



January 25, 2016

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:

Kidney Care Partners (KCP) applauds the Working Group for its diligent and comprehensive examination of how best to improve care delivery for individuals living with chronic conditions. Proper management of chronic conditions will improve the health and quality of life for millions of individuals, while reducing system-wide health care costs.

KCP is an organization of patient advocates, nephrology professionals, dialysis providers, and manufacturers whose mission is ensure that 1) individuals with chronic kidney disease (CKD) and end-stage renal disease (ESRD) receive optimal care and are able to live quality lives, 2) dialysis care is readily accessible to all those in need, and 3) research and development lead to enhanced therapies and innovative products. ESRD is an irreversible failure of kidney function that is fatal without a kidney transplant or dialysis treatments. There are more than 26 million adults living with CKD, which can lead to kidney failure if untreated. More than 636,000 Americans are living with kidney failure with about 430,000 of these individuals relying on dialysis. The number of individuals suffering from ESRD is expected to double over the next decade.

As noted in our prior submission to the Working Group, KCP is committed to passage of S. 598, the Chronic Kidney Disease Improvement in Research and Treatment Act, introduced by Senators Ben Cardin, Mike Crapo and Bill Nelson. This bill addresses kidney disease in a comprehensive manner – from more efficient research into the causes of the disease to effective management and treatment, but we understand that several parts of the bill are outside the scope of the Working Group's focus. We appreciate the time and thought the Working Group has put

into the option paper, and we thank the authors in particular for their consideration of policies to lift the prohibition on beneficiaries with ESRD enrolling in a Medicare Advantage (MA) plan, permanently extend Special Needs Plans (SNPs), and encourage the utilization of home dialysis.

Allowing ESRD Patient Access to MA Plans

Proper management and treatment of ESRD is extremely time intensive, which usually involves dialysis three to four times a week with each session lasting three to four hours. Individuals with ESRD do not live with this disease in a vacuum, but typically have one or more serious co-morbidities, such as diabetes, high blood pressure, cardiovascular disease, and congestive heart failure. The Working Group's work demonstrates an appreciation for the benefits, both to the patient and the health system as a whole, that are derived from effective care coordination. MA plans provide this type of care coordination, but the benefits of these plans are uniquely unavailable to the vast majority of dialysis patients.

Beneficiaries with ESRD who are on dialysis are the only group within the Medicare program prohibited from enrolling in MA plans, even though this vulnerable population would benefit significantly from the care coordination provided by these plans. As the Working Group noted, beneficiaries that age on to the program and are already enrolled in an MA plan prior to developing ESRD may continue with their MA coverage, but those who develop ESRD while in fee for service are prohibited from enrolling in an MA plan.

In 2013 according to the Medicare Payment Advisory Committee (MedPAC), 14 percent of ESRD beneficiaries were enrolled in an MA plan, demonstrating that plans can and do properly manage the care of these individuals. Since this population aged on to the program, they would tend to have more age related co-morbidities than those beneficiaries under 65 with ESRD. The argument that ESRD patients are too complex to be adequately managed by MA plans breaks down against the empirical evidence of plans current experience with aged ESRD patients. To the contrary, patients requiring careful coordination of care and management of multiple comorbidities are the very patients MA plans are expert at managing.

We understand that plans have critiqued the current risk adjustment model for Medicare Advantage, and the Working Group has asked whether the benchmark and bid process would have to be adjusted if MA plans were to take on additional ESRD patients. It is important to note that MA plans already receive a risk-adjusted payment for their ESRD enrollees. This risk adjustment methodology for ESRD patients is separate and distinct from the risk adjusted payments they receive for their non-ESRD enrollees that has come under criticism.

Unlike the bidding and benchmark capitated payment model that governs the vast majority of MA per member, per month payments, MA plans are paid a more granular, risk-adjusted payment based on a state-wide average of ESRD spending in traditional Medicare that reflects actual ESRD treatment type (dialysis, transplant, and functioning graft status). CMS has determined that this payment is more accurate for ESRD patients because the standard CMS-HCC model does not make the same important treatment distinctions. Such distinctions are critical in predicting the relative cost of treating the patient. CMS further refines MA ESRD

payments by adjusting for demographics, comorbid conditions, new enrollee status, and community versus institutional setting.

We believe plan experience with current ESRD beneficiaries, the relatively small number of people this policy would affect compared to the overall MA population, and the current unique risk adjustment methodology combine to demonstrate there is no need to adjust the bid and benchmark process if all ESRD beneficiaries were allowed the choice to enroll in MA plans.

The Working Group has also asked what quality measures are available to ensure that ESRD beneficiaries would have the information to make an informed choice when deciding whether to enroll in an MA plan. The National Committee for Quality Assurance (NCQA) health plan rankings does not report on condition-specific domain measures for many conditions most common in the Medicare population, including ESRD. Nevertheless, ESRD beneficiaries currently can glean valuable insights on an MA plan's overall quality through NCQA's publicly reported patient satisfaction domain scores and through scores for measurement domains related to prevalent, related comorbid conditions such as diabetes. ESRD beneficiaries also can look to CMS' own general star ratings for MA plans for additional information on plan performance.

KCP would be supportive of the development of a clinically valid and relevant measurement domain that provides an accurate assessment of the quality of care for ESRD patients by individual MA plans. However, ESRD patients should not have to wait for the development of such an approach before they are provided the choice to enroll in an MA plan.

As far back as 2000 MedPAC has recommended eliminating the prohibition on ESRD beneficiaries enrolling in an MA plan. Since that time, the evidence has only grown stronger that proper care coordination can lower health care costs and improve patient outcomes. Most importantly, ESRD patients want the choice that every other Medicare beneficiary has – to enroll in a Medicare Advantage plan. We strongly support the Working Group's policy proposal to lift this outdated prohibition.

Extending SNPs Permanently

The Working Group has also proposed a permanent or long-term extension of SNPs. As part of the deliberation of this proposal the Committee asked a broader overarching question on flexible benefit design in the Medicare Advantage program. KCP does not have a position or experience on that issue to provide any meaningful comment but we do believe the tailored benefits and specific expertise of SNPs play an integral role in caring for the ESRD population. We support the Working Group's move away from year to year extensions of SNPs and believe a long term or permanent reauthorization of SNPs would bring a degree of certainty needed to allow these plans to evolve to best serve the needs of vulnerable populations.

Testing New ESRD Care Models

In addition to modifying and extending existing programs, such as traditional MA plans and SNPs, KCP encourages the Working Group to develop and implement other care models that advance care coordination for ESRD patients. The high costs associated with ESRD patients'

care and the complexity of their clinical and non-clinical needs warrant this additional focus. In our view, the considerable time that ESRD patients spend at dialysis facilities creates a strong rationale for care models that support dialysis providers and clinicians with substantial kidney care expertise in assuming greater leadership and accountability roles in serving ESRD patients currently receiving care under FFS.

Encouraging Home Dialysis Through Telehealth

The Working Group has also explored ways to increase the utilization of home dialysis through telemedicine. KCP supports the recommendation to allow free standing dialysis clinics to be originating telemedicine sites. We believe the use of dialysis clinics as originating sites will increase the pool of individuals who can properly and effectively use home dialysis, particularly in rural and underserved areas. Home dialysis requires a special commitment to care, and for those individuals with the capability and support necessary to dialyze at home, the ability to use technology to have a virtual visit with their physician can improve the quality of care and quality of life for ESRD beneficiaries. While we recognize that the Working Group's proposal specifies home hemodialysis, we believe that patients using any home dialysis modality should be eligible to take advantage of telehealth options.

Currently, beneficiaries dialyzing at home are required to have a face-to-face visit once a month. The Working Group has asked whether a face-to-face physician examination every three months should be required if free standing clinics are used as originating telehealth sites. Facilities have the necessary professional expertise to work with patients in conjunction with a telemedicine visit with the physician to ensure the patient's home dialysis treatment protocol is working as intended, including an assessment of the access site. However, we do support requiring an in-person physician visit *a minimum of every three months*, which would ensure the physician is able to adequately determine the efficacy of the treatment, examine the access site, and engage with the patient to assess his or her overall health status. However, more frequent in-person visits are expected to be necessary on a case-by-case basis, and any policy developed in this area should make such allowances.

We thank the Working Group for its commitment to improving care delivery and outcomes for Medicare beneficiaries with chronic conditions. Without question, your work will lead to a more efficient health care system and improved quality of care and quality of life for millions of Americans.

Sincerely,

A handwritten signature in dark ink, appearing to read "Franklin Maddux". The signature is fluid and cursive, with a stylized "F" and "M".

Franklin Maddux, M.D.
Chairman