



January 29, 2016

The Honorable Orrin Hatch  
Chairman  
Senate Committee on Finance

The Honorable Ron Wyden  
Ranking Member  
Senate Committee on Finance

The Honorable Johnny Isakson  
Co-Chair, Chronic Care Working Group  
Senate Committee on Finance

The Honorable Mark Warner  
Co-Chair, Chronic Care Working Group  
Senate Committee on Finance

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

DaVita welcomes the opportunity to offer feedback on the Policy Options Document issued by the Senate Committee on Finance Bipartisan Chronic Care Working Group (“Working Group”). As the nation’s largest operator of medical groups and physician networks, we care for 959,000 health plan members, including 348,000 Medicare Advantage (MA) enrollees. We also operate and provide administrative services at over 2,200 outpatient dialysis centers, serving nearly 176,000 patients with end stage renal disease (ESRD).

Many of our patients, especially those who are dual eligibles or have ESRD, are among the sickest and frailest of beneficiaries. They often see numerous providers, take multiple medications, and face other barriers to care, such as lack of transportation. For these and other chronically ill beneficiaries, our team-based care approach along with additional non-clinical services and supports have helped them maintain their health.

Our participation in MA and fee-for-service (FFS) gives us a broad perspective on the Medicare program. We have first-hand experience with MA’s effectiveness in supporting providers such as DaVita to develop and implement innovative care strategies. We also fully understand how the inherent FFS payment incentives can thwart providers’ best efforts to coordinate care.

DaVita staunchly supports the Working Group’s efforts to continue Medicare’s transformation from a program that largely rewards service volume to one that better aligns financial incentives, meets beneficiaries’ needs, and delivers patient-centered care. These efforts will ensure that Medicare remains strong for generations of beneficiaries to come. We commend the Working Group for acknowledging that achieving that objective will require adoption of multiple beneficiary- and provider-focused policies. We are grateful for the Working Group’s recognition of MA’s valuable contributions in advancing quality and integrated care. Allowing ESRD beneficiaries to enroll in an MA plan regardless of the timing of the condition’s onset,

making Special Needs Plans (SNPs) permanent, and ensuring payment accuracy will make MA an even stronger coverage option and will be most effective in improving care for chronically ill beneficiaries.

We also appreciate that the Working Group recognizes the need for a variety of care delivery models in a transformed Medicare program. In that spirit, we encourage the Working Group to explore additional options to augment the availability of integrated care strategies for patients with ESRD. As the Working Group knows well, ESRD patients have complex health care needs and account for a disproportionate share of Medicare expenditures. Each week, ESRD patients spend upwards of 12 hours receiving treatment, making a strong case for a dialysis facility and its providers to serve as ESRD patients' medical homes. The Working Group should capitalize on the capacity of dialysis facilities and renal care providers to accept more central leadership and financial responsibility roles in providing integrated Medicare benefits to ESRD patients currently in FFS Medicare.

Again, DaVita appreciates the Working Group's commitment to soliciting stakeholder input and its open, deliberative approach. We respectfully offer the following comments on the specific policies under consideration and look forward to working with you as discussions move forward.

Sincerely,



LeAnne Zumwalt  
Group Vice President, Purchasing and Public Affairs

## SUMMARY OF COMMENTS

### POLICY OPTIONS RELATED TO MEDICARE ADVANTAGE (MA)

#### **Allowing ESRD Beneficiaries to Choose an MA Plan**

- MA's program experience supports allowing ESRD beneficiaries to choose an MA plan regardless of the timing of the condition's onset.
- Dialysis Facility Compare measures could be incorporated into the MA star rating system to ensure access to high-quality dialysis care.
- Currently used ESRD benchmarks and risk adjustment factors should apply with MA plans continuing to indicate expectations on ESRD beneficiaries' enrollment volume separately from non-ESRD beneficiaries.

#### **Providing Continued Access to MA Special Needs Plans (SNPs) for Vulnerable Populations**

- Congress should permanently authorize SNPs to promote program stability for beneficiaries and organizations offering or seeking to offer SNPs.
- Other changes may be necessary to ensure that SNPs can achieve sufficiently-sized enrollments to support investments necessary to establish and operate a SNP.

#### **Ensuring Accurate Payment for Chronically Ill Beneficiaries**

- Accounting for the number of conditions and using multiple years of data to calculate risk scores should help improve payment accuracy.
- The impact of such changes could be small, necessitating consideration of additional modifications to the risk adjustment model.
- Proposals to address payment accuracy for dual eligible beneficiaries also should ensure adequate payments for non-dual eligible beneficiaries, many of whom have complex conditions that lead to higher costs.
- Additional changes to the risk adjustment model should be considered in the context of other recent changes to the MA benchmark methodology and the model.
- A formal rulemaking process for major modifications would promote greater transparency and afford stakeholders sufficient time to assess proposals.
- The Centers for Medicare & Medicaid Services (CMS) should ensure that encounter data capture costs associated with the delivery of coordinated care.

### **Adapting Benefits to Meet the Needs of Chronically Ill MA Enrollees**

- Greater flexibility in benefit design could improve care and slow disease progression for beneficiaries with chronic illnesses.
- Steps should be taken to ensure that any additional flexibility results in true benefit enhancements.

### **Providing MA Enrollees with Hospice Benefits**

- Should Congress include hospice benefits in the MA program, plans must have sufficient time to attain the operational capacity to cover the benefit.
- Incorporating National Quality Forum (NQF) measures currently used under the Hospice Quality Reporting Program (HQRP) could help ensure quality.
- Additional measures should be developed to assess the extent to which symptoms are clinically managed.

### **POLICY OPTIONS RELATED TO FEE-FOR-SERVICE (FFS)**

#### **Expanding Access to Home Hemodialysis Therapy**

- Lifting the geographic requirements on the telehealth option for the clinical assessment for home dialysis patients will improve access and afford beneficiaries more dialysis treatment options.
- Congress should expand the list of originating sites to include free-standing renal dialysis facilities and patients' homes.
- There is no difference between a hospital-based dialysis facility and an independent dialysis facility for originating site purposes.
- Patients' homes also should be an originating site since some patients face barriers in getting to a facility for a clinical assessment via telehealth.
- Requiring beneficiaries to have an in-person clinical assessment every three months is a reasonable and clinically-justifiable approach to ensure patient safety under the expanded policies.

#### **Improving Care Management Services for Individuals with Multiple Chronic Conditions**

- Creating a high-severity code would help address the fact that the current chronic care management (CCM) code does not capture all of the labor and resource costs involved in delivering CCM to very sick beneficiaries.

- Eligibility criteria should not exclude beneficiaries with one condition, such as ESRD, given their extensive care coordination needs.
- Non-clinical factors, such as available social supports, should be considered in determining beneficiary eligibility since they can impact the severity of a patient's condition and CCM needs.
- Registered nurses, social workers, case managers, and other providers certified in chronic disease management should also be eligible for reimbursement under the current CCM code and a new high severity code.

### **Encouraging Beneficiary Use of Chronic Care Management (CCM) Services**

- Nominal cost sharing can lead many beneficiaries to forgo a Medicare service or benefit.
- Waiving the beneficiary coinsurance is an appropriate step to encourage beneficiary use of CCM services.
- CMS and providers must take additional steps to educate beneficiaries about the value of CCM services and inform them that CCM services do not require a face-to-face visit.

### **Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Condition**

- A one-time payment could be helpful, but counseling must continue to occur as the disease progresses, making the adoption of other CCM codes crucial for patients and providers.

### **Expanding Access to Prediabetes Education**

- Expanding access to prediabetes education will help beneficiaries avoid complications and slow the disease's progression.
- The benefit should be available in a wide variety of settings and delivered by certified diabetes educators.
- The Working Group also should consider expanding the kidney disease education (KDE) benefit by allowing: (1) beneficiaries with stage V chronic kidney disease (CKD) to receive the benefit and (2) clinical staff at renal dialysis facilities to provide the KDE benefit.

**POLICY OPTIONS RELATED TO ACCOUNTABLE CARE ORGANIZATIONS (ACOs)**

**Providing ACOs the Ability to Expand Use of Telehealth**

- The geographic requirements for using telehealth should be eliminated and the list of originating sites should be expanded to include stand-alone renal dialysis facilities; urgent care centers; stand-alone ambulatory surgery centers; and stand-alone radiology centers.
- A patient's home should be an originating site for certain home health, care management, or disease management visits; patient self-directed calls for a dermatological condition or medication reconciliation/management; and a clinical assessment for beneficiaries receiving home dialysis (with an in-person clinical assessment every three months).

**Providing Flexibility for Beneficiaries to be Part of an ACO**

- Beneficiaries should have the option to elect an ACO, which will promote greater patient engagement.
- Upfront payments would be helpful, but may present some hurdles for providers.

**POLICY OPTIONS RELATED TO OVERALL MEDICARE PROGRAM**

**Expanding Access to Digital Coaching**

- Adding disease-specific information to Medicare.gov may make the website overwhelming for beneficiaries.
- CMS could capitalize on the myriad of websites that have disease-specific information by creating a process to certify that a website meets specific standards. Providers could then be encouraged to share those sources with beneficiaries.

**Developing Quality Measures for Chronic Conditions**

- Additional measures to assess the quality of chronic illness care are much needed.
- Any new measures should be aligned across payers to ensure consistency and reduce administrative burden.

## DETAILED COMMENTS

### POLICY OPTIONS RELATED TO MEDICARE ADVANTAGE (MA)

#### **Allowing ESRD Beneficiaries to Choose an MA Plan**

DaVita supports the Working Group's proposal to allow beneficiaries with ESRD to enroll in an MA plan regardless of the timing of the condition's onset. In addition to years of program experience, two important facts support adoption of this policy. First, MA plans can deliver high-quality care, while achieving savings that allow them to offer additional benefits and services. DaVita, for example, reduced non-dialysis costs for ESRD care by 15 percent compared to FFS in a southern California plan while consistently delivering strong quality and patient satisfaction results. Second, CMS actuaries estimate that Medicare FFS costs will exceed MA payments for ESRD beneficiaries by 3 percent in 2016. As such, allowing patients with ESRD to enroll in an MA plan can lower overall Medicare spending.

To ensure high-quality ESRD care, measures such as those currently used to rate dialysis facilities under the Centers for Medicare & Medicaid Services' (CMS) Dialysis Facility Compare website could be incorporated into MA plan provider directories and/or the MA star rating system. In addition, some current MA star measures, which are contraindicated for ESRD patients, may need to be modified or excluded from overall scoring. With respect to benchmarks and risk adjustment, the policy should retain the current processes that establish distinct: (1) ESRD benchmarks based on a state average of FFS costs and (2) an ESRD risk adjustment model. MA plans should continue to indicate their expectations regarding enrollment of ESRD beneficiaries separately from beneficiaries without ESRD. Plans operating Chronic Care-Special Needs Plans (C-SNPs) for beneficiaries with ESRD should continue to submit separate bids.

#### **Providing Continued Access to MA Special Needs Plans for Vulnerable Populations**

DaVita is proud to partner with multiple health plans and provider organizations to offer integrated care to ESRD patients through ESRD C-SNPs. Focusing on a particular condition allows C-SNPs to develop highly sophisticated care delivery approaches targeted to their enrollees' needs. The C-SNPs in which we participate employ multiple care strategies to integrate services and improve patient engagement including:

- kidney-focused care management capability with proficiencies in ESRD care pathways and comorbidity management;

- multi-disciplinary care teams comprised of renal nurses and nephrologists who work with dialysis clinics and hospitals to coordinate care and coach patients;
- clinical data sharing with nurses to track fluid alerts, missed treatments, laboratory services, and medications and communicate care plan adjustments; and
- targeted medication reviews to help patients avoid medication-related hospitalizations.

The ESRD C-SNPs have achieved positive results for patients relative to Medicare FFS including:

- a 21 percent reduction in hospital admission rates;
- a 28 percent reduction in hospital bed days, significantly reducing risk of hospital-acquired infections; and
- a 24 percent reduction in central venous catheter rates.

Unfortunately, the series of short-term program extensions have limited the use and growth of SNPs. Forming a C-SNP requires significant planning and resources to acquire the specialized capacity to serve the enrolled population. A permanent authorization would create stability for entities seeking to offer a C-SNP and more importantly, for beneficiaries who rely on a C-SNP to receive the tailored care they need.

As the Working Group noted, other policy changes under consideration, namely allowing greater benefit flexibility for chronically ill beneficiaries under MA, have implications for SNPs and may necessitate additional SNP program modifications. Toward that end, we suggest considering changes to ensure that SNPs can achieve sufficiently-sized enrolled populations to merit the investments necessary to establish a SNP. The continuous enrollment policy is helpful in this regard, but the unique nature of certain C-SNP populations and aspects of MA marketing guidelines present challenges.

Beneficiaries with ESRD, 48 percent of whom are eligible, spend 12 to 15 hours each week at a dialysis facility. The treatment schedule, coupled with other barriers, often leaves them with fewer opportunities to learn more about their coverage options. In our view, the treatment area is an ideal location for clinical and non-clinical staff to help beneficiaries assess their coverage choices, yet MA marketing guidelines prohibit this activity. As such, we suggest modifying the guidelines – with appropriate measures to prevent marketing abuse – to allow physicians and dialysis center staff to: (1) approach patients and discuss coverage options in dialysis treatment areas and (2) distribute health plan materials on the dialysis treatment floor.

## Ensuring Accurate Payment for Chronically Ill Beneficiaries

The CMS-Hierarchical Condition Category (HCC) risk adjustment model has greater predictive ability than models that consider only demographic factors, but there remains room for further improvements in its accuracy. DaVita strongly supports efforts to accomplish that objective, which has become all the more important as the number of beneficiaries with chronic, complex illnesses continues to rise. For many beneficiaries, the presence of additional physical or behavioral conditions can complicate the severity and effectiveness of treatment for another unrelated condition, resulting in higher costs. In these circumstances, it can be more challenging for beneficiaries to understand and adhere to treatment plans. Taking steps to improve payment accuracy will help ensure that MA plans have adequate resources to invest in effective care management, integrated services, and patient education programs to meet their enrollees' needs.

Although the CMS-HCC model adjusts payments for interactions between certain combinations of conditions, accounting for the number of conditions and interactions between behavioral and physical health conditions are appropriate policy actions. Using more than one year of data to determine risk scores also has the potential to be more effective in addressing MA and FFS coding differences than across the board adjustments or removing certain condition categories from the model. These latter approaches can undermine efforts to identify diseases in their early stages and to slow a disease's progression.

Should the Working Group call for using multiple years of data, it should ensure that the policy does not inadvertently weaken the model's accuracy for beneficiaries with fewer than the specified number of months of data (e.g., <24 months). For example, CMS currently adjusts payments for "new" MA enrollees – those with fewer than 12 months of data – only by age and gender. Under a "multiple years of data" policy, the period during which only age and gender adjustments apply should not be extended. Rather, if at least one year of data exists, beneficiaries' risk scores should reflect their specific diagnoses. When an additional year (or years) of data become(s) available, beneficiaries' scores could reflect diagnoses recorded in the initial and additional year (or years).

Although the proposals to consider a beneficiary's total number of conditions and use more than one year of data will increase the model's predictive ability, MedPAC has expressed that the magnitude of improvement will likely be small. As such, policy makers should explore the feasibility of other options, including accounting for beneficiary functional status and differences in costs associated with dual eligible beneficiaries. As the Working Group considers policies related to dual eligibles, such as the proposal issued by CMS late last year, we

encourage it to keep in mind that many non-dual eligible beneficiaries also have complex health care needs that result in higher costs, and to ensure that any changes in the model result in adequate payments for these beneficiaries as well.

The Working Group also should consider the collective impact of recent changes to the model and MA benchmarks, and interactions between various proposals intended to improve the model's accuracy. For example, over the past few years, CMS announced and fully implemented the 2014 clinical revision, which among other changes, eliminated certain chronic kidney disease (CKD) condition categories due to concern about coding differences between FFS and MA. The Agency also began using encounter data to calculate blended risk scores.

With respect to the 2014 clinical revision, DaVita agrees that CMS must address inherent differences in coding practices between FFS and MA. However, we do not believe that CMS should use the model to address those differences. Regarding encounter data, we remain concerned that consistent with Government Accountability Office (GAO) recommendations, CMS has not conducted or released statistical analyses to validate the data's accuracy and completeness. CMS should then ensure that encounter data appropriately capture costs associated with the delivery of coordinated care, such as investments in information technology. Until completion of those analyses and accounting for costs related to delivery of coordinated care, we believe it would be premature for CMS to increase the portion of a beneficiary's risk score determined by encounter data. In addition, we submit that CMS should use a formal rulemaking process when making significant changes to the model to promote greater transparency and afford stakeholders sufficient opportunity to review evidence for the change and offer feedback.

### **Adapting Benefits to Meet the Needs of Chronically Ill MA Enrollees**

Although greater flexibility to tailor benefits based on enrollees' chronic conditions could improve care and slow disease progression, great caution should be taken to ensure that benefit designs under such a policy do not have unintended consequences. Specifically, the additional flexibility should not be a means for an MA plan to offer an enhancement while at the same time applying a limitation that renders the enhancement meaningless. For example, it should not be acceptable for MA plans to offer beneficiaries access to a broader provider network for some services, but predicate the network enhancement on seeing only a subset of providers for other needed services.

Assuming adoption of appropriate safeguards, all MA plans should have this additional benefit design flexibility. Disease states for which there exist physician-accepted, objectively-based

criteria or other clinical/laboratory value-based criteria or guidelines seem appropriate for this type of benefit differentiation. Requiring plans to consult with patient advocates and providers with expertise in caring for patients with a particular condition could help ensure the benefit

designs are true enhancements. To ensure that SNPs remain a strong option, Congress should permanently authorize the program and modify MA marketing guidelines as described in our response to “Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations”.

### **Providing MA Enrollees with Hospice Benefits**

DaVita understands the policy rationale for incorporating hospice into MA benefits. However, we encourage the Working Group to afford MA plans more time to assess the proposal’s operational impacts before moving forward. In addition to adjusting MA base payments and the risk adjustment model, MA plans will need to develop new staffing models, update systems to capture necessary documentation and clinical quality metrics, and expand internal audit functions.

Should the Working Group move forward after considering those issues, the following National Quality Forum (NQF) measures, currently used under the Hospice Quality Reporting Program (HQRP), could be considered for incorporation into the MA star measures:

- NQF #1617: Patients treated with an opioid who are given a bowel regimen
- NQF #1634: Pain screening
- NQF #1637: Pain Assessment
- NQF #1638: Dyspnea Treatment
- NQF #1639: Dyspnea Screening
- NQF #1641: Treatment Preferences
- NQF #1647: Beliefs/Values Addressed (if desired by the patient)

This list includes measures to gauge a patient’s symptoms during an initial hospice evaluation as well as more advanced process measures to evaluate treatments. In addition, it would be helpful to develop and eventually include outcome measures, such as a measure related to pain and dyspnea control, to assess the extent to which a patient’s symptoms are being clinically managed. These measures could be added as a new “End of Life” domain or alternatively, an existing domain (e.g., “Managing Chronic (and Long-Term) Conditions”) could be modified and expanded to include them. Patient and family satisfaction could be evaluated using the current or a modified version of the Consumer Assessment of Healthcare Providers and Systems

(CAHPS) Hospice Survey required under the HQR. Given the significant differences between the MA and hospice delivery models, we recommend that the CAHPS Hospice Survey remain separate from CAHPS for MA and Prescription Drug Plans (PDPs).

### **POLICY OPTIONS RELATED TO FEE-FOR-SERVICE**

#### **Expanding Access to Home Hemodialysis Therapy**

Conducting the required clinical assessment via telehealth rather than an in-office visit is an effective and welcomed alternative for many ESRD patients on home dialysis. The telehealth option was intended to address provider availability issues in rural and other areas. Although metropolitan areas may not lack providers, patients in urban locations often have unreliable transportation options, limited opportunities to take time off from work, or mobility challenges. These patients also deserve the same telehealth option. Advances in telehealth technology also lend a strong policy rationale for removing the geographic requirements.

With respect to originating sites, both independent renal dialysis facilities and patients' homes should be included. There is no difference between a hospital-based dialysis facility and an independent renal dialysis facility for originating site purposes. Failure to include patients' homes will render the geographic expansion less meaningful, especially for beneficiaries in urban locations who face challenges in getting to a facility for a clinical assessment via telehealth. Although certain services may require a care provider's physical presence, many services require only a tablet computer, making a patient's home a viable and suitable originating site. To ensure patient safety under these revised policies, an in-person visit every three months is a reasonable and clinically-justifiable requirement.

We also respectfully offer two additional changes to promote the use of telehealth in delivering effective, efficient, and quality care to ESRD patients. First, we encourage the Working Group to adopt language that allows providers to equip patients with the necessary technology without it being considered a patient inducement. Second, we urge the Working group to apply the changes to patients receiving home dialysis, which encompasses home hemodialysis (HHD) and peritoneal dialysis (PD), since the majority of home dialysis patients receive PD.

#### **Improving Care Management Services for Individuals with Multiple Chronic Conditions**

DaVita supports adopting codes under the physician fee schedule (PFS) to reimburse providers for the time and resources dedicated to chronic care management (CCM) services. As the Working Group noted, the current code captures only a portion of the labor and other resources associated with CCM. A high-severity code would help reflect that some patients have more intense CCM needs.

We share the Medicare Payment Advisory Commission’s (MedPAC) view that any new high-severity code must be carefully constructed to ensure that it does not simply increase spending without improving quality. We appreciate the need to develop eligibility criteria, but are concerned that the approaches under consideration would exclude patients for whom the code is appropriate. For example, all patients with ESRD – a single chronic condition – require services from, but not limited to, dialysis clinics, nephrologists, hospitals, interventional radiologists, and vascular access surgeons. As such, billing criteria should focus on the degree of care coordination required along with the potential for more intensive CCM services to improve outcomes.

We also urge the Working Group to consider that non-clinical factors, such as availability of social supports, lack of transportation, or language and cultural barriers, affect the severity of a patient’s condition and care management needs. Defining eligibility solely based on the presence of multiple physical conditions or a chronic condition in conjunction with Alzheimer’s, dementia, or impaired functional status could exclude patients with one condition, but who lack social supports or face other care barriers that require more intensive CCM services.

Registered nurses, social workers, case managers, and other providers certified in chronic disease management should be eligible to bill the new high-severity code. The National Committee for Quality Assurance (NCQA) process for disease management accreditation and certification could form the basis for qualifying a broader set of providers to bill for the current and proposed high-severity codes.

### **Encouraging Beneficiary Use of Chronic Care Management Services**

As the Working Group knows well, many beneficiaries live on fixed incomes. They carefully consider their out-of-pocket costs in selecting a MA plan or electing to receive a health care service. For beneficiaries with multiple chronic illnesses even nominal cost sharing, such as the \$8 coinsurance for CCM services, can quickly add up leading them to forego the benefit. Research also shows that beneficiaries with serious illnesses tend to have lower incomes, making it less likely that they have supplemental coverage for CCM services. For these reasons, we believe that waiving the applicable cost sharing in an effort to incentivize beneficiaries to receive CCM services is appropriate.

In concert with that policy change, additional CMS and provider actions are needed to ensure that beneficiaries fully understand the CCM services they receive. For example, summary of benefits notices could include additional explanatory information about the CCM service (e.g., “Your provider submitted information indicating these services, which do not require a face-to-face visit, were delivered on your behalf. You do not have any coinsurance responsibility for

these services.”). Other potential avenues for providing information include Medicare.gov and the Medicare & You Handbook. Providers and their staffs must continue to educate

beneficiaries about the availability and importance of CCM services. These education activities also will help offset any decrease in motivation that beneficiaries may feel to participate in CCM services if they no longer bear a financial obligation.

### **Expanding Access to Prediabetes Education**

DaVita supports providing payment under Medicare Part B for evidence-based lifestyle interventions to: help patients avoid developing diabetes; slow the disease’s progression; and reduce risk of developing comorbid conditions and other health complications. Prediabetes education services should be delivered in a wide variety of settings to accommodate patients who may lack transportation and allow participation in support groups, which could benefit patients struggling to adopt important lifestyle changes. To ensure quality, certified diabetes educators should deliver prediabetes education services.

In response to the Working Group’s request for feedback on services similar to diabetes self-management training (DSMT), we suggest considering expanding the current kidney disease education (KDE) benefit as envisioned in S. 598, the Chronic Kidney Disease Improvement in Research and Treatment Act of 2015, bipartisan legislation introduced by Senators Cardin and Crapo and cosponsored by Senator Nelson. Information and services delivered under the KDE benefit include:

- management of comorbidities for the purpose of delaying the need for dialysis;
- prevention of uremic complications;
- therapeutic options; and
- opportunities for beneficiaries to actively participate in the choice of therapy and for therapy to be tailored to meet beneficiaries’ needs.

Beneficiaries also receive assessments to measure their knowledge about chronic kidney disease (CKD) and the benefit’s effectiveness in preparing them to make informed decisions about their CKD-related health care options.

More than 30 million Americans have a form of kidney disease. A wide body of research has shown that absent patient education and preventive care, these patients face a greater risk of developing kidney failure. Currently, only beneficiaries with stage IV CKD can receive the KDE benefit from a limited set of clinicians. Making the KDE benefit available to beneficiaries with stage V CKD in addition to those with stage IV CKD, and allowing clinical personnel at renal

dialysis facilities to deliver the benefit. The GAO issued the recommendation in a November 2015 report on home dialysis, which found that less than 2 percent of eligible beneficiaries

received the KDE benefit in 2010 and 2011, and the percent had since declined. Stakeholders reported that statutory limitations on beneficiary and provider eligibility limited the KDE benefit's utilization, which the GAO stated could undermine CMS' goal of promoting wider use of home dialysis.

### **Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Condition**

DaVita appreciates the Working Group's recognition of the additional time necessary for patient-provider conversations upon initial diagnosis of a serious health condition. Although a one-time payment could be helpful, counseling must continue to occur as the disease progresses, making adoption of other CCM codes crucial for patients and providers.

#### **POLICY OPTIONS RELATED TO ACCOUNTABLE CARE ORGANIZATIONS (ACOs)**

##### **Providing ACOs the Ability to Expand Use of Telehealth**

Advances in telehealth technology that enable remote monitoring, help patients manage their chronic conditions, and allow providers to identify early signs of avoidable health complications have led to more efficient, effective health care spending. The geographic limitations on the use of telehealth do not align with these innovations in telehealth applications.

To promote telehealth's wider use, the geographic requirements should be eliminated and the list of originating sites expanded to include stand-alone renal dialysis facilities; urgent care centers; stand-alone ambulatory surgery centers; and stand-alone radiology centers. In addition, a beneficiary's home should be an originating site for:

1. A home health, care management, or disease management visit for a patient in care transition during which a registered nurse identifies acute symptoms that may require a clinical assessment and recommendation to avert an emergency department visit;
2. Patient self-directed calls to clinicians via mobile technology, such as cell phones or tablets, for a dermatological condition or medication reconciliation/management; and
3. The clinical assessment for beneficiaries receiving home dialysis (with an in-person clinical assessment every three months).

Additional language should be adopted to allow ACOs to equip patients with the necessary technology without it being considered a patient inducement.

## **Providing Flexibility for Beneficiaries to be Part of an ACO**

Under current policy, beneficiaries often do not realize that they have been assigned to an ACO or understand the value in seeking care from ACO providers. Allowing voluntary election of an ACO could help improve patient engagement, which is crucial to an ACO's success. However, permitting them to continue to receive care from non-ACO providers, except in certain circumstances (e.g., beneficiary needs highly-specialized, tertiary care from a non-ACO provider), could offset any gains in patient engagement that comes with voluntary enrollment.

Upfront payment for all services will create even stronger incentives for an ACO to deliver cost-effective, high-value care. However, it may present some hurdles. For example, it would be important for ACO providers that receive upfront payments to understand that they should not submit claims directly to Medicare.

### **PROPOSALS RELATED TO OVERALL MEDICARE PROGRAM**

#### **Expanding Access to Digital Coaching**

DaVita shares the Working Group's view on the need to improve patient engagement. To help accomplish that objective, we have made patient education a top priority and have made significant investments to develop on-line resources that cover topics including general information about kidney disease, available treatment options, and services, such as travel support and disease management. Our website also includes forums through which patients can ask questions and support each other. We pride ourselves on the rigor applied in developing the content and constantly work to ensure that it is clinically up-to-date.

Although Medicare.gov is the go-to place for Medicare information, we are concerned that adding disease-specific information could make the site overwhelming for beneficiaries. As an alternative, the Working Group could consider a policy to capitalize on the myriad of existing websites that offer disease-specific information. To ensure the information's validity and reliability, CMS, either directly or through a contract with an outside entity, could certify that the website meets specific standards. Providers could be encouraged to share those sources and websites that meet such standards with beneficiaries. At a minimum, the website should include general information about the disease and treatment options. They also should deliver the information in different formats since some beneficiaries prefer written materials, while others prefer videos and interactive tools.

## **Developing Quality Measures for Chronic Conditions**

Assessing the health care delivery system's performance and effectiveness of new chronic illness care policies depends on the availability of chronic illness-specific quality measures. Development of additional measures is much needed. The patient and family engagement, shared-decision making, and care coordination categories are particularly crucial, since such measures apply across a broad set of chronic conditions. Should the Working Group adopt the proposal to require that CMS incorporate chronic care measures into its quality measures plan, it should reinforce the need to align measures across payers. Ensuring consistency in measures will reduce administrative burden on providers; help promote development of best practices for all patients; and improve population health.