergo a state assessment, which varies state to state. State variation creates complexity for plans attempting to administer IE-SNPs across the country. This burden could limit access to IE-SNPs for Medicare beneficiaries at a time when an increasing number of Medicare beneficiaries are choosing to age in place. For example, in Oregon the state criteria for an institutional level of care is any person in an assisted living community. In Arizona, the state criteria include many medical, functional, and emotional criteria, resulting in fewer beneficiaries qualifying for the program. A demonstration could help develop appropriate criteria that is consistent across states.

10. Reinstate Seamless Conversion with Appropriate Protections

CMS has put a hold on any new plans in the seamless conversion program due to concerns about consumer protections. Through seamless conversion, health plans apply to CMS and CMS grants approval to enroll their commercial beneficiaries, including Medicaid Managed Care beneficiaries, in a comparable Medicare Advantage plan when they become eligible for Medicare. Beneficiaries must be informed, and can opt-out if they decide to choose a different Medicare Advantage plan or to enroll in FFS Medicare. In 2006, 46 D-SNPs were allowed to enroll dually eligible beneficiaries from their Medicaid Managed Care plans. Beneficiaries were notified in advance and able to opt-out. Seamless conversion has the potential to ensure that high risk beneficiaries, such as Medicaid beneficiaries who are newly eligible for Medicare, maintain continuity of care and stay in a managed care plan that is tailored to their needs.

In August 2016, BMA polled 68,258 BMA advocates to gain an understanding of their attitudes on seamless conversion. A total of 749 beneficiaries completed the survey. Less than 4% of respondents found the auto-enrollment process in seamless conversion to be negative (3.65%).⁹⁸ Through follow-up phone conversations, BMA staff found that many seniors feel that seamless conversion alleviates the complexity of researching many options. CMS should work with consumer advocates and health plans to reinstate and update the seamless conversion program to ensure it is available to beneficiaries and has appropriate protections for consumers.

CONCLUSION

SNPs embody the goals of innovation, choice, and flexibility inherent in Medicare Advantage. Congress has continued to reauthorize the program since 2003 because SNPs have been recognized as a valuable care delivery model for high risk beneficiaries. Congress should act on permanent authorization this year to ensure SNP authority does not expire in 2018.

There is broad consensus in Congress, MedPAC, and among stakeholders that SNPs should be permanently authorized. The Senate Finance Committee Chronic Care Working Group recommended permanent authorization of SNPs.⁹⁹ MedPAC has recommended Congress permanently authorize I-SNPs, and certain D-SNPs and C-SNPs.¹⁰⁰ Greater certainty will unlock the potential of these innovative, successful models that are meeting the needs of high risk, high need beneficiaries in Medicare Advantage across the country.¹⁰¹

In addition to permanent authorization, several policy changes would strengthen the effectiveness of SNPs. Increasing flexibility for SNP benefit design and supplemental benefits would allow services to be tailored more effectively to improve health outcomes for vulnerable beneficiaries. Providing beneficiaries with more information about SNPs would enable beneficiaries to better understand their options. Ensuring the effective implementation of the SNP Models of Care and better integration between Medicare and Medicaid will also strengthen the program. SNPs need accurate payment and flexibility to effectively adapt to the needs of each beneficiary.¹⁰²

SNPs are providing some of the highest need Medicare beneficiaries with comprehensive, coordinated, and personalized health care to manage chronic conditions and avoid preventable hospitalizations. Providing SNPs with greater certainty will help unlock the potential of these models across the country. Increased flexibility around benefit design will enable plans and providers to address beneficiaries' needs in the community through preventive care, effective care management, and tailored care driven by the consumer. Permanent authorization of SNPs will allow the program to continue operating effectively and enable CMS and states continue to improve the program into the future.

APPENDIX I

Table 1:
Medicare Advantage
and Special
Needs Plan (SNP)
Enrollment and
Percent of SNP
Beneficiaries by
State, 2017

Source: CMS. Medicare
Advantage Enrollment Data.
June 2017. [Web](#).

Notes: Puerto Rico has 578,405
Medicare Advantage enrollees
and 297,068 SNP enrollees.

* Cost, Demo, PACE removed.

** Includes only publicly
available data for SNPs with
over 10 enrollees with state
data.

State	Total Medicare Advantage Enrollment*	SNP Enrollment**	Percent of Medicare Advantage Beneficiaries enrolled in a SNP
National Total	17,970,289	1,902,513	
AK	702	0	0.0%
AL	361,953	51,959	14.4%
AR	133,434	6,203	4.6%
AZ	467,198	101,900	21.8%
CA	2,363,061	184,689	7.8%
CO	286,914	13,755	4.8%
CT	182,958	25,639	14.0%
DC	8,174	5,592	68.4%
DE	21,177	950	4.5%
FL	1,813,115	347,123	19.1%
GA	564,565	41,207	7.3%
HI	117,089	21,462	18.3%
IA	96,272	0	0.0%
ID	93,642	2,316	2.5%
IL	456,920	14,772	3.2%
IN	315,957	7,235	2.3%
KS	76,795	1,513	2.0%
KY	250,777	10,329	4.1%
LA	274,919	40,973	14.9%
MA	265,983	44,510	16.7%
MD	65,371	7,219	11.0%
ME	89,719	4,082	4.5%
MI	677,860	11,803	1.7%
MN	164,889	40,363	24.5%
MO	374,252	3,677	1.0%
MS	96,313	17,461	18.1%
MT	43,477	249	0.6%
NC	592,882	26,430	4.5%
ND	2,158	0	0.0%
NE	40,319	73	0.2%
NH	28,836	0	0.0%
NJ	331,911	27,128	8.2%
NM	132,408	19,765	14.9%
NV	170,900	11,118	6.5%
NY	1,336,902	257,946	19.3%
OH	793,765	24,413	3.1%
OK	125,556	202	0.2%
OR	357,727	27,815	7.8%
PA	1,065,044	129,371	12.1%
RI	77,481	2,906	3.8%
SC	246,810	5,396	2.2%
SD	7,973	0	0.0%
TN	472,000	92,851	19.7%
TX	1,274,955	191,009	15.0%
UT	129,211	8,347	6.5%
VA	222,135	6,754	3.0%
VT	12,164	0	0.0%
WA	387,374	32,934	8.5%
WI	386,578	30,597	7.9%
WV	109,010	477	0.4%
WY	2,704	0	0.0%

Table 2:
Medicare Advantage
Special Needs Plan
(SNP) Enrollment by
State and Type of
SNP, 2017

Source: CMS. "Special Needs Plan Comprehensive Report." CMS.gov. June 2017. [Web](#).

Notes: Puerto Rico has 297,068 SNP enrollees: 283,527 in D-SNPs; 13,541 in C-SNPs; 0 in I-SNPs.

Includes only publicly available data for SNPs with over 10 enrollees with state data.

State	Special Needs Plan Type			SNP Enrollment Grand Total
	D-SNP Enrollment	C-SNP Enrollment	I-SNP Enrollment	
National Totals	1,924,543	215,944	59,094	2,199,581
AK	0	0	0	0
AL	51,959	0	0	51,959
AR	6,203	0	0	6,203
AZ	87,769	11,528	2,603	101,900
CA	134,707	47,364	2,618	184,689
CO	10,635	46	3,074	13,755
CT	22,576	0	3,063	25,639
DC	5,499	93	0	5,592
DE	950	0	0	950
FL	273,240	69,466	4,417	347,123
GA	37,826	79	3,302	41,207
HI	21,462	0	0	21,462
IA	0	0	0	0
ID	2,316	0	0	2,316
IL	10,140	3,900	732	14,772
IN	6,144	0	1,091	7,235
KS	1,513	0	0	1,513
KY	9,641	497	191	10,329
LA	39,418	1,555	0	40,973
MA	44,409	0	101	44,510
MD	3,438	3,541	240	7,219
ME	3,933	149	0	4,082
MI	11,803	0	0	11,803
MN	40,363	0	0	40,363
MO	3,389	0	288	3,677
MS	17,461	0	0	17,461
MT	249	0	0	249
NC	23,433	125	2,872	26,430
ND	0	0	0	0
NE	73	0	0	73
NH	0	0	0	0
NJ	24,993	101	2,034	27,128
NM	19,765	0	0	19,765
NV	0	10,478	640	11,118
NY	239,109	804	18,033	257,946
OH	22,987	0	1,426	24,413
OK	0	0	202	202
OR	22,616	4,006	1,193	27,815
PA	122,162	2,960	4,249	129,371
PR	283,527	13,541	0	297,068
RI	1,240	0	1,666	2,906
SC	4,975	421	0	5,396
SD	0	0	0	0
TN	92,851	0	0	92,851
TX	150,619	40,105	285	191,009
UT	8,347	0	0	8,347
VA	2,687	3,315	752	6,754
VT	0	0	0	0
WA	31,553	0	1,381	32,934
WI	26,563	1,870	2,164	30,597
WV	0	0	477	477
WY	0	0	0	0

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Caring for ESRD Beneficiaries in Medicare & Medicare Advantage

EXECUTIVE SUMMARY

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.

There is interest in Congress in making changes to End Stage Renal Disease (ESRD) care, demonstrated by the passage of the ESRD Choice Act of 2016 (H.R. 5659) in the U.S. House of Representatives in September 2016. This bill would extend the choice of Medicare Advantage to all ESRD beneficiaries. In late October, the U.S. Senate Committee on Finance Bipartisan Chronic Care Working Group also included this policy change in a legislative discussion draft, with the stated goal of releasing final bill text in November 2016. Policymakers have expressed the belief that all Medicare beneficiaries deserve the choice of Medicare Advantage, and that Medicare Advantage can provide a better care framework for these high need patients.

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 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.

Caring for ESRD Beneficiaries in Medicare & Medicare Advantage

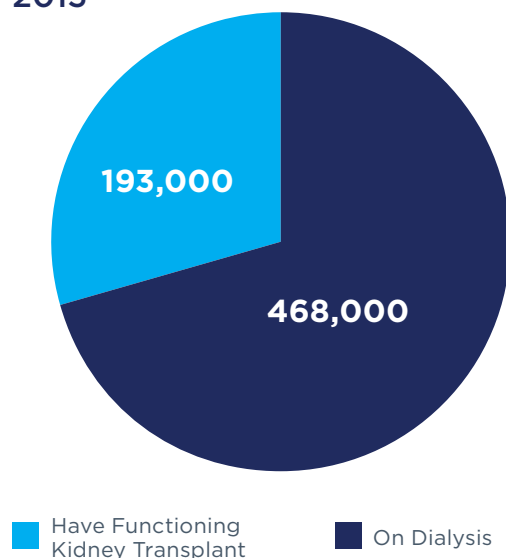
ISSUE PAPER

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.¹¹ CKD is divided into five stages based on degree of kidney function, with ESRD being the final stage.¹² When an individual's kidneys are functioning at less than 15%, they have developed ESRD and need a kidney replacement or dialysis.¹³

FIGURE 1

Patients Being Treated for ESRD, 2015



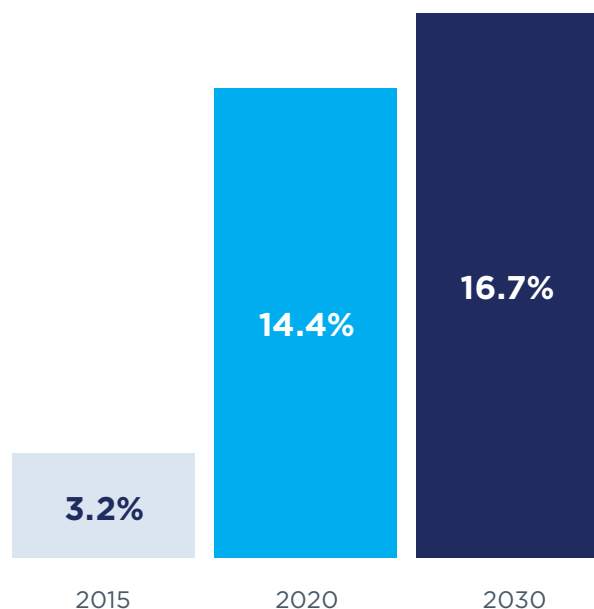
Source: CMS, 2017 Medicare Advantage Final Rate Announcement. April 4, 2016.

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.¹⁴ Over 70% of these individuals (468,000) are dialysis patients and the remaining 30% have a functioning kidney transplant (193,000).¹⁵ 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 2010.¹⁶ 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.¹⁷

FIGURE 2

Percent of Adults 30 Years or Older with CKD



Source: The United States Renal Data System (USRDS), 2015 USRDS Annual Data Report

Chronic Conditions Cause ESRD

Approximately 31 million people are living with CKD.¹⁸ In 2014, 17% of Medicare beneficiaries were living with CKD.^{18,19} 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.²¹ These two conditions are responsible for up to two-thirds of kidney disease.²² 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.²³ Currently over two-thirds of Medicare beneficiaries have at least two or more chronic conditions.²⁴

Preventing ESRD

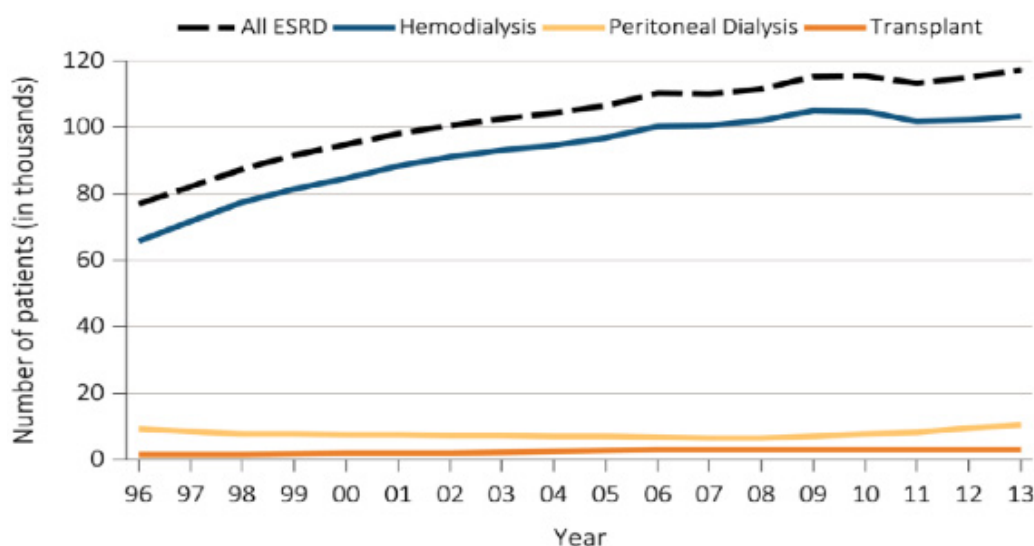
The earlier CKD is detected and treated the higher the chance disease progression can be slowed or stopped. An increased focus on early CKD detection, treatment, and education is an essential component of decreasing the prevalence of ESRD. Early intervention also ensures kidney patients are connected 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.²⁵

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.²⁶ 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.²⁷ 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.²⁸

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.²⁹ Individuals often must receive Hemodialysis three times a week for four hours.³⁰

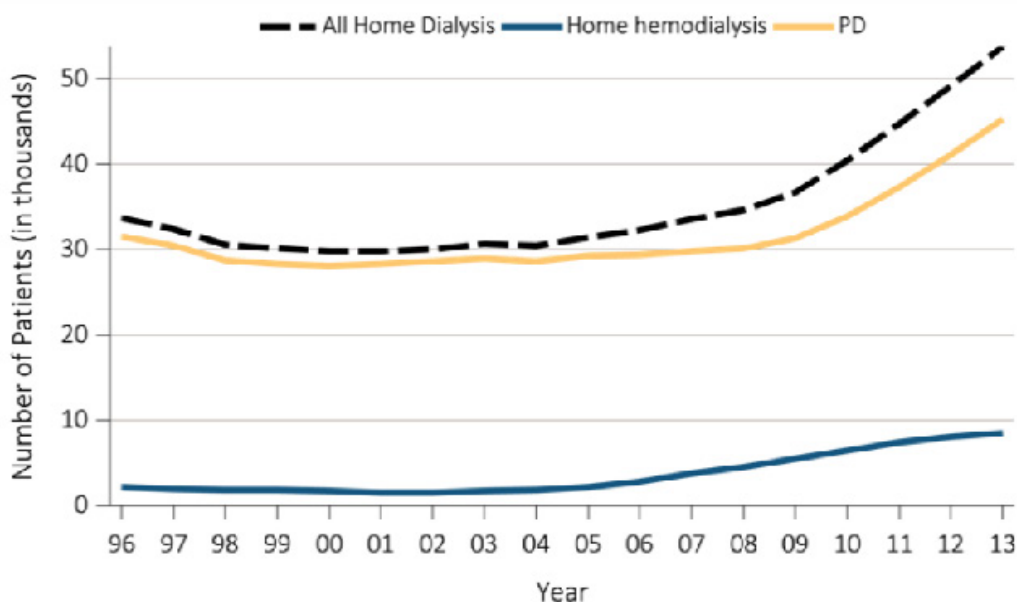
Peritoneal dialysis is the least common type of dialysis and allows blood to be cleaned in the body by placing a catheter into the abdomen. There are two main types of Peritoneal dialysis, Automated Peritoneal Dialysis, and Continuous Ambulatory Peritoneal Dialysis. Each cycle usually lasts 1-1/2 hours and exchanges are done throughout the night while the patient sleeps.³¹ 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.³²

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.³³ 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.³⁴ 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.³⁵

FIGURE 4

Trends in Number of Prevalent ESRD Cases (in Thousands) Using Home Dialysis, by Type of Therapy, in the U.S. Population, 1996-2013



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

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.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.^{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.³⁹ In 2013, Medicare Part D spending for ESRD patients per year was \$6,673, 2.6 times higher than for general Medicare patients.⁴⁰ In 2013, Medicare Part D spending for CKD patients was \$3,675, 1.4 times higher for general Medicare patients.⁴¹

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.⁴² Nephrologists also recommend that this increased attention to patient education include palliative care options.⁴³

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.^{44,45}

ESRD Medicare Eligibility

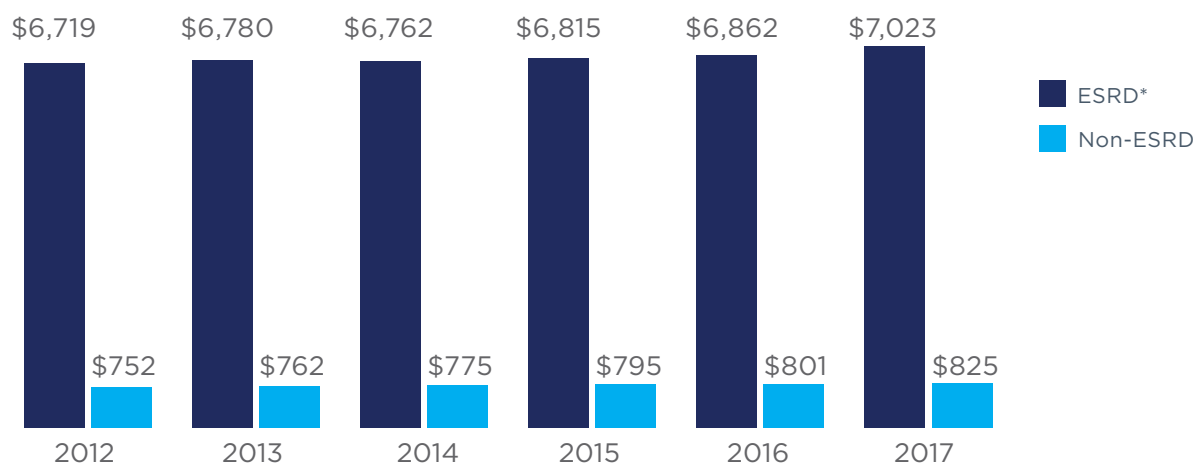
For individuals with ESRD who are not otherwise eligible for Medicare, there is a three-month waiting period before the individual can become eligible for Medicare.⁴⁶ Once eligible, these individuals are eligible for all covered services in Medicare, not only services directly related to ESRD. If the 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.⁴⁷

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.⁴⁸ This means that caring for ESRD beneficiaries is over eight times costlier than care for the average Medicare beneficiary.⁴⁹

FIGURE 5

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



Source: CMS, 2017 Medicare Advantage Final Rate Announcement. April 4, 2016.

FIGURE 6

ESRD FFS Medicare Payment Bundle

SERVICES INCLUDED IN THE ESRD FFS MEDICARE PAYMENT BUNDLE	SERVICES EXCLUDED FROM THE BUNDLE
<ul style="list-style-type: none"> • Composite Rate Services • Part B Drugs • Dialysis Related Laboratory Tests • Home Dialysis Support Services • DME Supplies and Equipment • Supplies and Other Services • Current Part D Dialysis Drugs With an IV Equivalent 	<ul style="list-style-type: none"> • Hospital Services • Physician Services • Blood and Blood Products, Vaccines, Transfusions • Home Dialysis Support Services • Part D Oral Drugs Without an IV Equivalent

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.⁵⁰ 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.⁵¹

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 adjusters 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.⁵² For payment in 2017, the ESRD Prospective Payment System in the Traditional FFS Medicare base rate will be roughly \$232.⁵³

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.⁵⁴ 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.⁵⁵ 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).⁵⁶ Additionally, there are no annual limits on out-of-pocket costs in Traditional FFS Medicare, which is a consumer protection for Medicare Advantage beneficiaries.^{57,58}

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 65.⁵⁹

As a result, individuals with ESRD face some of the highest costs associated with of 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).⁶⁶ As a result, less than 5,000 individuals with ESRD are enrolled in ESRD SNPs.⁶⁷ 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

NON-ESRD TOTAL	NON-ESRD FFS	ESRD TOTAL	ESRD FFS
51,567,000	33,193,000	500,000	404,000

Source: CMS, 2017 Medicare Advantage Final Rate Announcement. April 4, 2016.

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.⁶⁸ 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.⁶⁹ 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.⁷⁰

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).⁷¹ In 2014, 71% of all dialysis facilities were owned by two companies.⁷² Policymakers and researchers have long predicted and investigated the impact of dialysis provider concentration on access, quality, and cost.^{73,74} In some cases consolidation of the dialysis provider market has demonstrated clinical advantages, especially related to improved compliance, efficiencies, and broad scale quality improvements.⁷⁵ However, analyses have also outlined concerns that such a high level of market concentration inhibits price competition.⁷⁶ 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

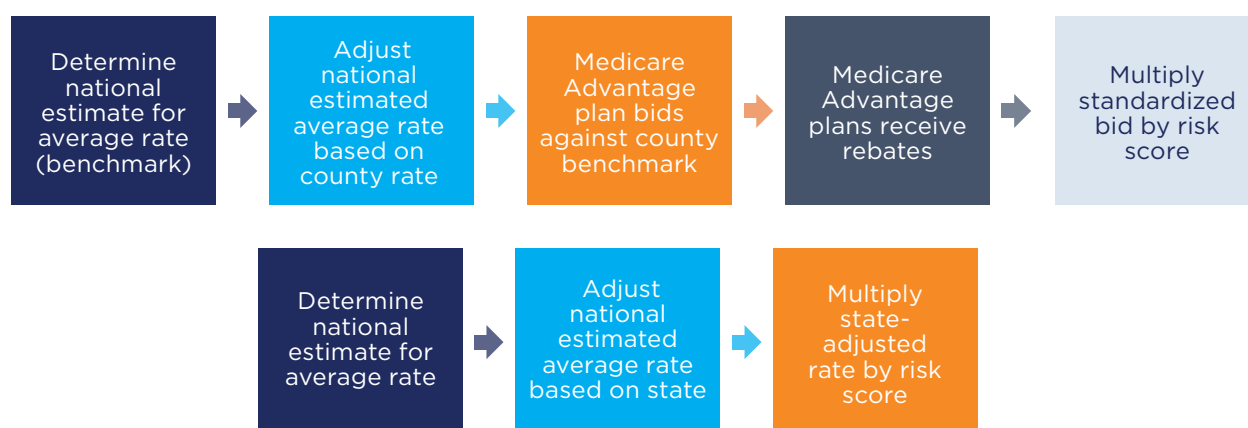
Payment in Medicare Advantage is based on a capitated (fixed) amount the government pays to Medicare Advantage health plans for each beneficiary. Therefore, CMS does not pay for ESRD treatment in Medicare Advantage through the same bundled payment methodology as Traditional FFS Medicare. For non-ESRD 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 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 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.⁷⁷ 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.⁷⁸ 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.

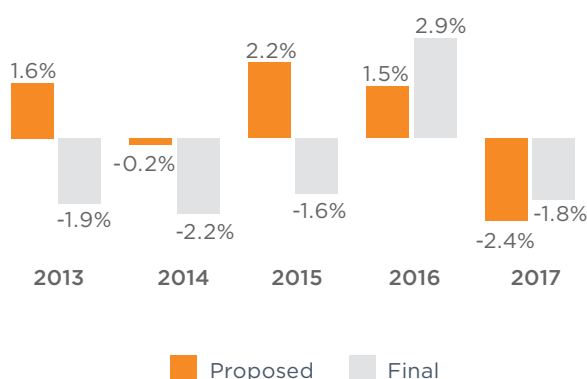
Volatility in Medicare Advantage ESRD Growth Rate Updates

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.

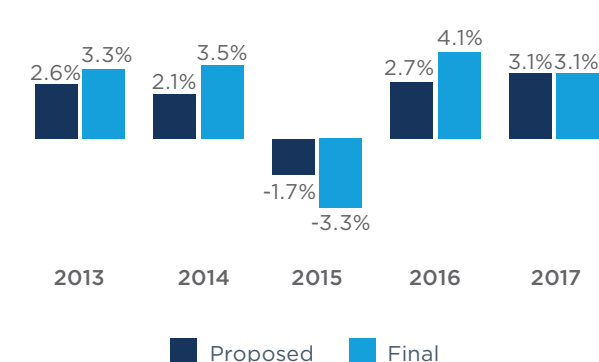
FIGURE 9

Medicare Advantage ESRD* Growth Percentage (Using FFS Spending) as Compared to Medicare Advantage Growth Percentage (Using FFS Spending), 2013 - 2017

Medicare Advantage ESRD* Growth Percentage (Using FFS Spending)



Medicare Advantage Growth Percentage (Using FFS Spending)



Source: CMS, 2013 - 2017 Medicare Advantage Proposed and Final Rate Announcements.

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.⁷⁹ Hispanics and Native Americans are nearly two times as likely as Caucasians to develop kidney failure.⁸⁰ 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.⁸¹ 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.⁸² One study found that in impoverished neighborhoods, African Americans were 57% less likely to get on a transplant list than their Caucasian counterparts.⁸³ African Americans are 30% less likely and Hispanics 10% less likely to receive the most common type of home dialysis.⁸⁴

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.⁸⁵

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.”⁸⁶ 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 2004.⁹¹ 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.”⁹² In late October, the Chronic Care Working Group also included the change in a legislative discussion draft.⁹³ 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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The Impact of the Medicare Advantage Benchmark Cap on Beneficiaries

ISSUE BRIEF OCTOBER 21, 2016

This issue brief explains the Medicare Advantage (MA) benchmark cap and highlights the consequences this policy has on MA beneficiaries.

This Brief Shows:

- The benchmark cap undermines the Quality Bonus Payment (QBP) and leads to fewer benefits for MA beneficiaries.
- Over three million MA beneficiaries in nearly 1,500 counties are impacted by the benchmark cap and may not receive the full benefits of being in a high quality plan.
- In 2016, over 2 million beneficiaries were denied additional benefits or cost sharing due to the benchmark cap.
- Better Medicare Alliance (BMA) ally organization Indiana University Health (IU HealthPlans) operates an MA plan in capped counties and beneficiaries may not receive the full complement of supplemental benefits that could be offered as a result.

The Issue Brief outlines the potential administrative and legislative solutions to address the benchmark cap issue.

The Department of Health & Human Services (HHS) is working to achieve goals of tying payments in Traditional Fee-For-Service (FFS) Medicare to quality and value. In Medicare Advantage (MA), payments are already tied to quality through MA's Star Rating system which rewards plans with a 4-Star rating or higher (on a 5-Star scale) with a Quality Bonus Payment (QBP). The QBP goes directly to beneficiaries, and must be applied to reducing cost sharing or increasing benefits for beneficiaries. The Star Rating system has been very effective at driving quality, in 2015 over 70% of MA enrollees were in QBP eligible plans, up from less than 20% in 2009.¹ However, due to a policy known as the benchmark cap, beneficiaries in certain counties are not able to benefit from the program. Across the country, beneficiaries in over 40% of counties are negatively impacted by this policy.²

The benchmark cap was implemented by the Affordable Care Act (ACA). The policy caps MA payment at the pre-ACA level (plus growth updates). The goal of the policy is to prevent benchmarks, the primary payment mechanism for MA plans, from exceeding the level of benchmarks pre-ACA. However, due to the implementation of this policy, high quality MA plans with 4+ Stars normally eligible for a QBP do not receive the quality incentive if they are in a capped county.

In 2016, over two million MA beneficiaries are negatively impacted by the benchmark cap, which means they are not receiving additional benefits for enrolling in a high quality MA plan, such as reduced cost sharing or supplemental benefits like dental or vision coverage.³ QBPs also help enable early intervention and disease management programs and innovations like the use of telemedicine. There is broad consensus from the Administration, Congress, and MedPAC that the benchmark cap policy undermines quality and perpetuates inequality across the country for beneficiaries.⁴ The impact of the benchmark cap on the Star Rating system must be addressed to preserve the goal of incentivizing quality and value in MA.

Explanation of the Benchmark Cap Policy

In MA, health care practitioners are incentivized to provide effective care in the best setting for the patient through the capitated (fixed) monthly payments, and quality is measured and publicly reported. MA plans are required to report on quality metrics and receive an annual rating using the Star Rating system, which is designed to help beneficiaries consider cost and quality in MA plans. FFS Medicare does not have an equivalent comprehensive quality accountability system.

Since the implementation of the ACA, the capitated payments using a benchmark level are set by CMS, and calculated based on FFS Medicare spending by county. MA plans submit bids based on the benchmark to determine the capitated payment amount the plan will receive to care for a beneficiary; this amount is risk adjusted for each beneficiary to account for differences in health status and other characteristics. Plans are able to receive a portion of the difference between their bid and the benchmark, called the rebate, to apply to supplemental benefits for beneficiaries.

The ACA also established the QBPs in the Star Rating system, which are awarded to plans with a 4-Star or higher rating. The QBP is a 5% higher benchmark and a larger percentage of rebate dollars that can be applied to additional benefits. Finally, the ACA placed a cap on the benchmarks to prevent them from exceeding the level of the benchmark pre-ACA, this policy is what is known as the benchmark cap.⁵

The Star Rating system QBPs are impacted by the benchmark cap because the QBPs are included in the benchmark calculation. This means if an MA plan earns 4+ Stars and earns a 5% higher benchmark, but receiving that bonus would make them exceed the cap, the plan will not be able to receive the QBP. The benchmark cap prevents over three million beneficiaries in nearly 1,500 counties from benefiting from the QBPs in the Star Rating system.⁶

How the Benchmark Cap Impacts Beneficiaries

Almost 1 in 6 MA beneficiaries in bonus-eligible 4+ Star or higher plans miss out on additional benefits due to the benchmark cap.⁷ These additional benefits include vision, dental, and hearing care, lower cost-sharing and innovations like telemedicine. As Figure 1 illustrates, applying an across-the-board benchmark cap impacts over three million MA beneficiaries or nearly 18% of beneficiaries. (See *Figure 1*.) Roughly 16% of beneficiaries in plans with 4 Stars, 21% of beneficiaries in plans with 4.5 Stars, and 15% of beneficiaries in plans with 5-Star MA plans are impacted by the benchmark cap. (See *Figure 2*.)

Better Medicare Alliance (BMA) ally organization Indiana University Health (IU Health) operates a Medicare Advantage plan as part of their integrated delivery system. IU HealthPlans provide insurance to Medicare beneficiaries including preventive services, chronic disease management programs, and supplemental benefits such as dental coverage.

Due to this high level of care, IU HealthPlans earned a Star Quality Rating of 4 (out of 5) stars for 2016. This high rating makes the plan eligible for Quality Bonus Payments (QBPs); however, 60% of the counties in which IU HealthPlans operate have a Benchmark Cap, preventing them from receiving QBPs in those counties.

For IU HealthPlans beneficiaries, this means fewer resources are available that could lower cost sharing or expand existing benefits like dental and vision. As long as the Benchmark Cap is in place, 6,000 IU HealthPlan beneficiaries, as well as any Medicare Advantage member in those counties with the cap, may not receive the full complement of supplemental benefits that could be offered.

FIGURE 1

Percent of MA Beneficiaries Affected by the Benchmark Cap in 2016

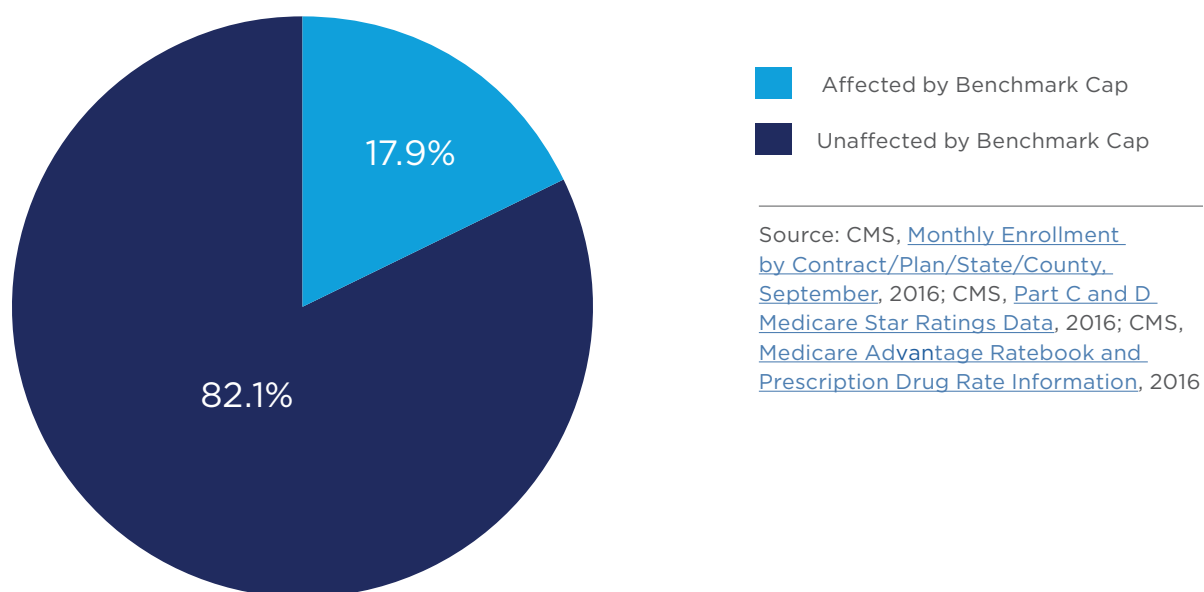
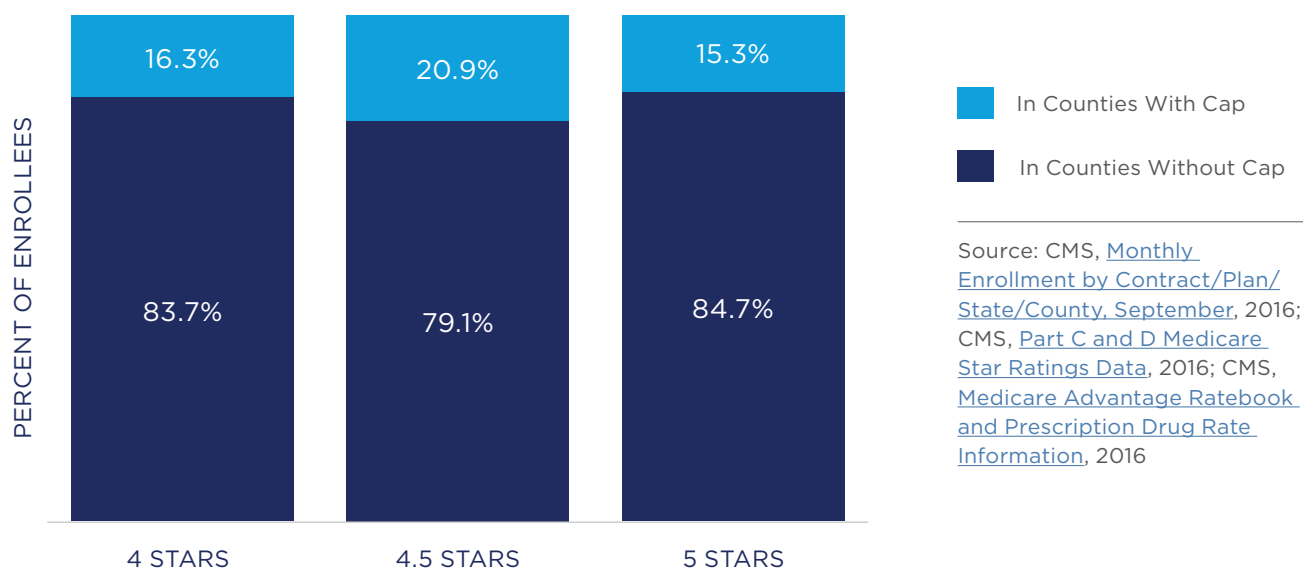


FIGURE 2

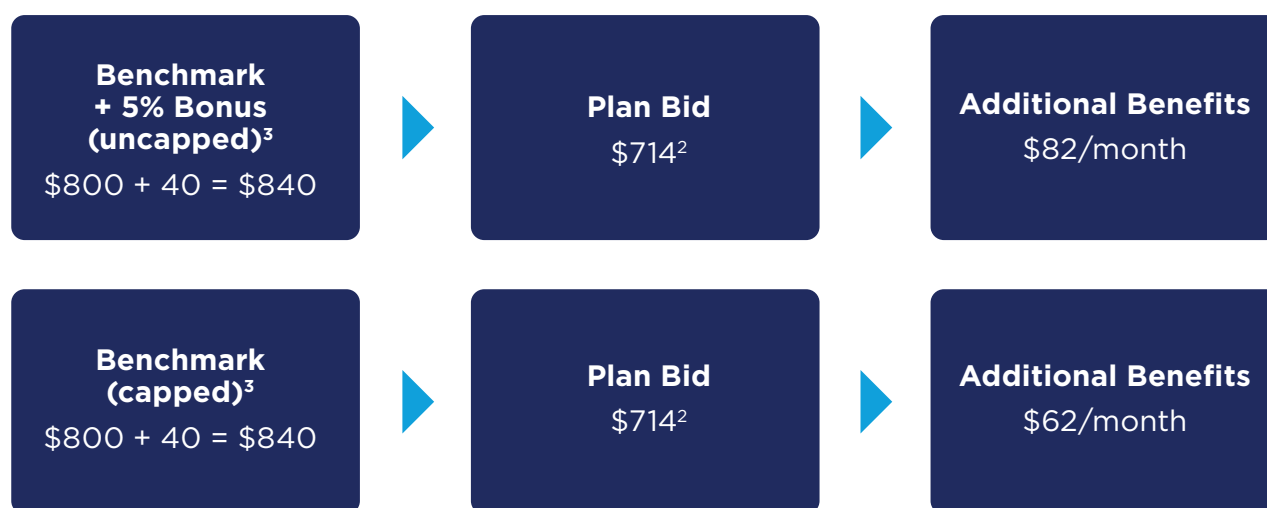
Distribution of MA Beneficiaries Impacted by the Benchmark Cap in 2016



MA beneficiaries are impacted by the Benchmark Cap in the form of decreased benefits and increased costs. The flow chart in Figure 3 illustrates how the Benchmark Cap could impact an MA beneficiary in Tippecanoe, Indiana. The following chart shows the MA benchmark (pre-bonus) is \$800. Thus, if a plan operating in that county receives a 4-star rating, it should receive a 5% bonus, which would result in a \$840 benchmark. However, the Benchmark Cap in Tippecanoe is \$809. Therefore, a high quality 4-star plan can only receive \$809, which amounts to \$20 less rebate dollars per month and \$240 less rebate dollars per year that can be applied to cost sharing or additional benefits for beneficiaries. (See Figure 3.)

FIGURE 3

For Example, In Tippecanoe, Indiana the Benchmark Cap May Decrease Benefits or Increase Costs



When plans bid below the benchmark, they receive a percentage of the savings in the form of rebates that must be used to provide extra benefits to beneficiaries. For a 4-star plan the rebate percentage is 65%.

¹ Capped rate obtained from the 2017 MA Ratebook

² Assumes plan has 4-Star Rating HMO Plan. Average Plan Bid by County Obtained from 2014 Plan Payment Data

³ Uncapped rate is estimated from 2017 MA Ratebook

Source: CMS, [Monthly Enrollment by Contract/Plan/State/County](#), September, 2016; CMS, [Part C and D Medicare Star Ratings Data](#), 2016; CMS, [Medicare Advantage Ratebook and Prescription Drug Rate Information](#), 2016

Geographic Distribution of Benchmark Impact

Research indicates MA plans have focused on achieving the quality measures that are the basis of QBPs.⁸ The increased focus on quality has driven improvements in quality measures in MA plans for beneficiaries. CMS data show 71% of MA enrollees are now in 4+ star plans, an improvement from less than 20% in 2009.⁹ However, across the country the Benchmark Cap could disincentive MA plans from achieving 4+ stars if they are not able to receive QBPs. In 2016, the Benchmark Cap will apply if a county's benchmark is projected to be more than 6.4 percent above the county's 2010 benchmark.¹⁰ In 1,434, or 44% of counties out of over 3,000 counties in the U.S., beneficiaries in MA plans are negatively impacted by the Benchmark Cap. (See *Figure 4*.)

FIGURE 4

Number of MA Beneficiaries and Counties Impacted by the Benchmark Cap in 2016

	Affected by Benchmark Cap	Unaffected by Benchmark Cap
Number of Counties	1,434	1,814
Number of Beneficiaries	3,068,729	14,100,169

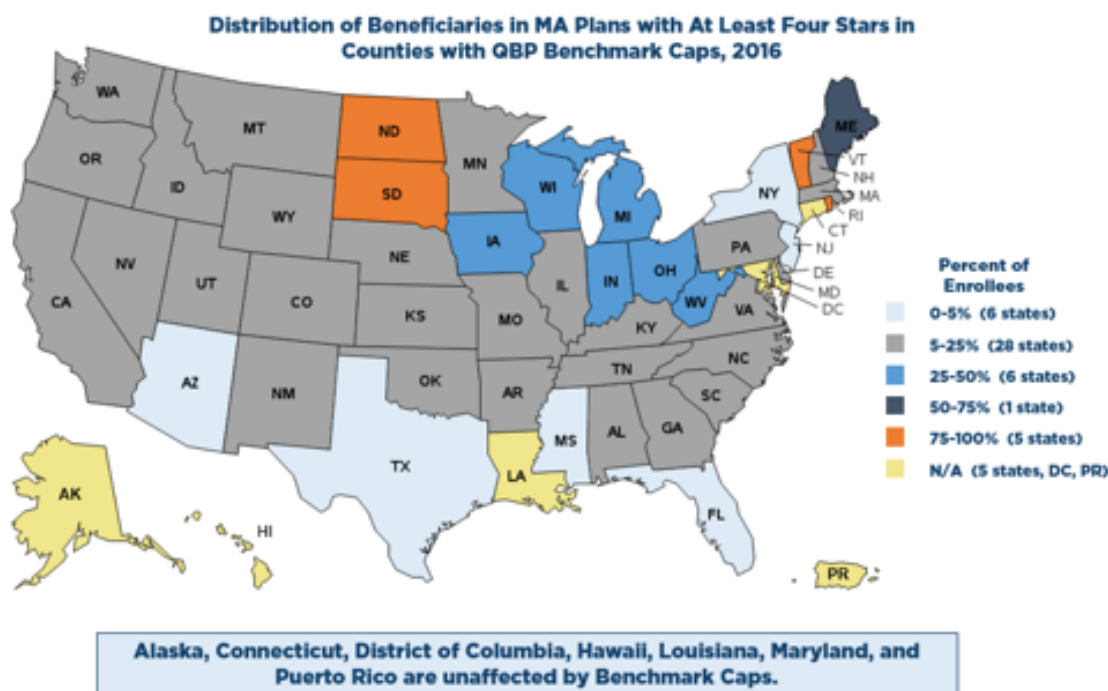
Source: CMS, [Monthly Enrollment by Contract/Plan/State/County](#), September, 2016; CMS, [Part C and D Medicare Star Ratings Data](#), 2016; CMS, [Medicare Advantage Ratebook and Prescription Drug Rate Information](#), 2016

Impact on the State Level

Some states are disproportionately impacted by the Benchmark Cap. In 11 states, at least 25% of beneficiaries in high quality MA plans with at least 4 stars are in capped counties. In Vermont, Rhode Island, South Dakota and North Dakota nearly all beneficiaries in high quality MA plans are impacted. In addition, MA plans in Iowa, Wisconsin, Michigan, Indiana, Ohio and West Virginia are disproportionately impacted. (See *Figure 5*.)

FIGURE 5

In 11 States, at Least 25% of Beneficiaries in at Least 4-Star MA Plans are in Capped Counties



Source: CMS, [Monthly Enrollment by Contract/Plan/State/County](#), September, 2016; CMS, [Part C and D Medicare Star Ratings Data](#), 2016; CMS, [Medicare Advantage Ratebook and Prescription Drug Rate Information](#), 2016

California has the most beneficiaries impacted by the Benchmark Cap with over 250,000 beneficiaries in high quality benchmark capped plans, which is 11.5% of MA beneficiaries in the state. (See *Figure 6*.) California also has three of the top ten markets affected by the Benchmark Cap. The top California markets are Sacramento, Santa Rosa and San Francisco. (See *Figure 7*.) Pennsylvania, Ohio, Michigan, and Wisconsin all have over 100,000 beneficiaries impacted. While Rhode Island has over 60,000 beneficiaries impacted, the number equates to 82.2% of the MA beneficiaries in the state. (See *Figure 6*.)

FIGURE 6

California has the Most Enrollees Impacted by the Benchmark Cap

State	Number of Enrollees in MA Plans with at Least Four Stars Where County Benchmark is Capped	Percent of Total MA Enrollees in State
CA	260,556	11.5%
PA	215,193	21.1%
OH	212,451	28.6%
MI	167,495	26.8%
WI	137,286	37.9%
NC	131,026	23.8%
IN	88,372	31.4%
TN	85,661	19.3%
IL	85,171	21.0%
RI	60,205	82.2%

Source: CMS, [Monthly Enrollment by Contract/Plan/State/County](#), September, 2016; CMS, [Part C and D Medicare Star Ratings Data](#), 2016; CMS, [Medicare Advantage Ratebook and Prescription Drug Rate Information](#), 2016

FIGURE 7

California has Three of the Top Ten Markets Impacted by the Benchmark Cap

Market Area	Number of Enrollees in MA Plans with at Least Four Stars Where County Benchmark is Capped	Percent of Total MA Enrollees in State
Sacramento, CA	154,601	89.1%
Providence, RI	79,059	85.8%
Milwaukee, WI	56,519	50.6%
Winston, NC	47,606	69.4%
Detroit, MI	47,007	18.9%
Santa Rosa, CA	41,896	100.0%
San Francisco, CA	41,610	13.9%
Harrisburg, PA	39,692	83.7%
Cleveland, OH	39,292	30.9%
Canton, OH	28,569	72.5%

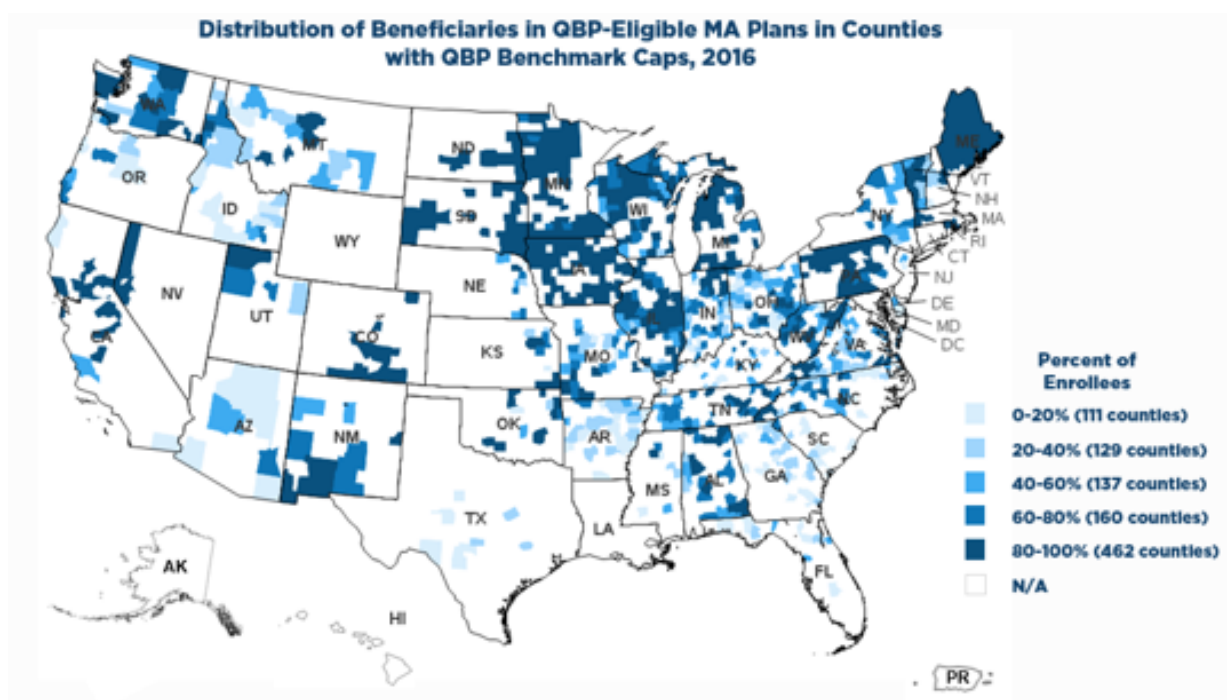
Source: CMS, [Monthly Enrollment by Contract/Plan/State/County](#), September, 2016; CMS, [Part C and D Medicare Star Ratings Data](#), 2016; CMS, [Medicare Advantage Ratebook and Prescription Drug Rate Information](#), 2016

Impact on the County Level

MedPAC has recommended eliminating or limiting the Benchmark Cap because the policy results in an unequal cut to quality incentive payments in some counties.¹¹ In nearly 500 counties across the U.S., 80% of beneficiaries in plans with 4+ stars are negatively impacted by the Benchmark Cap. In over 750 counties, 40% or more beneficiaries are negatively impacted by the Benchmark Cap. (See Figure 8.)

FIGURE 8

In 462 Counties, at Least 80% of Beneficiaries in MA Plans with at Least 4 Stars are Impacted by the Benchmark Cap



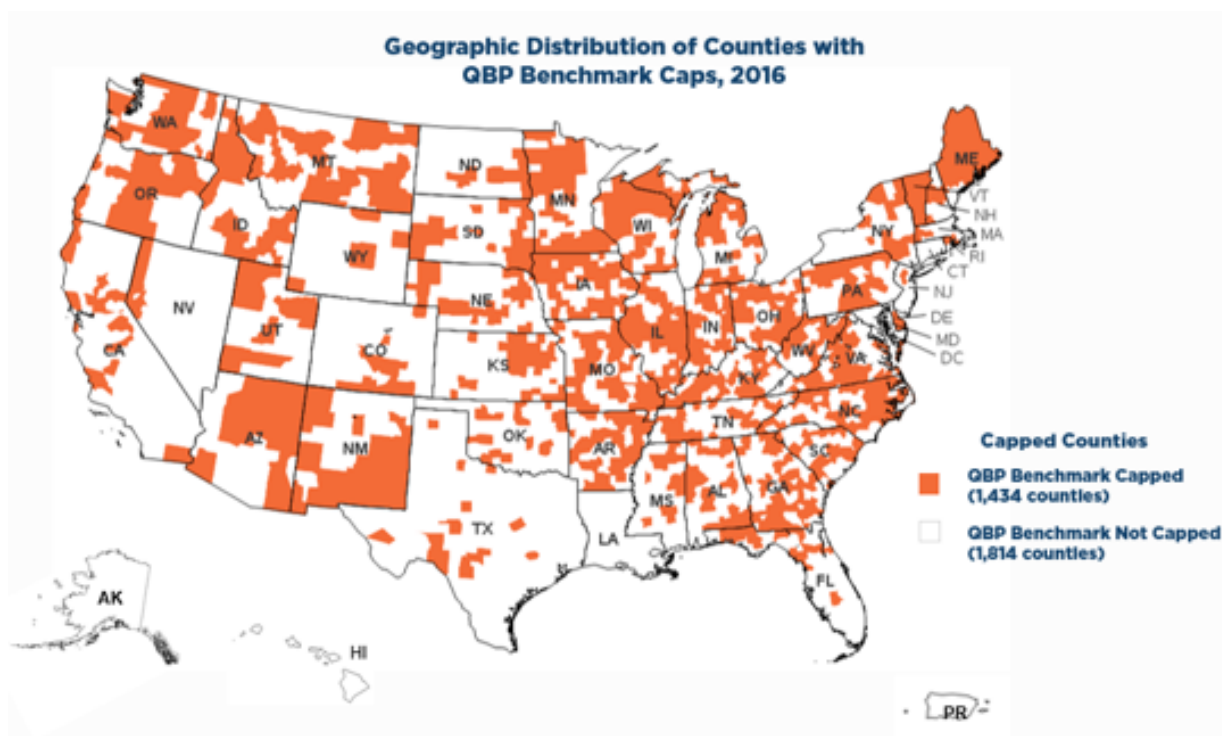
Source: CMS, [Monthly Enrollment by Contract/Plan/State/County](#), September, 2016; CMS, [Part C and D Medicare Star Ratings Data](#), 2016; CMS, [Medicare Advantage Ratebook and Prescription Drug Rate Information](#), 2016

In 2016, 5-star rates have been capped in about 40 percent of all counties in the U.S. Out of roughly 3,000 counties, over 1,400 counties experience the 5-star Benchmark Cap. The vast majority of states in the U.S. have 5-star contracts impacted by the Benchmark Cap. (See *Figure 9*.) Seven of the top ten counties impacted by the Benchmark Cap are in California and Ohio.

Sacramento County in California has over 100,000 beneficiaries impacted and San Mateo County, California has over 40,000 beneficiaries impacted. Additionally, in Cuyahoga County, Ohio over nearly 40,000 beneficiaries are impacted, Hamilton County, Ohio has nearly 30,000 beneficiaries impacted, and Stark County, Ohio has over 25,000 beneficiaries impacted. (See *Figure 10*.)

FIGURE 9

5 Star Rates are Capped in Roughly 40% Percent of Counties



Source: CMS, [Monthly Enrollment by Contract/Plan/State/County](#), September, 2016; CMS, [Part C and D Medicare Star Ratings Data](#), 2016; CMS, [Medicare Advantage Ratebook and Prescription Drug Rate Information](#), 2016

FIGURE 10

Seven of the Top Ten Counties Impacted by the Benchmark Cap are in California and Ohio

County	Number of Enrollees in MA Plans with at Least Four Stars Where County Benchmark is Capped	Percent of Total MA Enrollees in State
Sacramento, CA	107,783	94.9%
Milwaukee, WI	56,519	87.3%
Macomb, MI	47,007	90.7%
Providence, RI	41,984	100.0%
Sonoma, CA	41,896	100.0%
San Mateo, CA	41,610	96.6%
Cuyahoga, OH	39,692	52.0%
Placer, CA	35,244	100.0%
Hamilton, OH	27,900	57.6%
Stark, OH	26,677	72.2%

Source: CMS, [Monthly Enrollment by Contract/Plan/State/County](#), September, 2016; CMS, [Part C and D Medicare Star Ratings Data](#), 2016; CMS, [Medicare Advantage Ratebook and Prescription Drug Rate Information](#), 2016

Ways to Address Benchmark Cap Issue

CMS has stated “we appreciate the concerns” about the Benchmark Cap reducing or eliminating the value of quality incentives for 4+star plans. However, despite legal arguments that CMS has the regulatory authority to address the issue, CMS has denied discretion to waive the cap based on interpretation of the ACA.¹² As long as CMS maintains the inability to overturn the current policy, the Benchmark Cap must be addressed by a change in law. Legislative attempts have been made to address this policy issue. On June 17, 2015 the House passed H.R.2570, the Strengthening Medicare Advantage through Innovation and Transparency for Seniors of 2015. The bill expressed the sense of Congress that HHS could address the Benchmark Cap issue. The bill was non-controversial and passed by voice vote.¹³ Additionally, a bipartisan bill, H.R. 4275, the Medicare Advantage Quality Payment Relief Act of 2015 has been introduced in the House to disaggregate QBP from the benchmark cap calculation.

There is broad support in the Administration, Congress, and MedPAC to address the Benchmark Cap by lifting the cap completely, and at a minimum, removing the cap for 4-star or higher rated plans to ensure they receive their QBPs.¹⁴ The Administrations FY2017 budget supported “lifting the cap on benchmarks for plans that are entitled to receive a quality bonus payment.”¹⁵

Support to lift or mitigate the impact of the Benchmark Cap on QBPs continues to grow. Proposals to address the issue include continuing to urge the HHS Secretary to administratively address the Benchmark Caps by removing QPBs from the benchmark calculation or waiving the cap. Congress could also continue to urge CMS to apply the QPBs without the consideration of the benchmark cap or enact a law to clarify the statute.

The Benchmark Cap undermines the goals of moving payment incentives towards quality and value in MA and the Medicare program more broadly. Over two million MA beneficiaries are negatively impacted by the Benchmark Cap in the form of increased cost-sharing and decreased benefits. The impact on beneficiaries is unequal and states like California, Pennsylvania and Ohio are disproportionately impacted. It’s important that beneficiaries receive the high quality benefits and low cost sharing over 18 million beneficiaries have come to expect from MA. The negative impacts of the Benchmark Cap should be addressed to preserve the goal of incentivizing quality and value in Medicare.

Methodology

All data and figures prepared by Avalere Health for Better Medicare Alliance (September 2016) unless otherwise noted.

¹ CMS 2016 Star Rating data, 2015

² CMS, [Monthly Enrollment by Contract/Plan/State/County](#), September, 2016; CMS, [Part C and D Medicare Star Ratings Data](#), 2016; CMS, [Medicare Advantage Ratebook and Prescription Drug Rate Information](#), 2016

³ CMS, [Monthly Enrollment by Contract/Plan/State/County](#), September, 2016; CMS, [Part C and D Medicare Star Ratings Data](#), 2016; CMS, [Medicare Advantage Ratebook and Prescription Drug Rate Information](#), 2016

⁴ HHS FY 2017 Budget in Brief - CMS - Medicare. [HHS.gov](#). Web; MedPAC, [Medicare Advantage Benchmarks](#). Harrison, Scott. Oct. 8, 2015. Web; H.R.2570, [Strengthening Medicare Advantage Through Innovation and Transparency for Seniors of 2015](#). Web.

⁵ MedPAC, [Medicare Advantage Program Payment System](#). Oct. 2014. Web.

⁶ CMS, [Monthly Enrollment by Contract/Plan/State/County](#), September, 2016; CMS, [Part C and D Medicare Star Ratings Data](#), 2016; CMS, [Medicare Advantage Ratebook and Prescription Drug Rate Information](#), 2016

⁷ CMS, [Monthly Enrollment by Contract/Plan/State/County](#), September, 2016; CMS, [Part C and D Medicare Star Ratings Data](#), 2016; CMS, [Medicare Advantage Ratebook and Prescription Drug Rate Information](#), 2016

⁸ MedPAC, [Report to the Congress: Medicare Payment Policy](#). March 2016. Web.

⁹ CMS, [2016 Star Rating Data](#), 2015. Web.

¹⁰ MedPAC, [Report to the Congress: Medicare Payment Policy](#). March 2016. Web.

¹¹ MedPAC, [Medicare Advantage Benchmarks](#). Harrison, Scott. Oct. 8, 2015. Web.

¹² CMS 2016 Announcement, [Calendar Year \(CY\) 2017 Medicare Advantage Capitation Rates and Final Call Letter](#), April 4, 2016. Page 21. Web.

¹³ [Strengthening Medicare Advantage Through Innovation and Transparency for Seniors of 2015](#). Web.

¹⁴ HHS FY 2017 Budget in Brief - CMS - Medicare. [HHS.gov](#). Web; MedPAC, [Medicare Advantage Benchmarks](#). Harrison, Scott. Oct. 8, 2015. Web; H.R.2570, [Strengthening Medicare Advantage Through Innovation and Transparency for Seniors of 2015](#). Web.

¹⁵ Fiscal Year 2017, U.S. Department of Health & Human Services, [Budget in Brief](#). Web.