CMS FACT SHEET: PROMOTING TRANSPARENCY AND APPROPRIATE COVERAGE FOR DIALYSIS PATIENTS

On August 18, 2016, the Center for Medicare and Medicaid Services (CMS) issued a request for information regarding concerns that some dialysis facilities were steering Medicare- and Medicaid-eligible patients toward individual market coverage that was often not in the patient's best interest. In response to the request for information, social workers, health plans, patients, and other stakeholders provided evidence of ongoing abuse, with adverse health and financial consequences for patients. In response, CMS is issuing an interim final rule with comment (IFC) that will require Medicare-certified dialysis facilities to disclose the risks of different coverage options to their patients, improve transparency around third-party payments of individual market premiums, and protect patients from disruptions in coverage. In addition, CMS is seeking comment on whether to take additional steps to improve disclosure, prevent mid-year disruptions of coverage, and curtail third-party premium payments.

Background: Coverage Options for Patients with End-Stage Renal Disease

End-stage renal disease (ESRD) is an irreversible and permanent kidney impairment. Patients with ESRD must either receive a kidney transplant or undergo regular treatment at dialysis facilities. CMS is charged with regulating Medicare-certified dialysis facilities to protect patients from harm.

Dialysis treatment and other health care services for people with ESRD are very expensive, with costs averaging about $100,000 per year for Medicare beneficiaries. Recognizing the challenges of including this group in the commercial health insurance market, Congress in 1972 extended Medicare coverage to ESRD patients of any age. About half of non-elderly ESRD Medicare beneficiaries are also eligible for Medicaid coverage that reduces their out-of-pocket costs.

Third-Party Premium Payments and Inappropriate Steering

In recent years, some providers and provider-funded organizations have begun offering premium assistance to ESRD patients who purchase individual market coverage. This arrangement has large financial benefits for providers, since individual market reimbursement rates for dialysis treatment are as much as four times higher than Medicare and Medicaid's, adding up to a difference of $100,000 to $200,000 or more per patient per year. This easily dwarfs the several thousand dollar cost of providing premium assistance.

In response to CMS's request for information, dialysis facility social workers and others offered evidence that some dialysis facilities are aggressively steering vulnerable patients toward individual market coverage supported by premium assistance. For example, commenters reported that some facilities encourage all patients to sign up for individual market plans, irrespective of individual circumstances; fail to provide information about the downsides of individual market coverage for these patients; fail to inform patients of eligibility for Medicare or Medicaid; or discourage patients from signing up for these programs.

Comments submitted in response to the request for information and CMS's own data suggest that inappropriate steering of patients may be accelerating over time. Between 2014 and 2015, there were large increases in the number of ESRD patients enrolled in individual market coverage, particularly in some states.

Consequences for Patients

While individual market coverage is financially beneficial for dialysis facilities, it is often not the best coverage option for patients. Steering patients toward individual market rather than Medicare or Medicaid coverage can expose them to adverse health and financial consequences, including:

- **Interference with transplant readiness.** For patients with ESRD, securing a kidney transplant can be life-saving and dramatically improve health outcomes and quality of life. But patients with individual market coverage supported by third-party premium payments have sometimes struggled to demonstrate the continuity of coverage required for transplant readiness because third-party premium support ceases when individuals no longer need dialysis treatment.

- **Additional financial exposure.** Particularly for those who could otherwise enroll in Medicaid (or would be dually enrolled in Medicare and Medicaid), enrolling in individual market coverage instead can dramatically increase out-of-pocket costs. Patients can also face higher costs from late enrollment premium penalties and higher out-of-pocket costs if they later need to sign up for Medicare coverage.

- **Mid-year coverage disruptions.** Many insurers have a policy of not accepting third-party premium payments from health care providers. The current lack of transparency in these payment arrangements means that patients can have their coverage disrupted at any time if their issuer discovers and rejects the third-party payments. Naturally, coverage disruptions and gaps in coverage are highly problematic for ESRD patients.

Today's Rule

In response to these serious problems, the interim final rule with comment would amend Medicare's dialysis facility Patient Rights Conditions for Coverage to improve disclosure requirements and improve transparency around third-party premium payments. The Conditions for Coverage are a set of baseline standards that health care suppliers must meet in order to participate in Medicare and Medicaid. The new disclosure requirements will apply to Medicare-certified dialysis facilities that make payment of premiums for individual market health plans, whether directly, through a parent organization, or through another entity.

Specifically, the new policy will help ensure that patients get the information they need to make coverage decisions that are right for them and address the lack of transparency in this market. The rule requires:

- Up-front disclosures for patients regarding their coverage options, including information about available individual market plans, Medicaid or Children's Health Insurance Program (CHIP) coverage, and available options and costs of Medicare ESRD coverage;
- A summary of short- and long-term cost estimates of various health coverage options for patients and information on enrollment periods for those health coverage options;
- That facilities inform issuers of the individual market plans for which they make payments of premiums for individual market plans; and
- That facilities receive assurance from the issuer that it will accept these payment of premiums for individual market plans for the duration of the plan year, or else not make such payments.

The interim rule does not restrict the ability of individuals or facilities to donate to charitable organizations that appropriately support access to health care.

This interim final rule with comment period takes effect 30 days after officially publishing in the Federal Register and can be found at: https://www.archives.gov/federal-register/the-federal-register/indexes.html

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