

MEMORANDUM

To: Kim Gifford
Diane Mossholder
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From: Diane Millman
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Re: Renal Transplantation and Medicare Advantage Plans

Date: January 5, 2018

ESRD patients are currently eligible to receive benefits through Medicare Advantage (MA) only if they are enrolled in a MA Plan at the time they develop ESRD or if they choose to enroll in a MA Special Needs Plan. However, the 21st Century Cures Act expanded the eligibility of those with ESRD to enroll in MA Plans, and the PATIENTS Act would make the MA capitated payment rate methodology applicable to participating “Organizations” (i.e. large dialysis organizations). For this reason, we thought it might be useful to take a deeper dive into the methodology that is used to establish MA capitation rates for ESRD and for MA enrollees with CKD.

How are MA Organization Capitated Rates Established?

MAOs are currently paid under a methodology initially established by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and modified by the ACA., Medicare Advantage Organizations (MAOs) submit bids to the Medicare program, with bids representing the MAO’s estimate of the amount it would cost to provide the Part A and Part B benefit package to enrollees of average health. Each bid is compared to a payment area’s benchmark (or “Specified Amount”). When the plan bid exceeds the benchmark, the plan is required to charge a member premium for the amount by which the bid exceeds the benchmark. When a plan bid is below the benchmark, the plan retains 75 percent of the difference between the bid and benchmark, or the “beneficiary rebate amount,” which the plan must use to pay for additional benefits not covered under FFS or to buy-down premiums. Actual payment is determined based on a number of complex payment adjustments, the type of MA Plan involved, and a number of other factors.

CMS uses a different methodology to determine the rates for ESRD and non-ESRD (“age-disabled”) Medicare enrollees. For most Medicare enrollees (including those with CKD who are not on dialysis) the benchmark is determined based on the FFS costs in the county. However, a different—and substantially

higher --ESRD rate is calculated separately based on based on statewide fee for service data for Medicare beneficiaries on dialysis. All of these rates are published annually in a rate book

The differential in the capitated rates for age-disabled and ESRD enrollees is significant: For example, for 2018, the ESRD capitated rates fall within the range of \$6,000-\$8,000 per month while the monthly capitated rates for the age-disabled generally fall in the range of \$800-\$900 per month. This payment differential likely accounts for the interest of large dialysis organizations in basing payment on the MA methodology, under the PATIENTS Act.

This substantially higher ESRD rate is also paid for the months surrounding transplantation. In addition, CMS pays for the high one-time cost of a transplant by making payments over three months to cover the costs for the transplant and the immediate subsequent services. To estimate the “transplant factors” for the month of the transplant and the two following months, CMS uses fee-for-service expenditures in these three months (based on statewide data) and attributes 50% of the costs to the first month, and half of the remaining costs to each of the second and third months following the transplant.

The ESRD rate is not used as the basis for payment for post-transplant (functioning graft) Medicare enrollees. CMS defines these enrollees as those who received a kidney transplant at least three months before the payment month and have not returned to dialysis status since the transplant. While the capitated payment rates paid for post-transplant (functioning graft) ESRD enrollees takes into account the extra costs of immunosuppressive drugs and higher intensity of care for this group, the ESRD capitated rate is not used as a basis for payment for this group: Rather, payment is made based on the much lower capitated payment rate applicable to “age-disabled” enrollees (with appropriate risk and other adjustments). Different rate adjustments are made for months 4-9 after a transplant, and for months 10 onward.

It is thought that risk adjusting payment by ESRD treatment status avoids problematic incentives in specialty MA plans for ESRD beneficiaries. Without adequate risk adjustment, plans might enroll lower-cost functioning graft patients and avoid higher-cost dialysis patients. On the other hand, to the extent that specialty MA plans are successful in reducing the costs of Medicare patients on dialysis—and the data suggests that better care coordination can indeed result in considerable cost savings—it is also possible that this risk adjustment methodology creates a disincentive for specialty MA plans to transplant ESRD enrollees, since the considerably higher ESRD capitated rate will become inapplicable beginning four months post transplant (assuming that the transplant is successful.)

The 21st Century Cures legislation requires the ESRD capitated rate methodology to be reevaluated. In its December 27, 2017 “Call Letter” to MAOs, CMS announced its intent to complete that evaluation by December 2018, stating:

The 21st Century Cures Act also requires CMS to evaluate the risk adjustment model, including the ESRD model. This initial evaluation, required to be completed by December 31st, 2018, will include a discussion of the model criteria that CMS uses to develop models and to determine incremental changes. . . .As part of this effort, we will produce a wide range of predictive ratios, for various subgroups, including very high and very low cost enrollees, groups defined by the number of chronic conditions for enrollees, and for each condition category, similar to our 2011 evaluation.

How are capitated payment rates determined for Medicare enrollees with CKD who are not on dialysis?

The MA risk adjustment system assigns a value or “risk score” to each beneficiary according to his or her age, gender, health status, and other factors. The beneficiary’s risk score reflects the person’s predicted health costs compared to those of an average beneficiary. The risk score is based on the CMS hierarchical condition categories (CMS-HCC) model, which adjusts plan payments using diagnoses recorded on both inpatient and outpatient claims for a prior period. Each CMS-HCC category is assigned a weight, based in part on the cost of treating the same condition in a FFS beneficiary. For beneficiaries with multiple diagnoses, the weight for each condition is added together to determine the risk score. Risk adjustment payments are approximately proportional to risk score. The CMS-HCC risk adjustment methodology is necessarily imperfect since it bases each enrollee’s risk score on his or her health status for a prior period.

While a 2011 evaluation¹ suggests that the CMS-HCC risk adjustment methodology works fairly well in predicting actual expenditures, there is considerable controversy over this proposition, and CMS has been directed by Congress to examine changes, especially for high cost enrollees. A 2016 study conducted by Avalere entitled “Analysis of the CMS-Hierarchical Condition Category Model” indicates that total under-predicted expenditures to MA plans for all members with multiple chronic conditions are about \$2.6 billion (3.3 percent of total expenditures for all members) per year. For CKD stages 1 through 3, which were removed from the CMS-HCC model in 2014, total under-predicted expenditures are about \$400 million in the 2014 model or 4 percent of total expenditures for these members. In addition, the Avalere study indicates that the model substantially under-predicts costs for the highest cost beneficiaries. Interestingly, in illustrating this point, the Avalere analysis focuses on individuals with CKD, stating:

Because health costs are highly skewed—for example, among individuals with CKD (stages 1 through 5), average costs are \$15,204, but are \$80,923 for the top 10 percent—this inaccuracy on the top end of the cost range may lead to a misalignment of payments and costs for these members (see [Table 5](#)). In fact, the under-predicted expenditures for the high cost individuals are substantial. We estimate the model under-predicts expenditures for these high cost individuals with CKD stages 1 through 5 by almost \$4 billion.

Accordingly, CMS recently proposed an adjustment to the CMS-HCC risk adjustment methodology to once again include stage 3 CKD in the CMS-HCC model effective in 2019, thereby partially addressing this issue.

Interestingly, the Avalere study suggests that the CMS-HCC model substantially under-predicts the costs of caring for MA enrollees with ESRD, it substantially over-predicts the costs of transplantation (by 15%), suggesting that the utilization of transplantation as a treatment option for ESRD for MA enrollees may be lower than predicted.

Take-Aways

This review suggests a number of important take-aways:

¹ Gregory C. Pope, MS John Kautter, PhD Melvin J. Ingber, PhD Sara Freeman, MS Rishi Sekar, BA Cordon Newhart, MA “Evaluation of the CMS-HCC Risk Adjustment Model.” RTI International CMS Contract No. HHSM-500-2005-0029I TO 0006 March 2011

- Since the current ESRD rate methodology results in capitated payments in the range of 6,000-\$8,000/month (\$72,000-\$96,000 annually), Da Vita's enthusiasm for adoption of this methodology for use under the PATIENTS Act is not surprising.
- 21st Century Cures requires that the ESRD rate methodology be reevaluated, and CMS has announced that this reevaluation will be comprehensive and will be completed by December of this year.
- The current ESRD rate methodology does provide additional payment to MA Plans for transplantation costs (based on state-wide average costs), therefore, the costs of transplantation should not deter MA plans from encouraging transplantation. On the other hand, once a Medicare enrollee is successfully transplanted, the amount paid to a MA plan drops precipitously.
- There appears to be a significant "spread" in the costs of caring for enrollees with CKD, making it particularly important that there be strong safeguards against "cherry picking" healthier patients. The PATIENTS Act gives dialysis facilities an active role in marketing the demonstration to their patients, leaving the door wide open to manipulation of patient selection. In light of the relatively high capitated rates paid for ESRD enrollees under the current methodology, any organization that can successfully weed out high cost enrollees could do extremely well.