DPC
DIALYSIS PATIENT CITIZENS

Improving Life Through Empowerment

June 22, 2015

Hon. Johnny Isakson
Hon. Mark Warner
United States Senate
Washington, DC 20510

Re: Comments to the Chronic Care Working Group

Dear Senators Isakson and Warner:

As America's largest patient-led organization representing over 28,000 members, Dialysis Patient Citizens (DPC) works to improve quality of life for dialysis patients through education and advocacy. We appreciate this opportunity to advise the Working Group on how chronic illness care could be improved for patients with end-stage renal disease (ESRD). ESRD patients represent a small portion of Medicare beneficiaries but a disproportionately large percentage of Medicare expenditures. Much of these costs are due to complications of ESRD that could be preventable with increased care coordination.

We believe that the main barrier to care coordination for the ESRD population is the fragmented and siloed nature of Fee-for-Service Medicare. Although the bundled payment for dialysis and monthly capitation payment for nephrologists may encourage more holistic and longitudinal care than the more purely encounter-based payment methodology for other FFS patients, there is still insufficient flexibility and alignment of financial incentives to produce the kind of care that prevails in a more integrated delivery system. Below we discuss what we see as the three main methods of promoting chronic care for Medicare beneficiaries, and how they can be adapted to serve the ESRD population.

Medicare Managed Care – The Medicare Advantage Program.

Many if not most health policy experts believe that Medicare Part C is best suited to provide care to complex patients. In paying a health plan a capitated fee to provide all Medicare services to a beneficiary, there is greater flexibility to deliver appropriate services that are not reimbursed in FFS Medicare. Most health plans assign some type of case manager to complex patients to help them navigate the health care system and maintain their health between doctor visits or during transitions of care. The health plan's financial incentive is to help patients avoid hospitalizations—which account for most of the cost of care for ESRD patients—and measures to ward off complications may include offering free transportation, non-prescription vitamins or additional dialysis treatments when necessary.

ESRD patients are not entitled to enroll in Medicare Part C, but there is experience with health plans serving dialysis patients through Special Needs Plans (C-SNPs) and regular MA plans serving patients whose kidneys failed after enrolling at age 65. For example:

- At one ESRD Disease Management Demonstration site, by year three, hospitalization costs were reduced by 18 percent and overall expenditures by 11 percent. (This site continues today as a C-SNP.)
- The CareMore health plan assigns a nurse practitioner to each ESRD patient in addition to the nephrologist, and provides transportation if necessary to prevent missed dialysis sessions. This has reduced ESRD patients' hospital admissions by 36% and inpatient hospital days by 62%.

The ban on ESRD patients enrolling in Part C is an obsolete anomaly, a vestige of an era when both dialysis treatments and HMOs were novelties. MedPAC has called for the ban to be repealed. We hope that you will consider taking this step during your deliberations. Finally, we note that the C-SNP program through which ESRD patients are being served at several sites is scheduled to expire at the end of 2018; we ask that the program be permanently reauthorized.

Accountable Care Models - The ESRD Seamless Care Organization (ESCO)

The Accountable Care Organization (ACO) lies between capitation and pure FFS as an option that imposes performance risk on participants while retaining beneficiaries' freedom to utilize any provider. Shared savings give ACO participants a financial incentive to coordinate care to avoid hospitalizations. The Center for Medicare and Medicaid Innovation (CMMI) is testing an ESRD-specific variant of the ACO, the ESRD Seamless Care Organization (ESCO).

As with ACOs, the voluntary nature of ESCO participation means that CMS must balance the goal of reducing Medicare expenditures with generous enough terms to attract providers. Providers can vote with their feet by declining the opportunity to participate in an ACO or ESCO. In both cases, the program must set realistic expenditure targets, especially for later years.

Given that dialysis organizations have already shown their ability to coordinate care in partnerships with health plans, we are confident that ESCOs can improve outcomes for ESRD patients. We urge the Committee to monitor the progress of the ESCO program with an eye to ensuring that it is attracting a sufficient number of participants. A low level of participation would mean that Congress may need to step in to prescribe appropriate terms. From the patient perspective, the bottom-line goal is improved care coordination and fewer complications, so we are agnostic as to how the savings it generates are divided between Medicare and providers.

We further note that Senator Wyden's Better Care Organization concept may also be an appropriate vehicle for implementing an ESCO-type model, and urge the Working Group to explore that possibility with nephrologists and dialysis providers.

Add-on Payments for Chronic Care Management Services

CMS and other payers have been testing Medical Home models, and CMS is now permitting physicians to bill for chronic care management (CCM) services beyond individual office visits. Unfortunately, the $42 monthly CCM payment does not appear to be attracting significant take-up from nephrologists to perform these functions.

We were intrigued by a provision in an early discussion draft of H.R. 2 that would have permitted entities other physicians to receive CCM payments. It seems to us that dialysis organizations may have the economy of scale to provide chronic care management services to ESRD patients at or near this cost. We urge the Committee to explore the possibility of permitting additional entities to undertake CCM services. We understand the desire to limit CCM payments to physicians as opposed to, say, disease management vendors that may rely solely on telephonic contacts. But it strikes us that a dialysis organization already treating the patient would be well-situated to provide these services in a way that is integrated with the rest of the patient's ESRD care.

We commend Chairman Hatch and Ranking Member Wyden for initiating this important project, and thank you for your consideration of our views. If you have any questions, please contact our Director of Government Affairs, Jackson Williams, who can be reached at jwilliams@dialysispatients.org.

Respectfully submitted,

Hrant Jamgochian
Executive Director