MILLIMAN WHITE PAPER

How Medicare Advantage benchmarks differ for ESRD beneficiaries versus other Medicare beneficiaries

Catherine Murphy-Barron, MBA, FSA, MAAA
Eric A. Buzby, FSA, MAAA

The passage of the *21st Century Cures Act* expanded eligibility for Medicare Advantage plans to individuals with end-stage renal disease; however, the Medicare Advantage benchmark rate for ESRD beneficiaries is calculated using a different methodology to other beneficiaries. As ESRD beneficiaries become a larger share of a Medicare Advantage plan's total enrollment, there may be unintended revenue and cost inconsistencies for the plan. This paper examines how these two methodologies differ.

On December 13, 2016, the *21st Century Cures Act* was signed into law. The law allows patients with end-stage renal disease (ESRD) to enroll in a Medicare Advantage (MA) plan beginning with calendar year 2021 plans. Under prior law, Medicare-eligible ESRD beneficiaries were unable to enroll in an MA plan unless the beneficiary developed ESRD while enrolled in the plan and under a few other limited circumstances.[1] The 2021 Advance Notice indicates that CMS is implementing this change as prescribed by the law. In 2017, about 494,000 ESRD beneficiaries were covered under Medicare, 22% in MA plans. In comparison, about 37% of all Medicare beneficiaries are in MA plans.[2] CMS is projecting average enrollment of ESRD beneficiaries in Medicare Advantage to increase by about 41% between 2017 and 2022.[3]

According to the National Kidney Foundation, the goal of the bill allowing MA enrollment for ESRD beneficiaries was to "provide kidney patients the same freedom of choice in coverage as other Medicare beneficiaries" as MA plans may help to "reduce out-of-pocket expenses and provide access to additional benefits like transportation and dental."[4]

The MA benchmark for beneficiaries with ESRD[5] is calculated using a less refined methodology than that used for other Medicare beneficiaries and it is likely that the MA benchmark for an ESRD beneficiary in any one plan is not a true representation of the expected fee-for-service cost of providing Medicare services for that beneficiary. This paper examines the two methodologies and identifies inconsistencies. Currently, there are few beneficiaries with ESRD enrolled in MA plans so any inconsistencies are likely to have a limited, though potentially material, impact on a particular MA plan. However, as beneficiaries with ESRD become a bigger portion of an MA plan's total enrollment, any impact from these inconsistencies could be significant.

Medicare Advantage Payment Methodology

The following is a high-level description of the methodologies used by CMS to develop MA benchmarks for both the general risk pool and ESRD beneficiaries.[6] Some of the detailed adjustments have been omitted from this discussion for the sake of simplicity.

[1] CMS, Medicare Managed Care Manual Chapter 2 – Medicare Advantage Enrollment and Disenrollment https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/downloads/mc86c02.pdf, accessed February 6, 2020.
[2] CMS Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information, page 14 Part B enrollment only https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf, accessed February 6, 2020.
[3] CMS Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information, page 14 Part B enrollment only https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf, accessed February 6, 2020.
[4] National Kidney Foundation – https://www.kidney.org/sites/default/files/ESRD%20Choice%20Act.pdf, accessed February 3, 2020
[5] The MA benchmark for ESRD beneficiaries is for ESRD beneficiaries on maintenance dialysis only. ESRD beneficiaries with a functioning kidney transplant are included in the general risk pool.
[6] CMS 2021 Advance Notice https://www.cms.gov/files/document/2021-advance-notice-part-ii.pdf, accessed February 6, 2020.

GENERAL RISK POOL

For each non-ESRD, non-hospice enrollee, MA plans bid against a benchmark amount, which is calculated at the county level. The formula for calculating the benchmark is:

Minimum { [CY FFS Cost x ("Applicable Percentage" + "Quality Bonus Payment Percentage")] ; "Applicable Amount" }[7]

CY FFS Cost: The calendar year (CY) fee-for-service (FFS) cost is (1) the average cost per person for Medicare-covered services in the nation, called the US per capita cost (USPCC), times (2) the average geographic adjustment (AGA).

(1) The USPCC is equal to actual FFS claim payments repriced for the upcoming year's Medicare fee schedule and payment rules.

(2) The AGA for a county is the relative cost of that county as compared to the national average. It is calculated as the five-year rolling average of the average cost in each county relative to the national average, using the same repriced dataset used for the USPCC. The resulting AGA for each county is divided by the county's five year average risk score to normalize for the risk profile of each county's Medicare population.

Applicable Percentage: To determine the applicable percentage, the CY FFS cost for each county, as determined above, is ranked from highest cost to lowest cost and divided into quartiles. Each county is assigned a percentage multiplier, called the applicable percentage, based on the county's quartile ranking. The applicable percentages, ranked from highest cost counties to the lowest, are shown in the table below.[8]

Quartile	Applicable Percentage
4th (highest cost)	95.0%
3rd	100.0%
2nd	107.5%
1st (lowest cost)	115.0%

Quality Bonus Payment Percentage: Depending on the plan's quality score (its Star rating), the plan can earn an additional bonus for quality[9]. Plans with a Star rating of 4 or higher receive a 5% quality bonus payment. Plans with less than 4 Stars do not receive a bonus. This quality bonus payment is doubled if the plan's service area includes a qualifying county. Qualifying counties are generally lower cost counties.[10] Depending on the county, it is possible for a plan with a Star rating of 4 or higher to receive a benchmark up to 125% of the FFS cost (115% applicable percentage + (2 x 5% quality bonus payment)).

Applicable Amount: The benchmark, calculated based on the above formula, is capped at the Applicable Amount,[11] which is the pre-Affordable Care Act payment rate. For CY 2020, the Applicable Amount is the greater of the 2020 FFS Cost or the 2019 Applicable Amount increased by the CY2020 National Per Capita Medicare Advantage Growth Percentage. Therefore, even if a plan is eligible for a benchmark equivalent to 125% of the FFS cost, the actual benchmark may be lower than that due to the cap.

ESRD VS. GENERAL RISK POOL DIFFERENCES

CMS takes the same general approach to develop the FFS cost for beneficiaries with ESRD, based on the FFS cost (USPCC and AGA) specific to ESRD members, but with two important differences. First, the payment rates are calculated at the state level rather than by county.[12] Second, unlike the general risk pool, this FFS Cost is not adjusted for the "Applicable Percentage" or "Quality Bonus Payment Percentage.

While the methodologies used to develop the MA benchmarks for both populations generally follow the same approach the differences in the calculations which could have unintended consequences.

- ***ESRD rates are statewide rates as opposed to county-based.*** The AGA factors for ESRD beneficiaries are statewide factors rather than the county-based factors used for the general risk pool. Provider fee schedules under traditional Medicare are area-adjusted at a more granular level than the state level. The Medicare physician fee schedule has a geographic factor, called geographic practice cost index or GPCI, and the CMS inpatient DRG schedule has a wage index component that reflects differences in staff costs in different parts of the country and state. Medicare dialysis providers are paid based on a bundled payment methodology, the ESRD Prospective Payment System (PPS), which also has a wage index component and an adjustment for rural providers. Averaging the ESRD AGA factor for the MA benchmark at the state level removes any variation within the state from the benchmark rate, however, most MA plan service areas are not statewide. The result is that the statewide benchmark may not be a good representation

[7] CMS 2021 Advance Notice, page 10, IME phase out and kidney acquisition costs removed for simplicity https://www.cms.gov/files/document/2021-advance-notice-part-ii.pdf, accessed February 6, 2020.
[8] CMS 2021 Advance Notice, page 11 https://www.cms.gov/files/document/2021-advance-notice-part-ii.pdf, accessed February 6, 2020.
[9] The Star rating is calculated at the contract level which may include multiple plans.
[10] CMS 2021 Advance Notice, page 15 https://www.cms.gov/files/document/2021-advance-notice-part-ii.pdf, accessed February 6, 2020.
[11] Section 1853 (k)(1) Social Security Act https://www.ssa.gov/OP_Home/ssact/title18/1853.htm, accessed February 6, 2020.
[12] CMS 2021 Advance Notice, page 26 https://www.cms.gov/files/document/2021-advance-notice-part-ii.pdf, accessed February 6, 2020.

of the expected FFS cost for ESRD beneficiaries in the MA plan's service area depending on where within the state its ESRD beneficiaries receive their care.

- ***The MA benchmark for ESRD beneficiaries is not adjusted for the plan's quality score.*** The ESRD PPS noted above includes a quality component that rewards dialysis providers for providing quality care. This quality component is reflected in the ESRD FFS cost for those services. However, an MA plan's payment for ESRD beneficiaries, which includes non-dialysis services, does not account for the comparable metric, its Star rating.
- ***The MA benchmark for ESRD beneficiaries is not capped at the pre-ACA amount.*** The ESRD benchmark calculation does not factor in the "Applicable Percentage" which is based on pre-Affordable Care Act payment rates.
- ***ESRD historical revenue shortfall is classified as a mandatory supplemental benefit in the bid process.*** In addition to the differences in the development of the MA payment rates, the MA benchmark for ESRD beneficiaries is not treated in the same manner as the MA benchmark for non-ESRD beneficiaries in the MA bid submission. Specifically, the benefit expense for Medicare-covered benefits for ESRD beneficiaries is grossed up to reflect administration expenses and profit and then compared to the CMS revenue for these beneficiaries. Any shortfall is categorized as a mandatory supplemental benefit and funded with MA rebate dollars. This process reduces funding for ESRD beneficiaries.

Without a detailed analysis of Medicare claims for ESRD beneficiaries by county within each State it is hard to determine whether these discrepancies could create an advantage or disadvantage to any particular MA plan. However, it is likely that the MA benchmark for an ESRD beneficiary in any one plan is not a true representation of the expected FFS cost of providing Medicare services for that beneficiary. Currently, the number of ESRD beneficiaries in any given plan is small, though ESRD beneficiaries incur significantly larger expenses than non-ESRD beneficiaries. As a result these discrepancies likely have a limited impact on MA plans; however, this impact will become more material as the number of ESRD beneficiaries increases.

Caveats and Limitations

This information is intended to provide considerations related to the methodology used by CMS to determine MA payment benchmarks for Medicare beneficiaries, including ESRD beneficiaries. This information may not be appropriate, and should not be used, for other purposes. Milliman does not intend to benefit and assumes no duty of liability to parties who receive this information. Any recipient of this information should engage qualified professionals for advice appropriate to its own specific needs.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Catherine Murphy-Barron and Eric Buzby are members of the American Academy of Actuaries and meet the qualification standards for sharing the information in this paper. To the best of our knowledge and belief, this information is complete and accurate. We relied on the Centers for Medicare and Medicaid Services for select information contained in this paper.

This paper is an update to a paper published in September 2017. The original paper was sponsored by the Blue Cross Blue Shield Association.

Milliman

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT
Catherine Murphy-Barron, MBA, FSA, MAAA
cathy.murphy-barron@milliman.com

Eric A. Buzby, FSA, MAAA
eric.buzby@milliman.com