N K
C A
Nonprofit Kidney Care Alliance

January 11, 2017

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: CMS-3337-IFC, Medicare Program; Conditions for Coverage for End-Stage Renal Disease Facilities—Third Party Payment; Interim Final Rule with Comment Period, December 14, 2016.

Dear Administrator Slavitt:

On behalf of the Nonprofit Kidney Care Alliance (NKCA), I write to offer comments on the Interim Final Rule with Comment Period on the Conditions for Coverage for End-Stage Renal Disease (ESRD) Facilities—Third Party Payment. NKCA represents five nonprofit dialysis providers: Centers for Dialysis Care; Dialysis Clinic, Inc.; Independent Dialysis Foundation, Inc.; Northwest Kidney Centers; and The Rogosin Institute. Collectively, we serve over 20,000 patients at more than 280 clinics in 30 states. Consistent with our belief that we can do more to keep patients *off dialysis*, we also serve more than 4,500 patients with chronic kidney disease (CKD), with the goal of avoiding, or at least delaying, onset of ESRD. Approximately 85 percent of our patients are covered by Medicare, including Medicare Advantage plans.

NKCA feels strongly that no patient should ever be "steered," nor should payment of premiums and cost-sharing by third party entities be conducted in any way other than to promote the best interests of the beneficiary. As we stated in our comments on the original Request for Information (RFI) in September, to the extent that these two principles are being compromised, the Centers for Medicare and Medicaid Services (CMS) should focus its attention on the small minority of entities that may be doing so; employ the remedies which it already has at its disposal; and then, if necessary, provide additional guidance and regulatory remedies after notice and opportunity for comment.

Instead, CMS has published an interim final rule with comment (IFC) with an effective date only two days after the comment period closes. Not only does this call to question how stakeholder comments can be addressed, but also provides a significant challenge to implement in such a short time frame.

We urge CMS to withdraw, or at least suspend implementation of the IFC in order to take additional comment, carefully weigh stakeholder comments, and then issue a revised rule with sufficient time to implement. Such a process will also enable CMS to provide clear and consistent guidance to surveyors who will be assessing facility compliance with the new Conditions for Coverage (CfC).

CMS needs to distinguish between "steering," which should not be tolerated, and the education, counseling and navigation carried out in the best interest of the patient. Responsible providers assist their patients every day in understanding the financial challenges they face and making the right decisions for themselves and their families. Plans should not be "selected against" either by the actions of providers or other plans. In this regard, it is critical that CMS provide for robust risk adjustment in both Marketplace and Medicare Advantage plans so that plans are adequately reimbursed for the high cost of caring for dialysis patients.

Most dialysis patients will face enormous healthcare, social and financial challenges which will confront them for the rest of their life. It is not "steering" if a patient, after understanding the health and financial choices they face, chooses to enroll, or stay enrolled, in a Marketplace plan. In some cases, a patient may prefer enrollment in a private plan if the provider network and/or the plan's drug formulary is more robust.

For dialysis patients, the out-of-pocket cost for in-center dialysis treatment prior to becoming Medicare eligible, is nearly $9,000 ($2995.07/month for three months). But if the patient qualifies for Medicaid, his or her dialysis payments may be largely, if not fully covered. However, a patient in Medicaid may not have access to appropriate specialists needed for their care.

If not eligible for Medicaid, and after 90 days they are Medicare eligible, they face monthly Part B premiums ($121/month) and 20% coinsurance of approximately $720 per month, after satisfying the Part B deductible of $166. Thus, in the first year, waiting 90 days until eligibility, the patient faces approximately $16,735 just for the cost of dialysis care. In future years, the annual cost of dialysis care would be approximately $10,258.

We urge CMS to recognize that while Medicaid coverage may be an option for some patients, reimbursement is generally so low that access to specialists is often limited, if available at all. We trust CMS is aware of this disparity and were surprised to see it ignored in the IFC. If a patient cannot reasonably obtain access to the specialty care they need because the practices/providers are closed to Medicaid patients, then an individual market plan will be the better alternative both for the patient and ultimately to the healthcare system.

In some states, there are other public programs in addition to Medicare and Medicaid that help with the cost of premiums and coinsurance for Medicare, Medigap, as well as individual market plans. However, many small, nonprofit ESRD providers operate in states lacking such programs which must then turn to private third party foundations, such as the American Kidney Fund to help their patients. Yet, while the IFC only implicates individual market plans directly, CMS does not provide guidance on how ESRD providers can contribute to third party payment entities for premium assistance in Medicare, Medigap, and group health (including COBRA).

On the one hand, CMS notes:

> However, third party assistance is also frequently available to offset out-of-pocket costs for Medicare enrollees. Moreover, if dialysis facilities were not providing assistance for

individual market coverage on such a widespread basis, they might use these resources to make assistance for out-of-pocket Medicare costs even more available.

Yet, aside from its comment in footnote 16 that "mere recitation on a check that a contribution cannot be used for premium payments would not establish that an organization is unable to use the contribution for such payments," At this time, CMS does not provide guidance on how contributions can be made in a clear manner that facilities can rely upon and that surveyors will find easy to validate.

Our greatest concern in the IFC is what amounts to a back door pre-existing condition exclusion, in which, even after an ESRD patient is informed of their options, the IFC requires the facility to ask a payer if they will accept third party premium assistance. We know of no other federal healthcare policy wherein a patient can effectively be discriminated against in such a manner. While the IFC carries the statement, "Regulations…prohibit issuers from discriminating against or employing marketing practices that discriminate against individuals with significant health care needs", the practical effect of the requirement to ask payers if they will accept third party premium assistance for an ESRD patient is the same. ESRD is an essential health benefit in Qualified Health Plans under the ACA. We are now in year four of the Marketplace private plans, and plan actuaries should have a better grasp of their risk pool. Clearly, the cost of caring for dialysis patients is much greater than for the typical patient. This underscores the need for a robust risk adjustment system so that no single plan be disadvantaged. We recognize that in some markets, area's plans may confront a highly concentrated market, reflecting the concentration in the national dialysis market. This should not affect the ability of patients to choose the best plan, public or private, that best serves their needs. We urge CMS to withdraw this provision.

Thank you for the continued opportunity to comment on the issue of third party payment. As nonprofit providers, we are affected by these changes much differently than others. We would be pleased to discuss our comments in greater detail at any time. If you have any questions, please feel free to contact Martin Corry at 202-580-7707 or info@nonprofitkidneycare.org.

Sincerely,

Martin Corry
Executive Director