



## THE KIDNEY CARE COUNCIL

*Providers of Quality Care for the Nation's Dialysis Patients*

June 22, 2015

The Honorable Orrin G. Hatch  
Chairman  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, D.C. 20510

The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, D.C. 20510

The Honorable Johnny Isakson  
United States Senate  
131 Russell Senate Office Building  
Washington, D.C. 20510

The Honorable Mark Warner  
United States Senate  
475 Russell Senate Office Building  
Washington, D.C. 20510

Dear Senators Hatch, Wyden, Isakson, and Warner:

On behalf of the Kidney Care Council (KCC), the nation's association of dialysis providers serving the complex clinical needs of more than 381,000 individuals with End Stage Renal Disease (ESRD) in more than 4,930 dialysis facilities across the United States, we appreciate the opportunity to provide input to your inquiry regarding Medicare improvements for beneficiaries with chronic disease. KCC member companies include large, medium and small providers, both for profit and not for profit, serving individuals with ESRD in all geographies across the country. Below we offer constructive solutions for the complex needs of some of the Medicare program's most costly, chronically ill beneficiaries.

### **End Stage Renal Disease (ESRD) is a Chronic, Disabling and Costly Condition**

Individuals with ESRD suffer from kidney failure, a chronic condition that requires either transplantation or regular dialysis in order to stay alive. ESRD is the last stage (stage five) of chronic kidney disease (CKD). This stage is reached when an individual's kidneys are functioning at 10–15 percent of their normal capacity or below and, therefore most patients will need dialysis to sustain life. Kidneys are vital organs that remove toxins from the blood and perform other functions that support the body, such as balancing fluid and electrolytes, and producing certain hormones. When kidneys fail, they cannot effectively perform these functions, and renal replacement therapy, such as dialysis or a kidney transplant, is necessary to sustain life.



The most common type of dialysis is hemodialysis, which is predominantly performed in specialized outpatient facilities. Hemodialysis is a therapy that filters waste products, removes extra fluid, and balances electrolytes (sodium, potassium, bicarbonate, chloride, calcium, magnesium and phosphate), replacing the mechanical functions of the kidney. Traditional in-center hemodialysis is generally performed a minimum of three times a week for about four hours each session. Due to the significant impact of dialysis treatment on the body, the resulting fragility of those with the disease, and the amount of time involved in treatment, access to the renal replacement therapy modality that is right for the individual is of critical importance.

Individuals with ESRD frequently have a number of other chronic, co-morbid conditions such as diabetes and hypertension, the leading causes of kidney failure, as well as conditions related to the impact of kidney failure on other organ systems, all of which continue to require further primary care and specialist interventions along with the management of complex polypharmacy. Medicare provides coverage of dialysis care for individuals with ESRD regardless of an individual's age through the ESRD program.

Individuals with ESRD are some of the highest cost Medicare beneficiaries. In 2013, Medicare spent \$11 billion on dialysis care for 430,000 individuals with ESRD.<sup>1</sup> That sum does not include non-dialysis costs incurred by individuals with ESRD, including hospital and other expenses associated with ESRD care and the management of comorbid conditions.

Medicare does a good job providing essential clinical services for the complex array of conditions associated with dialysis care. However, the current ESRD prospective payment system (PPS) is limited to the delivery of renal dialysis services and does not extend to provide resources for care coordination and clinical integration. With MA plans there is a greater possibility of better managing patient care outside of the dialysis facility where they receive dialysis treatments three times per week. These very sick patients must self-navigate a complex healthcare system to treat their multiple comorbidities without the benefit of coordinated guidance to achieve best care and outcomes. This does not need to be the case. Care for chronically ill beneficiaries with ESRD should not end at the dialysis facility door.

---

<sup>1</sup> Medicare Payment Advisory Commission, Report to Congress (March 2015)



### **Pass S. 598 and Allow Access to Medicare Advantage for Individuals with ESRD**

The single most effective measure the Committee could take to improve care for individuals with ESRD would be to pass S. 598, the Chronic Kidney Disease Improvement in Research and Treatment Act of 2014, co-sponsored by Senators Crapo (R-ID) and Cardin (D-MD). Among other important changes S. 598 would make to the ESRD program to improve beneficiary education and payment accuracy in traditional Medicare and would end decades of discrimination against individuals with ESRD and allow them to enroll in Medicare Advantage plans.

Under current law, Medicare beneficiaries with ESRD are prohibited from enrolling in Medicare Advantage plans unless they were already in a Medicare Advantage plan when they are diagnosed with kidney failure, denying them the same benefit choices and program advantages available to other beneficiaries on the basis of their disease. Recognizing the benefits associated with comprehensive, coordinated care available to other Medicare beneficiaries who enroll in Medicare Advantage plans, MedPAC has regularly advised Congress to eliminate the unfair Medicare Advantage enrollment prohibition for individuals with ESRD since 2000.

Importantly, allowing beneficiaries with ESRD to enroll in Medicare Advantage could help low-income patients because these plans often offer lower deductibles and copayments and are required by law to cover all beneficiary costs above a set threshold, protecting beneficiaries from catastrophic health care spending. And unlike traditional Medicare, Medicare Advantage plans have flexibility to redistribute clinical resources to address unique patient needs and to provide more integrated, coordinated care, which can be especially impactful to individuals with ESRD.

KCC member companies know this from experience. Since the early 2000s, several KCC members have partnered with health plans in CMS demonstration projects and in special needs Medicare Advantage plans, and have offered comprehensive clinical services outside of the dialysis facility itself. On balance, individuals with ESRD who had access to seamless, comprehensive care in demonstration projects and in special needs plans showed improved outcomes compared to individuals with ESRD who were enrolled in traditional Medicare.

The choice to enroll in a Medicare Advantage plan should not be limited to only some Medicare beneficiaries. All Medicare beneficiaries, regardless of their disease state or chronic illnesses, should have equal rights of access to the comprehensive medical and social services and financial supports offered by Medicare Advantage plans. Individuals with ESRD are uniquely suited to benefit from the care coordination and additional benefits provided by Medicare Advantage plans, and are among those beneficiaries most in need of the clinical



integration and seamless care services Medicare Advantage plans provide that are not available in the traditional Medicare program. The KCC urges the committee to initiate this critical reform for the care of Medicare's most chronically ill individuals and pass S. 598.

### **Enact Delivery Reforms That Promote Quality and Encourage Innovation**

In addition to allowing individuals with ESRD access to Medicare Advantage, the Committee could improve care for chronically ill individuals, especially those with ESRD, by designing new voluntary policy options in Medicare that incentivize care coordination and clinical accountability, permit the assumption of risk, and encourage organizations to provide comprehensive care coordination services. Such new programs or models should be made available to *any* organization, including providers and groups of providers with the goal of improving care for complex, chronically ill beneficiaries and generating better outcomes and reduced spending. A critical design feature of any such system to improve Medicare for the chronically ill is *openness*, or non-exclusivity. The Committee should not approach such models with an expectation that only some organizations, such as health plans, hospital systems, or only larger health care organizations, have the operational or economic capacity to take the helm of new programs and accelerate improvements in chronic disease care. Within the provider community, we encourage the Committee to facilitate models that would allow a variety of providers to effectively participate including providers large and small, urban and rural, and for-profit and not-for-profit organizations.

The Committee should not constrain the management of complex chronic care to only one type of organization. Rather, novel programs aimed at improving chronic care management should be open to organizations with appropriate clinical expertise and experience. Medicare designation (provider, supplier, plan etc.) or corporate status should not be used as the "test" for or gateway to leadership in a new program or to demonstrate the efficacy of a particular program feature. For example, a requirement that only health plans or organizations contracting with health plans can assume risk and be held accountable for clinical outcomes is too narrow and forecloses important leadership contributions from providers and other organizations. The Committee should proceed with an openness that allows willing organizations to take leadership and responsibility for improving the care of individuals with complex chronic conditions.

For instance, a program designed to improve the care of individuals with ESRD, or with diabetes, congestive heart failure, or other chronic conditions should be open to leadership from specialist groups or organizations focused on renal care, endocrinology, and cardiology, working together. Changes underway in health care delivery have given providers new opportunities to become clinically and economically integrated, efficient, and sophisticated at managing chronic



care cost. Providers have historically welcomed models that offer single sided risk to innovate, but many are also prepared to assume financial risk associated with clinical performance – and providers should not be foreclosed from doing so simply because they are not insurers or health plans.

The KCC supports allowing dialysis organizations to serve in such clinical leadership capacity under new payment models the Committee may design. In particular, the KCC welcomes opportunities to provide leadership in coordinating and integrating care for individuals with ESRD. The Center for Medicare and Medicaid Innovation (CMMI) has developed a pilot program, the Comprehensive ESRD Care (CEC) Initiative, which is scheduled to begin this summer. KCC appreciates that CMMI recognized the value and opportunity for integrated care models for ESRD Medicare beneficiaries and remain hopeful that there will be a great deal to be learned from the CEC Initiative as it moves forward. However, the KCC urges the Committee, given the especially high cost of ESRD care, to take additional, bolder steps to authorize an ESRD-specific coordinated care program led by dialysis organizations that would expand the opportunity for dialysis providers to demonstrate the value of integrated care for ESRD beneficiaries in Medicare. We welcome the opportunity to work with the Committee on such an important initiative in the near future.

Provider leadership in managing complex chronic disease is essential to ensuring the kind of advancement the Committee seeks in this area, because providers interact with beneficiaries *directly*. In the dialysis setting, physicians, nephrology nurses, dieticians, patient care technicians and social workers treat patients three times per week or more, for up to four hours each day, offering medical, nutritional and supportive care services that sustain the individual undergoing dialysis treatment – and serving as a *de facto* “medical home” for individuals with ESRD. Those clinical professionals can and should be empowered to do more, however, so that care does *not* end when the beneficiary leaves the dialysis unit. The Committee should ensure that care continues from the facility setting into homes and communities to promote medication and treatment compliance, coordination with family members and other medical professionals and drive better overall outcomes for individuals with chronic disabling conditions like ESRD.

Over the last decade, providers have made substantial investments ranging from electronic health record technology and remote patient monitoring systems to training sophisticated clinical experts, including physicians and allied health professionals, in the art of complex chronic disease care. Accordingly, the KCC urges the Committee to ensure that the design of new payment and delivery models for chronic disease care are open to leadership from providers or groups of providers, including those who are willing to assume financial risk for their performance.



## **Conclusion**

Passing S. 598 and allowing individuals with ESRD to join Medicare Advantage plans is the single most effective way the Committee can improve care and quality for individuals living with one of society's most complex and costly diseases. Further, allowing dialysis organizations or other providers to take clinical and financial responsibility for the totality of medical needs faced by the chronically ill, rather than limiting that responsibility to health plans alone, will foster an innovative environment in traditional Medicare that will improve care and drive clinical outcomes for those living with chronic diseases, and that generate efficiencies and lower system costs.

The KCC appreciates your attention to these important issues and to our views. If you have any questions, or would like to discuss our suggestions further, please do not hesitate to contact me at 202-744-2124 or [ccepriano@kidneycarecouncil.org](mailto:ccepriano@kidneycarecouncil.org).

Respectfully Submitted,

Cherilyn T. Cepriano  
President