



Nonprofit Kidney Care Alliance

July 12, 2016

The Honorable Dean Heller
324 Hart Senate Office Building
Washington, DC 20510

The Honorable Bill Nelson
716 Hart Senate Office Building
Washington, DC 20510

Dear Senators Heller and Nelson:

On behalf of the Nonprofit Kidney Care Alliance (NKCA), I want to thank you for your commitment to better care for patients with end stage renal disease (ESRD). However, we believe that all patients with kidney disease deserve better care through open access and choice, therefore we cannot support S. 3090, the Dialysis PATIENT Demonstration Act of 2016 at this time.

NKCA represents five nonprofit dialysis/kidney care providers: Centers for Dialysis Care; Dialysis Clinic, Inc. (DCI); Independent Dialysis Foundation, Inc.; Northwest Kidney Centers; and The Rogosin Institute (Rogosin). Collectively, we serve over 20,000 ESRD patients at more than 280 facilities in 30 states, as well as thousands of patients with chronic kidney disease (CKD). Although the members of NKCA are committed to providing the best possible care for ESRD patients, we also have a broader commitment to focusing “upstream” on the earlier detection and the improved management of patients with CKD so that fewer patients need dialysis (or at least delay its start) and are better transplant candidates. Our collective programs in these areas, including the improvement of kidney transplantation rates, are aimed at producing a lower burden of disease, as well as better quality of care at lower cost for those who need it.

With specific regard to ESRD patients and the Dialysis PATIENT Demonstration Act of 2016, we offer the following comments:

First and foremost, our goal, as NKCA and as providers caring for individuals with ESRD, is for patients to have a choice in their dialysis provider. If we can continue to have a broad range of providers, patients on dialysis can benefit from the different and often innovative approaches developed by each provider. We see no reason for beneficiaries to be involuntarily enrolled in a plan and then required to opt-out, in order to preserve their freedom of choice. This puts an unnecessary burden on the patient. Moreover, while we appreciate your intent to make S. 3090 broadly inclusive, the bill falls short of that objective and runs the risk of creating further concentration in a sector that is already highly consolidated. To participate in this demonstration, providers must be able to bear capitation risk or partner with an entity who can. Very few, if any, small and medium dialysis providers could do this, leaving just a handful of large entities participating in this model. If fewer providers, including nonprofit, locally-based community providers, are able to continue to care for their patients, we are concerned that patients will have less choice in their provider, that the quality of their care could diminish, and that costs to the government and society could increase.

Second, S. 3090 relates only to ESRD patients, where there are already two models in place: the Comprehensive ESRD Care (CEC) model and Medicare Advantage (MA) ESRD Chronic Condition Special Needs Plans (C-SNPs). Therefore, the Dialysis PATIENT Demonstration Act seems to us to be redundant. The Centers for Medicare and Medicaid Services (CMS), through the Center for Medicare and Medicaid Innovation (CMMI), launched the CEC model in October 2015. Two NKCA member companies (DCI and Rogosin) were chosen to participate among the thirteen ESRD Seamless Care Organizations (ESCOs). CMMI intentionally worked with dialysis providers to develop the CEC model in order to give all providers an opportunity to participate. For example, CMMI included a provision whereby small organizations could participate through aggregation. There are also protections to limit the size of ESCOs, so that LDOs cannot use the demonstration to expand their markets. The ESCO model is now off to a good start with CMMI having announced a second round of applications, due July 15, 2016, to further expand participation in this model. We strongly believe that it makes more sense to see how the first two years of this model progress, rather than introducing a new, competing model that will only produce more confusion and dilute much needed focus on a model that is now in place.

In addition, it is important to note that a model beyond that of the ESCO is already in place; ESRD specific Medicare Advantage C-SNPs. In contrast with S. 3090, MA C-SNPs include strong beneficiary and provider protections around network adequacy, marketing, and plan expansion. Moreover, SNP authority will need to be reauthorized by 2018, which offers an opportunity to make needed improvements in its design so that it can better serve not only ESRD beneficiaries, but also the tens of millions of CKD patients, keeping as many of them as possible off dialysis.

A third and critical point is that it is imperative that Congress and CMS focus on reducing the number of beneficiaries who need dialysis by addressing CKD and transplant options, rather than focus on ESRD. Kidney disease (both CKD and ESRD) is a prime model of chronic illness in our country. Both CKD and ESRD don't exist alone—they are accompanied by multiple comorbidities including diabetes, congestive heart failure, and high blood pressure, among others. Kidney disease can exist over many years and demands multimodal, highly coordinated care. In 2013, Medicare expenditures for all stages of kidney disease totaled more than \$99 billion, with about \$68 billion spent caring for those with CKD. We believe so strongly in the importance of addressing this issue that many NKCA members have started their own innovative CKD programs, because more than 26 million American adults have kidney disease, but most don't know they have it. Creating new models for ESRD patient care should not be our priority. Rather, it must be addressing chronic kidney disease and its contributing causes much more effectively. If we do so, not only will we better fulfill our responsibilities to provide better health, health care, and quality of life, but also reduce costs.

In this respect, we should emphasize again that, since we see kidney transplantation as the optimal care for patients with kidney disease, much more must be done to increase the number of transplants. This can be achieved first by providing better care to beneficiaries (with CKD or ESRD), so they become better candidates for transplantation and, secondly, by increasing organ donor capacity through live donor means, as well as enhanced support for those who are donors.

Beyond this, we believe that each patient should be able to choose the treatment he/she receives, even if it's medical management without dialysis. Dialysis may not be the right choice for every

patient, and we want to empower patients to make those difficult decisions when the time comes. We also want patients to have the ability to transition smoothly into hospice care. Policy that helps facilitate these choices should be where the legislative priorities must be.

We appreciate your leadership on this issue and share with you the belief that we can make a difference in the care of all individuals with kidney disease. We look forward to working with you on future legislation that will expand policy to address the CKD population as well and thereby make a major contribution to the improvement of U.S. health care. If you have any questions, please feel free to contact Kelly Delmore at 202-580-7704 or kdelmore@health-law.com.

Sincerely,

A handwritten signature in blue ink that reads "Martin Corry". The signature is written in a cursive style with a long, sweeping tail on the letter "y".

Martin Corry
Executive Director