
HMA

HEALTH MANAGEMENT ASSOCIATES

*End-Stage Renal Disease
and
Medicare Advantage*

PREPARED FOR
ANTHEM PUBLIC POLICY INSTITUTE

BY
HEALTH MANAGEMENT ASSOCIATES

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Executive Summary

The 21st Century Cures Act included a provision that alters the enrollment options for Medicare beneficiaries with End-Stage Renal Disease (ESRD). Starting in 2021, individuals with ESRD will be able to enroll in any Medicare Advantage (MA) plan in their area, like all other Medicare beneficiaries.

Over the past several years, MA plans have noted that the current payment mechanism for ESRD beneficiaries used by the Centers for Medicare & Medicaid Services (CMS) may not appropriately reflect the costs for these enrollees.¹ In particular, the use of a statewide average payment amount for ESRD may not appropriately reflect the local costs of care; and the effect of the statutorily-required maximum out-of-pocket (MOOP) on ESRD spending results in higher plan liabilities than the costs borne by the Traditional Fee-for-Service (FFS) Medicare program.

The Anthem Public Policy Institute engaged Health Management Associates to explore these issues and identify any possible modifications that either CMS or Congress could make to more closely align payment with costs.

Based on our evaluation, we have identified the following:

- **Issue 1: Maximum Out-of-Pocket (MOOP)**—The effect of the MOOP on ESRD spending increases MA costs by approximately 8-9% on average compared to FFS spending.
 - **Policy Consideration:** CMS or Congress should alter the methodology for calculating ESRD benchmarks to reflect the impact of the statutorily-required MOOP.
- **Issue 2: Regional versus State Spending**—Costs for ESRD enrollees vary significantly within a single state, including different growth rates by market.
 - **Policy Consideration:** CMS should use its current authority to set ESRD benchmarks at more localized geographic areas, to align costs with MA payments.

¹ Centers for Medicare & Medicaid Services. “Announcement of Calendar Year 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter”. April 1, 2019.

Medicare Advantage Payment Overview

Medicare Advantage plans receive a fixed payment per member per month to cover all Medicare services. For most enrollees, this payment is determined in advance and generally reflects four components: the plan bid, the local area benchmark, the rebate, and the risk score. These components are briefly described below.

1. The plan bid represents the estimated cost to the health plan of offering the exact same services as FFS.
2. The local area benchmark represents the maximum amount that CMS will pay a plan to provide the exact same services as FFS in an area. The benchmark varies as a percentage of local FFS spending, with higher percentages applied to areas with lower absolute FFS costs. In addition, benchmarks are increased for plans with high performance in the MA Stars program.
3. The rebate is a percentage of the difference between the plan bid and the benchmark, provided the plan has bid below the benchmark. This rebate percentage varies depending on the Star Rating of the health plan. The rebate must be used by the plan to offer additional benefits to enrollees, such as reduced co-pays or supplemental benefits.
4. The risk score is beneficiary-specific and is measured by the CMS Hierarchical Condition Category (HCC) risk model. The CMS-HCC model accounts for spending variation caused by age, gender, dual eligibility status, and 86 medical condition categories such as diabetes, dementia, multiple sclerosis, congestive heart failure, and chronic kidney disease.

The payment to MA plans for enrollees with ESRD is structured differently. Plans do not submit a bid with the estimated costs for ESRD enrollment. Instead, CMS calculates a state-level benchmark that represents the average statewide FFS spending on FFS enrollees with ESRD. The ESRD benchmark is not adjusted based on the quality (i.e., the Star Rating) of the health plan. Plans receive the state-level benchmark for each enrollee as the base payment, adjusted by an ESRD-specific version of the HCC risk model. If a health plan believes the average ESRD enrollee will cost more than the state-level benchmark, the plan must use its rebate dollars or additional premiums to cover the additional costs.

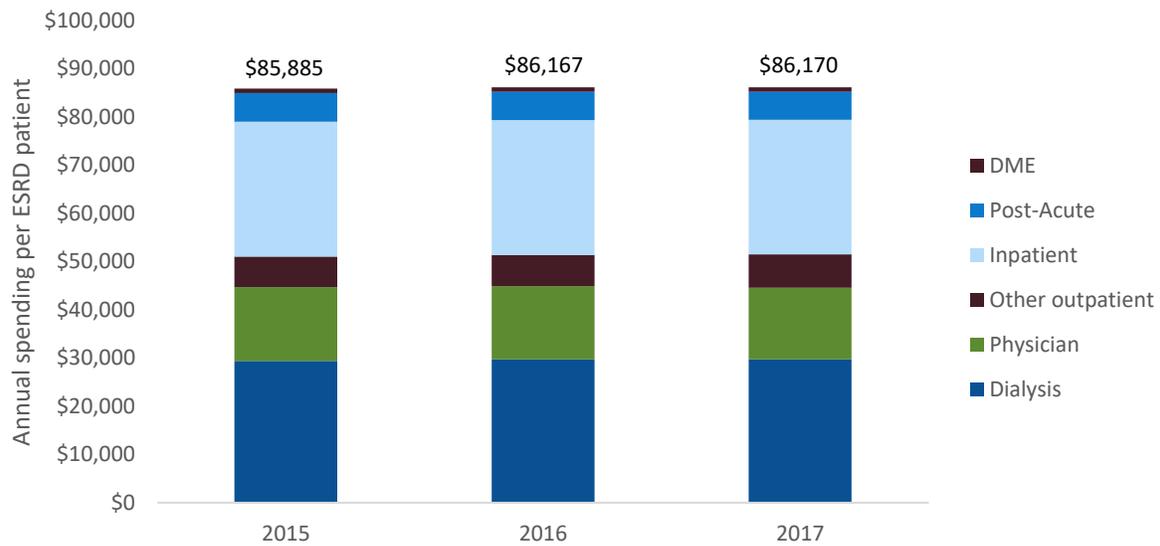
ESRD Total Cost of Care

Individuals with ESRD have significantly higher total healthcare costs compared to an average Medicare beneficiary. People with ESRD require outpatient dialysis treatment a minimum of three times per week in order to address the health issues related to failed kidneys. In addition, the average individual with ESRD has 1.7 inpatient hospital stays per year as well as 3.0 visits to the emergency room per year.²

Based on an analysis of the 2015-2017 FFS claims data, we estimate that the average total spending for a Medicare FFS beneficiary with ESRD was \$86,000 per year (see Figure 1). Of that amount, nearly \$30,000 (35%) was for outpatient dialysis, \$28,000 (32%) was for inpatient hospital care, and \$15,000 (17%) was for physician services. The beneficiary was responsible for approximately \$13,000 (15%) of the total cost.

² United States Renal Data System (USRDS). 2018 Annual Data Report, Volume 2: End-Stage Renal Disease in the United State, Chapter 4.

Figure 1: Annual FFS Spending on Medicare Beneficiaries with ESRD, 2015-2017

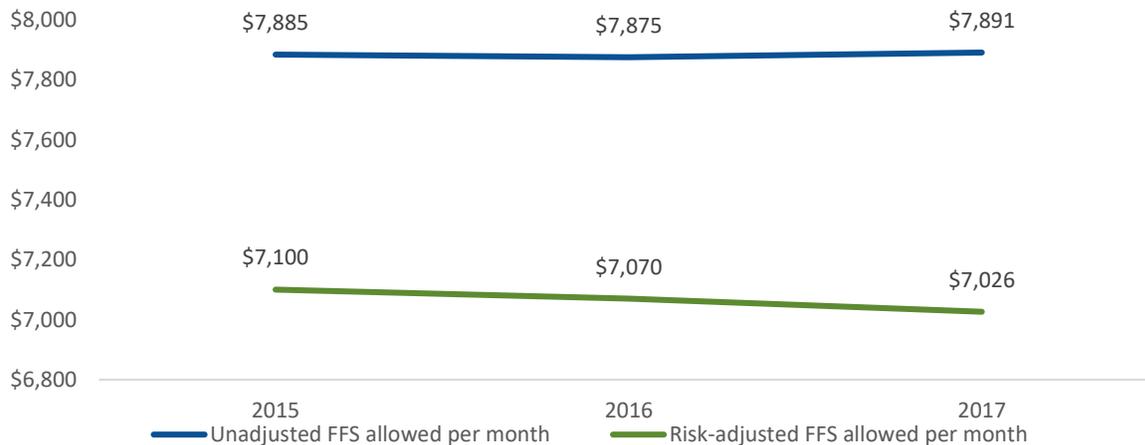


Source: HMA analysis of Medicare 2015-2017 5% Limited Data Set

When CMS calculates the benchmarks used to determine payment for enrollees with ESRD in MA plans, it uses actual state-level FFS spending for Medicare beneficiaries with ESRD. Those spending amounts are adjusted, using the ESRD HCC model, to remove variation in payment caused by known patient factors³ and compute a benchmark that reflects spending for an average beneficiary.

As shown in Figure 2, while actual FFS spending per ESRD beneficiary per month has increased 0.1% per year between 2015 and 2017, risk-adjusted spending per month has declined 0.3% per year over the same time frame. This difference was caused by a 0.4% increase per year in the average risk score of ESRD enrollees in the FFS program.

Figure 2: Unadjusted and Risk-Adjusted FFS Spending on ESRD Per Beneficiary Per Month, 2015-2017



Source: HMA analysis of Medicare 2015-2017 5% Limited Data Set

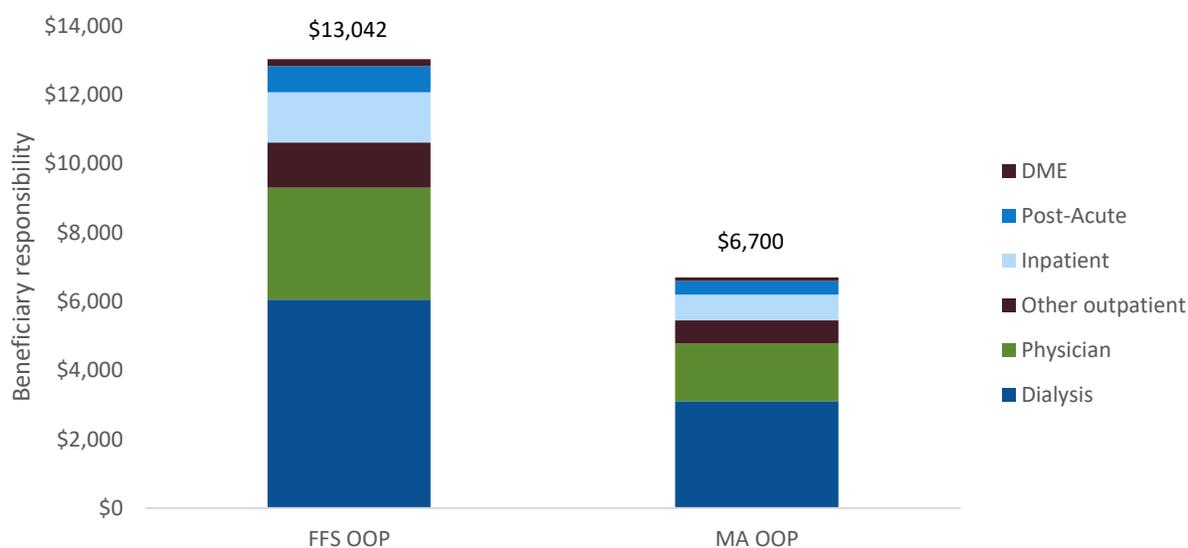
³ CMS currently uses the same set of medical conditions in the ESRD HCC model as the non-ESRD HMCC model to estimate the incremental cost of care, but applies separate factors to each condition in each model.

Issue 1: Medicare Advantage Maximum Out-of-Pocket

Medicare Advantage plans are required to implement a maximum out-of-pocket (MOOP) for all enrollees.⁴ In 2020, the MOOP for in-network services is \$6,700.⁵ MA plans may have a lower MOOP for their enrollees, or may lower cost-sharing amounts for specific sets of services which could reduce the costs borne by members.

For most individuals with ESRD with FFS coverage, the average annual OOP responsibility is approximately \$13,000. Notably, many patients do not pay this amount directly, due to secondary coverage from Medicaid, Medigap, or an employer retiree plan. Regardless, there exists a subset of ESRD enrollees who are liable for the entire OOP costs, often due to lack of eligibility for supplemental coverage options.

Figure 3: ESRD Beneficiary Out-of-Pocket Responsibility, FFS vs MA



Source: HMA analysis of Medicare 2015-2017 5% Limited Data Set

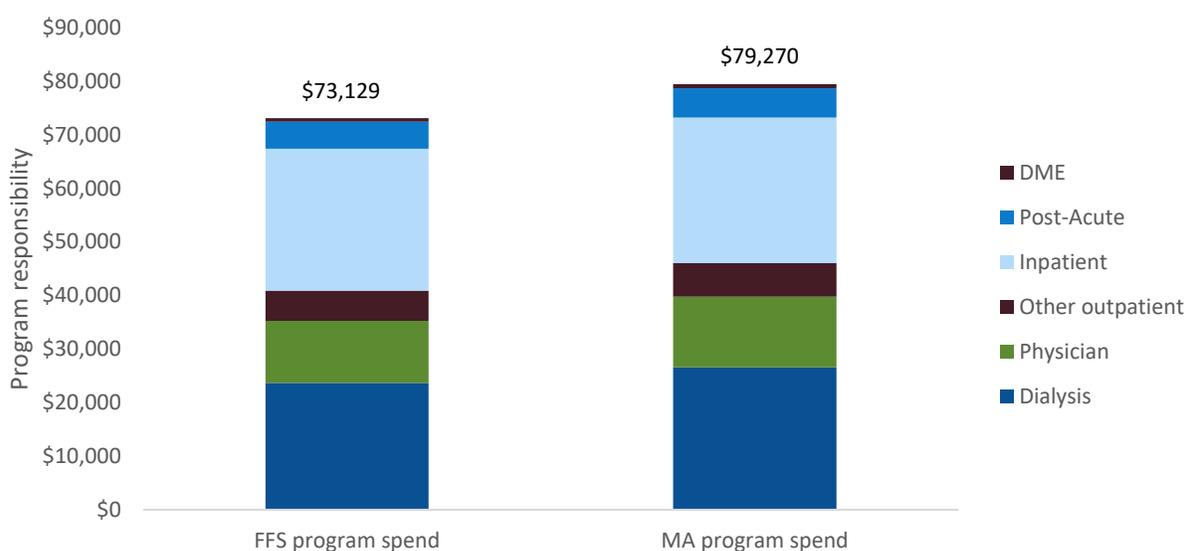
While the MA MOOP provides financial protection for enrollees, it increases the costs to the MA plan. Given the consistently-high spending needs of individuals with ESRD, an MA plan must include the \$6,300 difference between the FFS OOP and MA MOOP as part of its expense estimates.

CMS does not adjust the ESRD state-level benchmarks to reflect the higher expected costs for MA plans due to the MOOP requirement. Per statute, MA benchmarks reflect the costs paid by the federal government under the FFS program, which exclude any beneficiary responsibility amounts.⁶ As a result, the average ESRD benchmark, based on FFS program spending, is approximately 8-9% lower than the minimum amount an MA plan would need to spend, assuming equivalent total costs for the enrollee.

⁴ 42 CFR 422.100(f)(4)

⁵ Centers for Medicare & Medicaid Services. "Announcement of Calendar Year 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter". April 1, 2019.

⁶ 42 CFR 422.258(d)(2)

Figure 4: FFS vs MA Program Spend for Individuals with ESRD

Source: HMA analysis of Medicare 2015-2017 5% Limited Data Set

CMS recently proposed to modify the calculation of the MOOP to address the higher costs of ESRD enrollees compared to non-ESRD enrollees.⁷ This adjustment will be phased-in over the next several years, in order to minimize the overall increase expected in the MOOP and the impact it could have on plan enrollees. While this adjustment may help reduce the program payment differences shown in Figure 4, it does not eliminate the difference and MA plans will likely continue to be responsible for consistently higher costs than the amount determined by the current ESRD benchmark methodology.

Policy Consideration, Issue 1

CMS or Congress should identify ways to account for the higher ESRD spending requirement for MA plans due to the MOOP. An adjustment could be made by a re-estimation of FFS costs for ESRD enrollees after application of the MA MOOP for the year. While it is unclear if CMS has statutory authority to implement such an adjustment on a permanent basis, it may be able to utilize its demonstration authority. A demonstration may allow CMS time to test possible modifications to the benchmarks and determine the best way to ensure reimbursement issues do not serve as a barrier to MA plan enrollment. Alternatively, Congress could instruct CMS to make this change.

Issue 2: Regional versus State ESRD Spending

CMS currently pays MA plans a statewide benchmark rate for ESRD beneficiaries, based on the FFS costs in the state. Section 1853(d)(3) of the Social Security Act (SSA) states that the payment area for ESRD “shall be a State or such other payment area as the Secretary specifies.”⁸ CMS has historically chosen to

⁷ Centers for Medicare & Medicaid Services. “Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly”. Proposed Rule. February 5, 2020.

⁸ Social Security Act, Section 1853(d)(3)

use the state-level payment area. Notably, the SSA also allows MA benchmarks to use a geographic adjustment based on metropolitan areas.⁹

We examined the average risk-adjusted Medicare per member per month (PMPM) spending for beneficiaries with ESRD in large metropolitan areas in four different states. We identified states with significant non-ESRD MA penetration levels, expecting that these markets could see the most rapid increases in ESRD enrollment starting in 2021. We also restricted our analysis to states with multiple large metropolitan areas given the limitations of our dataset.

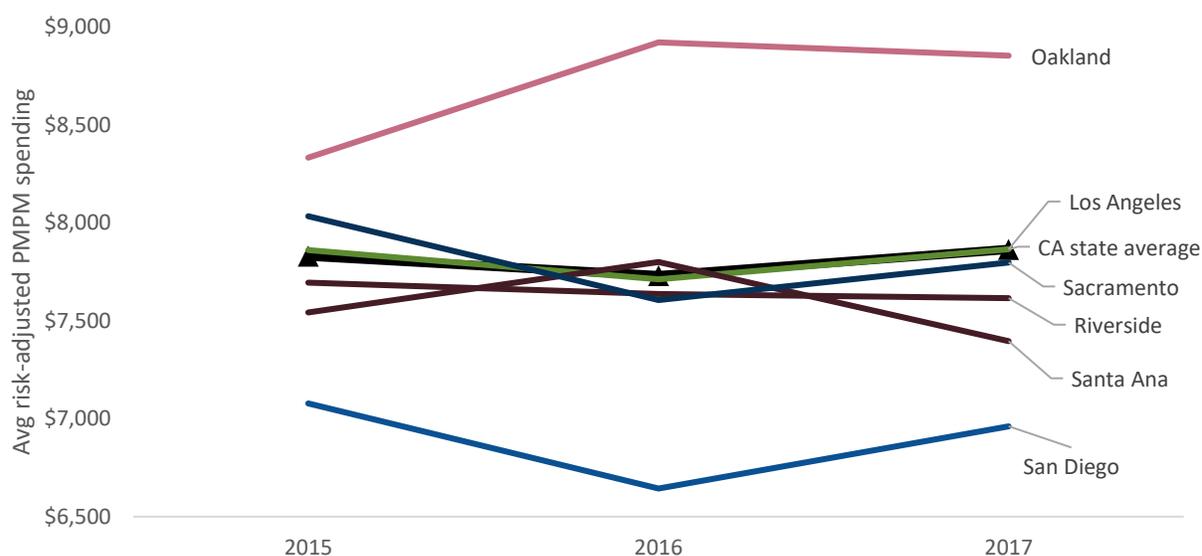
Figures 5-8 depict average FFS costs per month for Medicare beneficiaries with ESRD in four states from 2015-2017—California, Florida, Ohio, and Texas. While some metropolitan areas are significantly above the state’s average, others are significantly below. In addition, many metropolitan areas swing from above the state average to below over the course of three years, or vice versa, demonstrating the local volatility in spending that is masked by a state average.

California

The data in Figure 5 indicate that the average FFS costs in Oakland were 106% of the state average in 2015, increasing to 115% in 2016 before declining to 113% in 2017. Average FFS costs in San Diego were 90% of the state average in 2015, declining to 86% in 2016 before increasing to 89% in 2017.

Health plans in San Diego would likely have an easier time covering the costs associated with ESRD enrollees, whereas plans in Oakland may have to reduce rebate dollars to pay for the expected losses on their ESRD membership.

Figure 5: Average Medicare FFS Costs per Month for Beneficiaries with ESRD in California, 2015-2017



Source: HMA analysis of Medicare 2015-2017 5% Limited Data Set

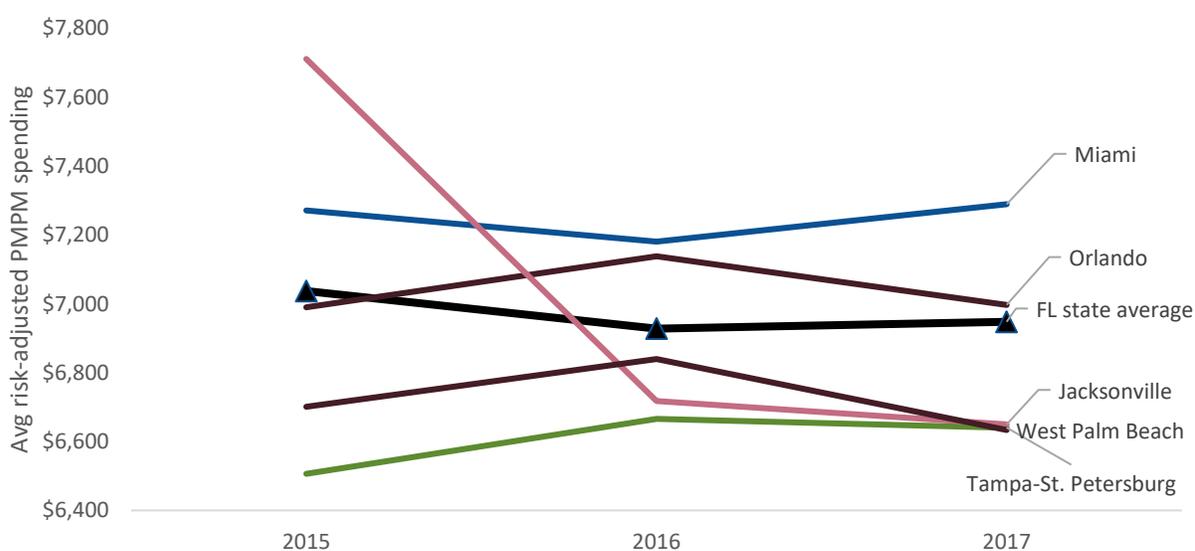
⁹ Social Security Act, Section 1853(d)(4)(C)

Florida

Figure 6 describes data from metropolitan areas in Florida. The average FFS costs in Miami were 103% of the state average in 2015, increasing to 105% in 2016 and 2017. Average FFS costs in Tampa/St. Petersburg were 93% of the state average in 2015, increasing to 96% in 2016 and 2017. Average FFS costs in Jacksonville were 110% of the state average in 2015, but then dropped significantly to 97% in 2016 and 96% in 2017.

MA plans across Florida have noticeable differences in costs for their ESRD enrollees, but all would receive the same state-level average payment. While costs in Tampa-St. Petersburg and Jacksonville were roughly equal in 2017, costs had been declining in the latter while increasing in the former, highlighting the significant geographic differences that MA plans in different regions are likely experiencing.

Figure 6: Average Medicare FFS Costs per Month for Beneficiaries with ESRD in Florida, 2015-2017

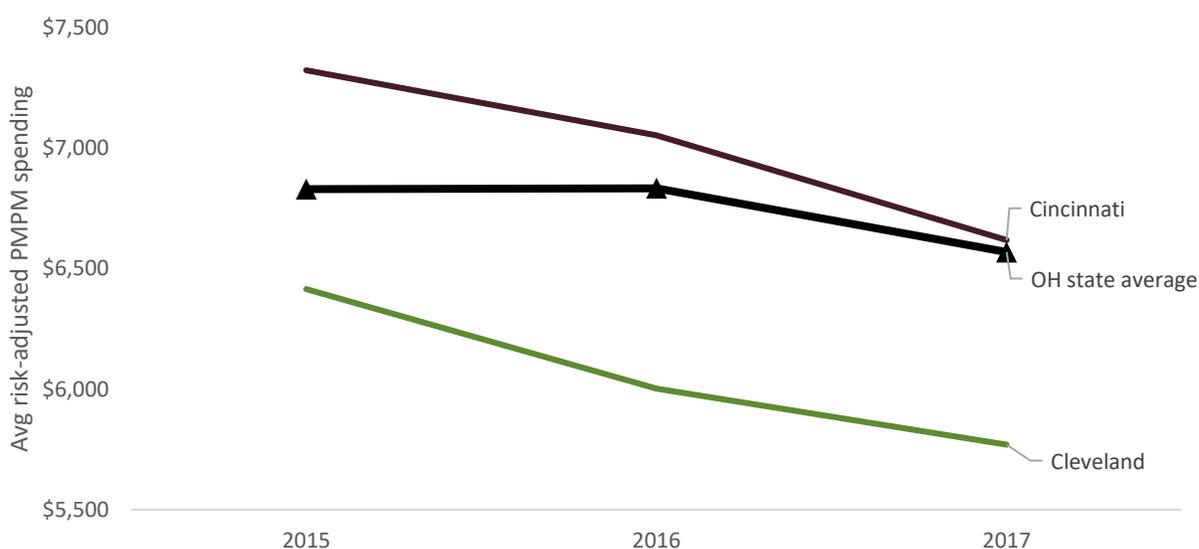


Source: HMA analysis of Medicare 2015-2017 5% Limited Data Set

Ohio

The data in Figure 7 indicate that the average FFS costs for ESRD beneficiaries in Cleveland -- the largest metropolitan area in the state -- was 94% of the state average in 2015, declining to 88% in 2016 and 2017. Average FFS costs in Cincinnati were 107% of the state average in 2015, dropping to 103% in 2016 and 101% in 2017.

Both the Cleveland and Cincinnati markets saw a decline in actual costs by nearly 10% between 2015 and 2017, while the overall Ohio average only declined by 4%. This suggests some of the smaller, more rural areas of Ohio had FFS costs for ESRD enrollees that may have increased, again demonstrating the significant disparities in cost patterns across a single state.

Figure 7: Average Medicare FFS Costs per Month for Beneficiaries with ESRD in Ohio, 2015-2017

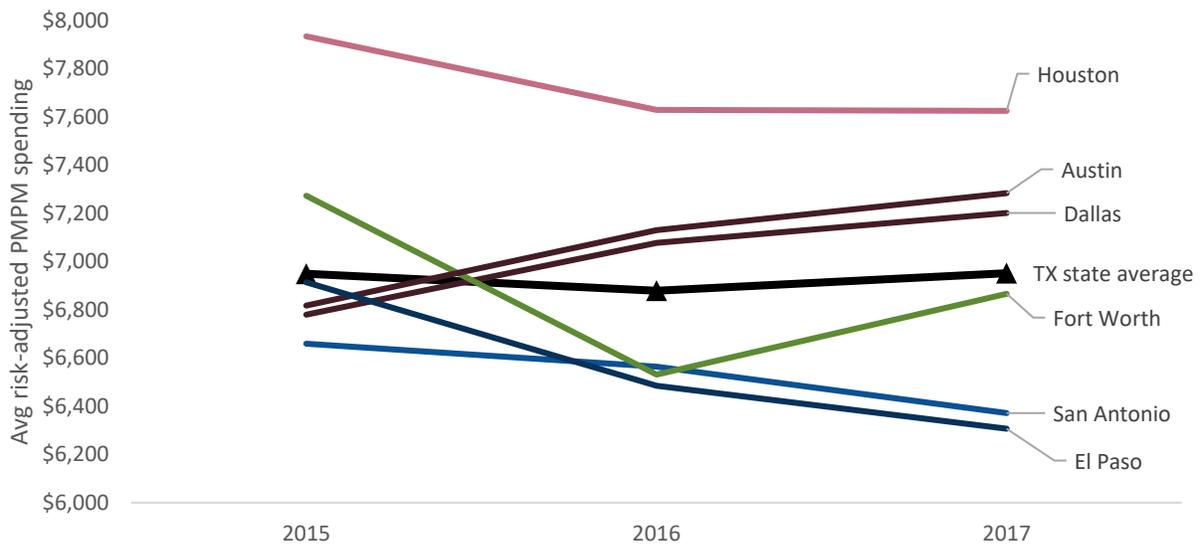
Source: HMA analysis of Medicare 2015-2017 5% Limited Data Set

Texas

Figure 8 describes data from metropolitan areas in Texas. Houston had average FFS costs for ESRD beneficiaries which were 114% of the state average in 2015, declining to 111% in 2016 and 110% in 2017. Average FFS costs in San Antonio were 96% of the state average in 2015, dropping to 95% in 2016 and 92% in 2017.

Three metropolitan regions in Texas (Dallas, Fort Worth, and Austin) shifted from below to above the state average (or vice versa) during these three years. Spending in Dallas and Austin increased significantly over the three years of the analysis, while the overall state average spending was generally the same for all three years. Fort Worth went from 105% of the state average in 2015 to 95% of the state average in 2016, before reaching 99% of the state average in 2017.

The spending patterns across metropolitan areas in Texas provides one of the starkest examples of the potential geographic payment disparity. If a plan had a service area that stretched across the entire state, it might face average costs for ESRD beneficiaries that matched the MA benchmark. However, many plans have more localized coverage areas, in order to better address the needs of Medicare beneficiaries. These local plans must account for the local costs of their ESRD enrollees, which can vary significantly compare to the state average.

Figure 8: Average Medicare FFS Costs per Month for Beneficiaries with ESRD in Texas, 2015-2017

Source: HMA analysis of Medicare 2015-2017 5% Limited Data Set

Policy Consideration, Issue 2

Given the variation in spending across metropolitan areas in a single state, CMS should consider modifying the ESRD benchmark calculation to represent more localized areas. County-level estimates, like those created for the non-ESRD benchmarks, may not be feasible due to the small number of ESRD enrollees in many counties. Based on our analysis, metropolitan-level estimates appear feasible to develop, and may be an option given the current allowances in the SSA. We note this modification should not result in an overall increase or decrease in expected payments to MA plans for ESRD enrollees, but instead ensure that the payments are better matched to the expected spending in the area.

Conclusion

The number of Medicare beneficiaries with ESRD enrolled in MA plans is expected to increase starting in 2021. As demonstrated in our analysis, there are several aspects of the process used to set MA payment rates for ESRD beneficiaries that may create payment inaccuracies. CMS or Congress may wish to address these items in advance, to ensure ESRD beneficiaries can enroll in MA plans as envisioned in the 21st Century Cures Act.