



June 18, 2015

The Honorable Orrin Hatch  
Chairman  
Senate Finance Committee  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Ron Wyden  
Ranking Member  
Senate Finance Committee  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Johnny Isakson  
United States Senate  
131 Russell Senate Office Building  
Washington, DC 20510

The Honorable Mark Warner  
United States Senate  
475 Russell Senate Office Building  
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden and Working Group Leaders Isakson and Warner:

On behalf of the members of Kidney Care Partners (KCP), we appreciate the opportunity to submit comments as the Committee begins exploring solutions to improve outcomes for Medicare beneficiaries with chronic care needs. Senators Cardin, Crapo and Nelson have introduced S. 598, the Chronic Kidney Disease Improvement in Research and Treatment Act. The bill provides a holistic approach to improving the care of those with End State Renal Disease (ESRD) from research to treatment. Given the focus of the Working Group our comments will focus on three areas addressed in the legislation: a voluntary ESRD care coordination program, Medicare Advantage (MA) for Medicare beneficiaries with ESRD, and reauthorization Special Needs Plans (SNPs), though all provisions in the legislation are directly relevant to your work.

KCP is a coalition of patient advocates, dialysis professionals, care providers, and manufacturers dedicated to working together to improve the quality of care for those with renal failure. ESRD is an irreversible failure of kidney function that is fatal without a kidney transplant or dialysis treatments. Because of the limited number of kidneys available, about 70 percent of ESRD patients undergo dialysis, a process which removes wastes and fluid from the body.<sup>1</sup> In 1972, Medicare was extended to cover all individuals with ESRD, regardless of age. Today, more than 80 percent of dialysis patients rely on Medicare.

There are over 26 million adults living with chronic kidney disease (CKD), which can lead to kidney failure if untreated. More than 636,000 Americans are living with kidney failure with

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<sup>1</sup> Medicare Payment Advisory Commission, Report to Congress: March 2015, page 141

about 430,000 of these individuals relying on dialysis. The number of individuals suffering from ESRD is expected to double over the next decade.

KCP applauds the Committee for its focus on chronic care. Addressing chronic conditions requires a coordinated approach to treatment. This is especially true for those suffering from ESRD. The ESRD patient population is complex and diverse. Most patients are living with multiple comorbidities. These patients often take more than eight different medications and are hospitalized at least twice each year. Given these facts, KCP believes it is critically important to incentivize opportunities for improved care coordination services. KCP members believe the policies contained in S. 598, especially those focused on improving care coordination for ESRD patients, should be a top consideration of the Committee.

### **Eliminate Law Prohibiting ESRD Beneficiary Access to MA**

The Medicare Payment Advisory Commission (MedPAC) noted in its March 2015 Report to Congress that Fee-for-Service Medicare “lacks incentives to coordinate care and is limited in its ability to modify care delivery.”<sup>2</sup> At the same time, current law<sup>3</sup> prohibits Medicare beneficiaries in fee for service who develop ESRD from enrolling in an MA plan as a new enrollee. However, if an individual in an MA plan develops ESRD, that individual is able to maintain his/her current plan. Additionally, an MA enrollee with ESRD who has his/her plan terminated has a one-time right to choose another MA plan. That beneficiary can opt into another MA plan immediately, or he/she can also be placed back into fee for service and still have a one-time right to enroll in an MA plan later. The argument that plans do not have the ability to adequately care for ESRD patients is simply not supported by the facts. According to MedPAC, in 2013 about 14 percent of ESRD beneficiaries were enrolled in MA plans.

The highly coordinated care provided by MA plans can lead to improved health outcomes for ESRD patients with complex medical conditions. Additionally, access to MA plans for these beneficiaries could alleviate some financial hardships faced by these populations. Many Medicare ESRD beneficiaries are under the age of 65, and in most states these beneficiaries do not have the option of purchasing a Medicare Supplemental Insurance Policy (Medigap) to help defray the cost of co-pays and cost sharing, which can be significant. Many MA plans offer reduced cost sharing, which would be an invaluable benefit for ESRD beneficiaries.

Both Congress and MedPAC have recognized the benefits that ESRD patients could derive from accessing an MA plan. The Conference report accompanying the Balanced Budget Refinement Act of 1999 states, “the parties to the agreement also believe Medicare enrollees with ESRD could benefit by being offered the opportunity to enroll in Medicare+Choice plans.”<sup>4</sup> In 2000, MedPAC recommended removing the prohibition of MA as a choice for ESRD beneficiaries.<sup>5</sup> Yet, the prohibition, which still remains in place, eliminates a valuable choice that is available to non-ESRD Medicare beneficiaries.

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<sup>2</sup> Medicare Payment Advisory Commission, Report to Congress: March 2015, page 319

<sup>3</sup> Section 1851(a)(3)(B) of the Social Security Act

<sup>4</sup> The Conference report did state that a new risk adjustment model should be used for calculating plan rates for individuals with ESRD. CMS instituted a new risk adjustment model specifically for ESRD enrollees in 2005.

<sup>5</sup> Medicare Payment Advisory Commission, Report to Congress: March 2000, page 143

The power of removing the prohibition on ESRD patient access to MA is evident in data provided by one large dialysis provider. The data show that ESRD patients enrolled in MA had a 9 percent lower mortality rate than ESRD fee-for-service and a 23 percent lower hospitalization rate. These data, derived from the U.S. Renal Data System claims database for 28,000 patients new to dialysis from 2009 to 2011, help illustrate the positive impact of care coordination through MA plans on ESRD patients as well as the potential cost savings that could be realized by the Medicare program.

Many members of the Committee have expressed concern with the current risk adjustment model in the MA program, particularly as it relates to individuals suffering from CKD. A properly constructed risk adjustment model is a vital component to ensuring these beneficiaries receive the highest quality care. Proactively managing the care of those suffering from CKD can improve the quality of life for these individuals, but can also save the health system resources by delaying or preventing the patients' devolution to kidney failure. It is not widely known that MA plans actually already have a separate risk adjustment mechanism for ESRD enrollees – one that is distinct from the regular MA risk adjustment model. For ESRD beneficiaries, MA plans are paid based off the state-wide average cost of an ESRD beneficiary in fee for service. While there may be ways the current ESRD-specific risk adjustors could be improved, it is important to note the fears that current risk adjustors are not sufficient to address the unique costs of ESRD beneficiaries are unfounded.

We recommend that the Committee eliminate the prohibition disparity and allow Medicare beneficiaries with ESRD the option to enroll in MA plans. MA plans offer beneficiaries more structured, coordinated care than the more fragmented fee service program. This statutory change would provide beneficiaries with ESRD the same choice and access to coordinated care as other Medicare beneficiaries, as well as offer significant cost savings.

### **Permanent Reauthorization of Special Needs Plans**

The Medicare Access and CHIP Reauthorization Act (MACRA) provides an extension to authorization for SNPs through December 31, 2018. However, prior to the enactment of MACRA, the SNP program faced an annual reauthorization process, which created uncertainty for those looking to invest in ESRD SNPs. Special Needs Plans are able to tailor their benefits package to meet specific populations. Due to the highly specialized nature of the plan and the populations they serve, SNPs have demonstrated their ability to efficiently coordinate care and improve patient outcomes.

We recommend that the Working Group permanently reauthorize ESRD SNPs. MedPAC has recommended discontinuing certain types of Special Need Plans. However, the Commission has urged the continuation of SNPs for patients with certain complex conditions, including ESRD, and recognized in its 2013 annual March report the innovative nature of these plans in the care delivery for these populations.<sup>6</sup> The permanent reauthorization of these plans would ensure stability and protect patient access to these plans and allow continued innovation in the treatment of ESRD.

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<sup>6</sup> Medicare Payment Advisory Commission, Report to Congress: March 2013, page 325

## **Voluntary Care Coordination Program**

The kidney care community is well situated to accomplish the goal of providing patient-centered, high-quality, coordinated care to patients with kidney failure. As the principal providers for patients with kidney failure, dialysis facilities and nephrologists are in the best position to determine how to establish integrated care models that improve quality and increase efficiencies for this unique patient population.

While the Centers for Medicare and Medicaid Services (CMS) has proposed the Comprehensive ESRD Care Initiative, the design of this initiative is problematic and many questions remain unanswered. For example, the issues related to enrolling beneficiaries, the economic framework, and waivers necessary to run a functioning ESRD Seamless Care Organization (ESCO) remain problematic. KCP is concerned that the flaws in the initiative's design will hamper its ability to meet its goal of promoting high-quality care coordination for ESRD beneficiaries.

For patients, care coordination means having the opportunity to work with a team of providers whose expertise is in caring for individuals living with kidney failure and implementing new and innovative strategies for delivering disease-specific care. Dialysis facilities and nephrologists are in the best position to promote accountability for the population of patients with kidney failure, as well as to coordinate Medicare Part A and B services for these patients. That is because these providers engage directly with beneficiaries with kidney failure much more frequently than other providers because most ESRD beneficiaries receive dialysis treatments in facilities at least three times a week. Nephrologists see patients between one and four times each month. This frequency of direct patient contact, which is necessary and unique within the Medicare program, allows providers the opportunity to work closely with their patients to educate them about their disease, co-morbidities, and treatment options. It also provides for closer patient monitoring.

S. 598 includes a provision that would establish an alternative model to the current CMS initiative. If implemented, this program would, among other things, establish a gainsharing program for nephrologists, renal dialysis facilities, and providers of services that develop coordinated care organizations to provide a full range of clinical and supportive services for beneficiaries with kidney failure. The program would be designed to allow all types and sizes of dialysis facility providers to participate and reward them for reducing non-dialysis Medicare costs. Most importantly, the program would prioritize the attribution of beneficiaries on dialysis to dialysis facilities participating in the voluntary care coordination program, rather than force them into non-dialysis-based programs. This policy would ensure that beneficiaries relying upon dialysis receive care coordination services from providers whose expertise is in caring for individuals with kidney failure.

While we appreciate that CMS has developed a model to incentivize coordinated care, care coordination for the ESRD population is too important to focus on a single initiative. Therefore, we recommend you consider the voluntary care coordination provision from S. 598 as you develop legislation to promote chronic care coordination policies. Given the complexities of creating viable care coordination models we understand there may be other structures the Working Group may consider and we offer ourselves as a resource as you develop policies in this important area.

We appreciate the opportunity to submit our thoughts on ways to improve care for Medicare beneficiaries with chronic conditions. KCP believes these changes will go a long way to improve care coordination and the lives of those living with ESRD. KCP representatives will be available to meet with the Working Group and its members to answer any questions on the proposals or kidney care in general. We appreciate your interest in addressing these important issues.

Sincerely,

A handwritten signature in black ink, appearing to read "E. Jones, M.D.", written in a cursive style.

Edward Jones, M.D.  
Chairman