January 28, 2016

Senator Orrin Hatch
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

Senator Ron Wyden
Senate Committee on Finance
221 Dirksen Senate Office Building
Washington, D.C. 20510

Senator Johnny Isakson
Co-Chair
Finance Chronic Care Working Group
131 Russell Senate Office Building
Washington, D.C. 20510

Senator Mark Warner
Co-Chair
Finance Chronic Care Working Group
475 Russell Senate Office Building
Washington, D.C. 20510

Re: Bipartisan Chronic Care Working Group Policy Options Document

Dear Chairman Hatch, Ranking Member Wyden, and Chronic Care Working Group Co-Chairs Isakson and Warner:

On behalf of the American Society of Transplant Surgeons (ASTS), we are pleased to have this opportunity to comment on the Chronic Care Working Group (CCWG) Policy Options Document dated December 2015. ASTS is a medical specialty society representing approximately 1,800 professionals dedicated to excellence in transplantation surgery. Our mission is to advance the art and science of transplant surgery through leadership, advocacy, education, and training.

We applaud the CCWG for its comprehensive approach to improving care for this vulnerable patient population. Our comments address one of the proposals in the Options Paper which would make Medicare Advantage (MA) Plan enrollment accessible for Medicare patients with End Stage Renal Disease (ESRD).

We recognize that MA Plans may hold significant advantages over traditional fee for service Medicare for the ESRD patient population, especially in terms of increased coverage for pharmaceuticals and care coordination benefits for patients on dialysis. However, we are concerned that any expansion of MA that focuses exclusively on the dialysis population will downplay (possibly omit or deny) transplantation as a health benefit. This would be a huge disservice to ESRD Medicare beneficiaries who choose to enroll in MA Plans.

Kidney transplantation has significant clinical and cost advantages over dialysis for the treatment of most patients with ESRD. The average kidney transplant recipient lives more than twice as long as compared to remaining on dialysis (USRDS data) and enjoys markedly improved quality of life and longevity. Life expectancy after starting dialysis is 5.7 years and after kidney transplantation is 15.8 years. Transplanted patients are also more likely to be able to work than dialysis patients. Thus, to the extent that enrollment in an MA Plan either establishes barriers or impedes access to transplantation, it may significantly and adversely impact the life expectancy and quality of life of these Medicare patients with ESRD.

We understand that MA Plans are required to provide coverage for all services that are covered under Medicare Part A and Medicare Part B, including transplantation, and that MA Plans are subject to network adequacy and quality requirements. However, we also understand that MA Plan transplant center networks are currently limited and are concerned that access could be negatively impacted if patients require referral from the MA Plans in addition to the dialysis units. We encourage the CCWG to include provisions protecting access to transplantation in any legislation enacted to make MA Plan enrollment accessible for ESRD patients. Potential avenues to achieve this objective may include, for example, requiring access to transplantation quality metrics for MA Plans that enroll ESRD Medicare beneficiaries or mandating special CMS review of network adequacy for these services.

We appreciate the opportunity to comment on the CCWG Options Paper, and, again, appreciate the CCWG's detailed and comprehensive work on improving the quality and decreasing the cost of caring for this very special patient population.

Sincerely,

Charles M. Miller, MD
President

American Society of Transplant Surgeons
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