NRAA National Renal Administrators Association

June 22, 2015

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

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

Dear Senators Isakson and Warner:

On behalf of the National Renal Administrators Association (NRAA), I am pleased to submit comments to the Senate Finance Committee's working group on chronic care for your consideration as work begins on developing policies to improve chronic care in Medicare.

The NRAA is a voluntary organization representing dialysis providers throughout the United States. Our membership is primarily small dialysis organizations, both for-profit and non-profit providers serving patients in urban, rural and suburban areas in both free-standing and hospital-based facilities. We work with patients who suffer from End Stage Renal Disease (ESRD) and Chronic Kidney Disease (CKD), as well as the physicians, nurses and other care team members who treat them. Our work with these patient populations has given us great insights on the ways Medicare's policies can inhibit the most effective treatment of patients with chronic conditions. Reform in this area is long overdue, and we applaud the Committee for taking on this initiative.

Reforms to Medicare's Current Fee for Service Programs and Barriers to Care Coordination

Care for chronic conditions in Medicare could greatly improve if Medicare was able to hold the patient, as well as the providers, accountable for the care they receive. Although most patients are active participants in their care, there are some that consistently refuse to follow the recommendations of the providers who are treating them or adhere to treatment plans. For patients such as these, typical tools for increasing patient adherence, such as education, are ineffective. In the health care system, cost control has three pillars: the payer, the patient, and the provider. All three entities have to work together to improve care and control costs—especially in the area of chronic disease—but Medicare's current structure places all of the burden on the payers and the providers. Patients must be an equal partner in improving their health care outcomes and any reforms to the Medicare program should address this need.

The Committee should also examine the restrictions that Medicare places on reimbursement regarding where the care is delivered. For example, primary care physicians are not currently allowed to bill Medicare if they see patients in an outpatient dialysis clinic. This restriction on reimbursement removes any opportunity for the dialysis clinic to coordinate the patient's care while the patient is dialyzing. Patients who receive dialysis treatment in an outpatient facility receive treatment three times a week for four hours at a time. If other providers were allowed to bill for services they provide outside of their offices, the dialysis facility could take an active role in coordinating care for dialysis patients by arranging for them to see other providers while they are receiving treatment. Allowing care to be coordinated in such a way would make it easier for the patients, who often must see multiple providers, and would help ensure that they are getting all of the medical care they need. This flexibility could greatly enhance the coordination of care and communication between providers.

The Committee should consider revisions to the Medicare program that would support greater flexibility for the delivery of care in various settings.

The current fee for service structure does not encourage case management. Although Medicare does currently provide reimbursement for chronic care management (CCM), the requirements for receiving the reimbursement are too onerous. In order to get reimbursed through this mechanism, Medicare requires that physicians be available to provide general supervision to cover 24/7 call at all times. It is also only available for patients with certain chronic conditions. Additionally, the reimbursement is only available to physicians and is not inclusive of other providers that may be involved in patient case management. Medicare should provide reimbursement for care coordination and case management activities in all settings where patients receive chronic care, and it should be inclusive of all providers who are involved in these activities.

We applaud the efforts underway at CMS to formally establish delivery systems that will provide for increased coordination in care for patients with chronic conditions. One of these efforts is the Comprehensive ESRD Care (CEC) Initiative, which allows groups of health providers and suppliers to come together in ESRD Seamless Care Organizations (ESCOs) to provide care for ESRD patients. The CEC Initiative is the first disease-specific Accountable Care Organization (ACO) model designed by CMS. NRAA submitted comments to CMS throughout the ESCO design process, and we are hopeful that the agency will find success in the demonstration project. We encourage the Committee to consider ways to support the further development of the ESCOs and other entities like them. However, we also urge the Committee to consider how to transfer the ESCO model, and others like it, to smaller entities. In the CEC Initiative, dialysis facilities were required to have at least 350 patients to participate. Unfortunately, this requirement meant that many smaller dialysis facilities are not able to participate in the demonstration and understand its benefits for their patients. Small facilities would also like to be able to bring a system of care coordination with other providers to their patients. The Committee should consider establishing a program that would focus on small providers and that would allow them to participate in ESCO or ACO-type projects without having to meet the onerous requirements that only large providers can meet. Such a program would make all providers eligible to participate in the Medicare delivery reforms that Congress and CMS are trying to enact.

Finally, barriers to the exchange of patient information between inpatient and outpatient providers often prohibit care coordination. For patients with chronic conditions who often have multiple health care providers, these barriers are especially problematic. For example, when a dialysis patient is discharged from a hospital to an outpatient facility for treatment, the facility is often unable to get the discharge information about their condition from the referring hospital, physician, or nursing home. There is no common medical database that allows all providers to exchange patient information. Additionally, the patients don't always bring their records with them when they come to a facility for the first time. Often, the facility is entirely dependent on the referring provider to send the appropriate patient information. If the facility is not part of another provider's system, it is often told it cannot have access to a patient's hospital records and discharge information. In rural and frontier areas where the physical distance between various providers and facilities are far apart and relationships are harder to establish, getting patient records is even more difficult. This situation is exacerbated for dialysis facilities because they are not eligible for Medicare incentives provided to physicians and hospitals for establishing meaningful use of interoperable health information technology systems. When dialysis facilities are unable to get information on a patient's health background, comorbid conditions, previous treatments, and inpatient discharge instructions, it costs Medicare money because proper care for the patient may be delayed. Incentives for improving the exchange of patient information among providers would help give each provider the necessary tools they need to make the best decisions for their patients. The Committee should also consider establishing a patient database within Medicare to make this information easier for providers to obtain.

Medicare Advantage

Patients with CKD, Stage 5, who are enrolled in Medicare Advantage typically have a harder time receiving appropriate care than they do under traditional fee for service Medicare. One of the biggest problems is that these plans require preauthorization for dialysis treatment. Medicare Advantage plans should also be strictly monitored to ensure that they are adhering to Medicare's reimbursement policies for patient benefits. Finally, reimbursement for dialysis in Medicare Advantage plans is lower than in traditional fee for service and is wholly inadequate. Low reimbursement places a hardship on facilities that may already be struggling to provide care for these patients. Unfortunately, Medicare Advantage plans are not achieving the promise of care coordination for patients with CKD, and other patients with chronic diseases may be facing similar problems. The Committee should consider changes to the Medicare Advantage program that would provide patients with more flexibility on their choice of provider, allow patients to receive care at any Medicare certified facility with only a one-time pre-authorization, ensure patients are receiving the benefits they were promised, and provide adequate payment to providers.

Telehealth

Patients with chronic conditions often have treatment plans that require frequent visits with their health care providers. Telehealth can be a valuable tool for facilitating these visits and providing improved access to care for beneficiaries. Because of this value, NRAA suggests the Committee consider changes to the Medicare program that would allow for increased coverage of ESRD services offered by telehealth. Increased use of telehealth services will allow both home and in-center dialysis patients greater flexibility in scheduling with and increased access to their physician or practitioner. The result will be better patient care.

Medicare does not currently allow a patient's home to be an originating site for telehealth services in the Medicare program. Outpatient dialysis facilities that are not in rural, medically underserved areas also cannot be an originating site for Medicare telehealth services. This statutory restriction prevents dialysis patients from taking full advantage of the benefits of telehealth, and we advocate for its elimination. We also recommend that the monthly physician capitation payment for ESRD services for home dialysis be added to the list of approved Medicare telehealth services. Further, CMS should be encouraged to provide flexibility regarding the monthly face to face requirement for dialysis provided in a facility. All of these changes together would allow dialysis patients to take full advantage of the benefits that telehealth has to offer.

Both home dialysis and in-center dialysis patients are required to have one face to face visit per month with their physician or practitioner. NRAA understands the value of the face to face requirement, and is not advocating for its elimination. However, there are instances where the face to face requirement may not be possible to meet every month. In many cases, the patient's schedule does not align with that of the practitioner or providers. Scheduling can be especially difficult in rural areas where patient homes and their dialysis facilities can be far apart. When that happens, the patient's consultation with their health care provider could be delayed. Telehealth is a viable tool to help alleviate these scheduling difficulties and to make sure that patient contact with their nephrologist remains consistent. The changes we are recommending would allow telehealth to be used to satisfy the monthly face to face requirement and also provide patients with more options regarding the care they receive.

Patient Education, Empowerment, and Engagement

NRAA and the entire nephrology and dialysis community strongly believe there is a significant opportunity to improve outcomes for dialysis patients by providing them with CKD education. Currently, Medicare fee for service only allows this education for patients in a nephrologist's office or in a clinic setting. It is also restricted to patients who are in CKD Stage 4. Dialysis facilities should be allowed to provide this education for patients

who are in CKD Stage 5 and to CKD Stage 5-Dialysis patients who have not received CKD education prior to initiation of renal replacement therapy. Additionally, other providers besides physicians should be reimbursed for providing this education to patients. Unfortunately, physicians are often too busy to spend the necessary time with CKD patients to provide the education they need to become informed and engaged in their care. Dietitians, social workers, and nurses who are subject matter experts all take an active role in providing patients with the necessary education, and they should be recognized by Medicare for doing so. Education for CKD Stage 5 patients on fluid and diet restrictions would help patients establish habits that may even help to delay the progression of CKD and ultimately reduce inpatient hospitalizations. Educating CKD Stage 5-Dialysis patients would also encourage more patients to opt for home dialysis or transplantation, which may be better care options. Home dialysis patients have fewer hospitalizations, use fewer medications, and enjoy a higher quality of life. Education would also help establish a patient mentality where they see themselves as partners in their care with their nephrologist, dialysis facility, and other providers. The knowledge they would receive would provide them with the necessary tools to communicate with their providers and feel informed about the decisions they and their providers make about their care.

Additionally, the NRAA recommends that the Committee encourage Medicare to provide uniform education tools and materials for dialysis providers and other practitioners to use with CKD and ESRD patients. Currently, there is no central repository, resource, or curriculum that providers can turn to when Medicare does allow them to provide patient education. As a result, the information that patients receive is often fragmented and incomplete. Small providers, especially, may struggle with having the necessary resources to provide patient education. A centralized, uniform, set of tools and guidelines within CMS would help ensure patients are receiving all the education they need to fully participate in their care.

Conclusion

NRAA appreciates your consideration of these recommendations for improving care for Medicare patients with chronic conditions, especially those with Chronic Kidney Disease and End Stage Renal Disease. If you have any questions, please do not hesitate to contact Debbie Cote at (434)924-5590 or dcote@virginia.edu or Cary Gibson at (202)530-4875 or cary.gibson@prime-policy.com.

Sincerely,

Deborah A Cote MSN, RN, CNN, NE-BC

Debbie Cote
President