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Nonprofit Kidney Care Alliance

June 26, 2017

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
c/o Angela Tejeda
Office of the Assistant Secretary for Planning and Evaluation
200 Independence Avenue SW
Washington, DC 20201

Re: Public Comment on Renal Physicians Association Incident ESRD Clinical Episode Payment Model

Dear Committee Members:

On behalf of the Nonprofit Kidney Care Alliance (NKCA), I write to offer comments on the proposed Renal Physicians Association (RPA) Incident End Stage Renal Disease (ESRD) Clinical Episode Payment Model. NKCA represents five nonprofit dialysis providers: Centers for Dialysis Care; Dialysis Clinic, Inc. (DCI); 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 5,000 patients with chronic kidney disease (CKD), with the goal of avoiding, or at least delaying, onset of end stage renal disease. Approximately 85 percent of our patients are covered by Medicare, including Medicare Advantage plans. Four of our five members also participate in the Comprehensive ESRD Care (CEC) Model through the Centers for Medicare and Medicaid Innovation (CMMI). Collectively we are responsible for 10 ESRD Seamless Care Organizations (ESCOs) across the country in both one-sided and two-sided risk models.

Approximately 26 million Americans suffer from kidney disease, at an estimated cost to the Medicare program of $99 billion[1]. Our goal is to improve patients' quality of life by providing the best care, not just for dialysis patients but also for those with chronic kidney disease, to reduce the risk and slow the progression of kidney disease to avoid, or at least delay, the onset of ESRD, and increase the number of patients who can benefit from kidney transplants. Kidney disease (both CKD and ESRD) is a chronic illness that doesn't exist alone. It is often accompanied by multiple co-morbidities, including diabetes, congestive heart failure, and high blood pressure. Kidney disease also exists over many years, making it a particularly appropriate candidate for coordinated care models.

While many of the tenets of the Clinical Episode Payment (CEP) model match our own, we are concerned the model does not go far enough to address CKD and does not include the appropriate providers to be meaningful. We offer our comments based on our experience in the current ESCO model and our CKD programs.

[1] USRDS. 2014 Annual Report

Addressing CKD Upstream for Better Outcomes

The NKCA believes the single most important change that can occur for patients with kidney disease is to better align the incentives of the current reimbursement system and metrics to encompass care for patients with kidney disease, at whatever stage of their journey, rather than focus predominately on patients on dialysis. To provide optimal care, interventions should focus on the patient where that person currently sits, instead of seeing the patient as someone who may need dialysis in the future. We believe that by focusing on CKD "upstream" we can reduce the number of patients who need dialysis, and increase those who can benefit from transplant.

We are pleased to see in the proposed CEP Model a focus on appropriate transitions that support better outcomes and lower costs. We believe that transplant is the optimal therapy for individuals with kidney disease. For those individuals who need dialysis as a therapy, it is critical to work with the patient early enough that the patient can make the best decision for his or her own care. Unfortunately, too many patients start dialysis in the emergency room unaware until then that they had kidney disease, or at least are ill-prepared. By preparing patients early, and following them closely, there are many positive results for patients dealing with this disease. Several of our members have programs specific to CKD in which we see the following:

- **More patients receive a pre-emptive kidney transplant and avoid dialysis**. Nationwide the pre-emptive transplant rate is 2.6%. In The Rogosin Institute's CKD program, patients have a 14% pre-emptive transplant rate.
- **Patients are educated on medical management without dialysis and when appropriate patients choose this option.** In the DCI CKD program in Spartanburg, SC, more than 15% of patients are choosing medical management without dialysis.
- **More patients receive education on and then choose home dialysis.** In the Northwest Kidney Centers' Choices CKD program in Seattle, WA, 31% of patients start dialysis at home.
- **More patients start hemodialysis with a permanent access.** In the Northwest Kidney Centers' Choices CKD program, more than 76% of patients start hemodialysis or peritoneal dialysis with a permanent access and never have a catheter.
- **More patients receive their first dialysis treatment as an outpatient and avoid an initial hospitalization.** In the DCI program in Spartanburg, SC, 58%, and in the Northwest Kidney Centers' Choices CKD Program 64% of patients starting dialysis in 2015 from the CKD programs avoided a hospitalization for their first treatment.
- In the DCI REACH program 500 (out of 4500 patients in 29 sites) are now being cared for at CKD Stage 5 and are being kept off dialysis.

While we appreciate the intention to encourage these modalities in the CEP model, we believe it does not go far enough or capture patients early enough in the progression of CKD to have the impact necessary for these patients. In their proposal, RPA notes that many nephrologists only see patients for the first time just before the onset of ESRD, making the structure of this model initiating at the start of dialysis difficult.

Currently, there is a huge missed opportunity to improve care for these patients, since most of these patients are not receiving care related to their kidney disease. According to the United States Renal Data System (USRDS), only 7.7% of patients with stage 3 CKD even know that they have kidney disease and for patients with stage 4 CKD, only 53% of the patients even know that they have kidney disease. Data suggests that earlier referral to nephrologists can slow the rate of progression of kidney disease and better prepare a patient for transition to the next step in care. Equally important is that patients' primary care physicians diagnose CKD earlier. Unfortunately in the United States, the majority of patients still "crash" into dialysis without having the opportunity to be educated and explore the full set of options available to them.

We recommend that a model going upstream to address transitions in ESRD care must identify the eligible population based on their Glomerular Filtration Rate (GFR). We believe the most appropriate GFR level for a model should be a GFR less than 45, or CKD stage 3b, in order to provide the opportunity to slow progression of CKD and, ideally, avoid dialysis.

We estimate that a program managing this population would have the following distribution of patients based on the National Health and Nutrition Examination Survey (NHANES) data[2]:

- Stage 3b (GFR 30-45): 69.2% (14,750 patients per 1 million patients)
- Stage 4a (GFR 20-30): 15.0% (3,200 patients per 1 million patients)
- Stage 4b (GFR 15-20): 7.5% (1,600 patients per 1 million patients)
- Stage 5, not on dialysis (GFR < 15): 6.6% (1,450 patients per 1 million patients)
- Transitioning to renal replacement therapy each year: 1.7% (359 patients per 1 million patients)

The cost of care for these patients is significant and as the patient's kidney disease progresses, the cost of care increases. The following is an estimate of cost of care by stage, based on an analysis of 2013 Medicare 5% claims data:

- Stage 3: $23,680 per year (2.2 times the cost of care for typical patient with Medicare coverage)
- Stage 4: $33,374 per year (3.1 times the cost of care for typical patient with Medicare coverage)
- Stage 5 *not on dialysis*: $36,147 per year (3.3 times the cost of care for typical patient with Medicare coverage)
- Stage 5, *on dialysis*: $84,645 per year (7.8 times the cost of care for typical patient with Medicare coverage)

We note the difference in cost of care for a patient with stage 5 CKD not on dialysis and a patient on dialysis. For every month that the start of dialysis is delayed, there is not only a decrease in the cost of care for Medicare by more than $4,000 per patient but also for some a better quality of life. These costs can also be compounded since many CKD patients also have diabetes and hypertension.

[2] 2015 USRDS

Role of the Nephrologist and Other Partners

We believe that the role of the nephrologist is the most important aspect of any model addressing CKD or ESRD. We consider them to be the captain of the ship and should always be the one to make the clinical decisions for the patient and take on a leadership role within the APM entity. With that in mind, based on the CEP proposal, we are concerned that there is no discussion, and even an exclusion of other providers in the model. Without any other partners in the administration of the model, nephrologists and nephrology practices may not have the necessary infrastructure to administer the model. ***We believe that others, including dialysis providers, hospitals, or others are necessary to carrying out this model to encompass all care services for these patients, while also providing the structural support necessary for success.***

We believe having various partners, such as in the current ESCOs, is incredibly valuable in order to coordinate services, provide financial and administrative support, and share in the decision-making of the entity. For instance, in the ESCO, nephrologists are owners in the model, along with dialysis and other providers who sit on a board for the organization to promote coordinated decision-making and support, while still keeping the nephrologist at the center of patient care. Our members have also utilized less formalized partnerships in the ESCOs with hospitals, primary care physicians, hospice providers, and local community groups to expand their reach and the services provided to patients. We feel strongly that any model moving forward should include all providers responsible for the care of patients with kidney disease.

Conclusion

Thank you for the opportunity to comment on the proposed Renal Physicians Association Incident ESRD Clinical Episode Payment Model. We would be happy to discuss any of our comments further if that would be of assistance to PTAC members. If you have any questions, please feel free to contact me at 202-580-7707 or info@nonprofitkidneycare.org.

Sincerely,

Martin Corry
Executive Director