



June 22, 2015

The Honorable Orrin Hatch
Chairman
Senate Committee on Finance
219 Senate Dirksen Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
219 Senate Dirksen Office Building
Washington, DC 20510

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

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

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

On behalf of the Nonprofit Kidney Care Alliance (NKCA), I am pleased to have this opportunity to submit comments in response to your May 22 letter to stakeholders on chronic care in Medicare. 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 end stage renal disease (ESRD) patients at more than 280 facilities in 30 states, as well as, thousands more patients with chronic kidney disease (CKD). We believe that it is critical that we focus “upstream” on patients with CKD so that fewer patients need dialysis (or at least delay its start) and we help create better transplant candidates.

As nonprofit providers, we receive approximately 85% of our payments from Medicare. Our goal is to provide the best service possible for all patients with kidney disease, not only for patients on dialysis but also to decrease the number of patients needing dialysis and increasing the number who can benefit from transplants. Kidney disease (both CKD and ESRD) is really the prime model of chronic illness. Several factors underscore this. First, both CKD and ESRD don’t exist alone—they are accompanied by multiple co-morbidities. Secondly, kidney disease, including and especially ESRD, can exist over many years and is therefore the epitome of chronic illness that demands multimodal, highly coordinated care. Kidney disease should be a prime focus for the new care models that the Committee seeks to encourage.

In response to the issue areas that were listed in your letter, we wish to focus on the following three:

- Question #2. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternative payment models (APMs) currently underway at CMS, or by proposing new APM structures;

- Question #3. Reforms to Medicare’s current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions; and
- Question #7. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers.

Question #2. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternative payment models (APMs) currently underway at CMS, or by proposing new APM structures.

The Centers for Medicare and Medicaid Services (CMS), through the Center for Medicare and Medicaid Innovation (CMMI), is about to launch the Comprehensive ESRD Care Initiative (CEC). Three of our member companies are finalists in that initiative from which we hope will emerge best practices that can improve care and increase value for all patients on ESRD. We hope that as CMS and CEC participants gain experience with what works and what doesn’t, Congress and CMS can begin to apply those lessons to the underlying fee-for-service ESRD program.

Moreover, while the CEC model does not address earlier stages of kidney disease, we believe that care coordination and patient engagement activities in the CEC’s ESRD Seamless Care Organizations (ESCOs) will provide important lessons for the care of patients with chronic kidney disease. NKCA believes that ultimately, what is needed is an integrated program that covers *all* stages of kidney disease, including its prevention (with the promotion of healthy living), screening to detect early disease, management of CKD so that there is less end-stage disease, and finally, the improved management of all aspects of the care of ESRD patients with their multiple co-morbidities. Such an approach will be important to the development of alternative payment models (APMs) called for in the recently enacted Medicare Access and CHIP Reauthorization Act (MACRA), as well as Medicare’s growing emphasis on prevention, screening, and related care efforts.

Question #3. Reforms to Medicare’s current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions.

Medicare has been focused on treatment of beneficiaries with kidney failure, through ESRD, but has largely neglected the potential to improve beneficiary health and lower costs by going “upstream” to address chronic kidney disease, which not only leads to kidney failure but is also strongly associated with cardiovascular disease and metabolic disorders, most especially diabetes. Beneficiaries are often unaware that they have CKD until it is well advanced. There are elements in the existing Medicare program that can help identify those at risk and promote better coordination of their care: the annual wellness visit along with high risk assessment; diabetes screening; cardiovascular screening; chronic care management services; and Part D’s Medication Therapy Management program. Currently they all operate as separate and distinct payment provisions. More could be done to coordinate their delivery to focus on CKD.

Moreover, with the enactment of MACRA, Medicare’s current disjointed and overlapping quality and performance measures will be consolidated into a single merit based incentive program (MIP). The

measures that are incorporated into MIPs can be honed to incentivize physicians and other clinicians to better identify, educate, and care for patients with CKD. NKCA members believe that overall outcome measures must be developed and used to assess more accurately the quality of the care provided by physicians, as well as the entire care team. Scoring highly on the MIP's outcome measures (both quality and cost) should be the basis of incentive rewards for physician, nurses, and the whole care team.

Question #7. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers.

Starting dialysis is a life-changing event, making it critical that patients be engaged in the decisions about their options, and the management of their care when started. The members of NKCA have been working for several years with their patients to accomplish these objectives through:

- Chronic Kidney Disease Care Coordination
- Pre-Dialysis Education with Navigation Services
- Transition Care Coordinators
- Family and community outreach & mobilization

Across each of these practices, the goal is to empower patients to play a greater role in managing their health and meaningfully engaging with their health care providers. NKCA members believe that the potential of having patients and families manage their own health has barely been tapped. In fact, our current system of care emphasizes the professional side almost to the exclusion of real patient involvement. Any new approach to improving the care provided to patients at risk for, or living with, chronic illness must incorporate this potential if meaningful improvements in the incidence and prevalence of these disease states, the quality of care provided, and the cost of care are to be made. This belief is based on the many years of experience of the NKCA members with their care of patients with renal disease, not just those with ESRD. For example, one of our members, The Rogosin Institute, has more than thirty years of experience in mobilizing individuals, families and whole communities in thirty-two countries, as well as work here in the United States in the Mississippi Delta, Houston, Texas, and the U.S. Affiliated Pacific Islands. (See Problem Solving for Better Health, (Smith, Hoyt-Hudson, Fitzpatrick, Eds, Springer, New York, 2011)).

The engagement of patients, their families and communities more broadly can be achieved by a variety of means.

By providing one-on-one and small group in-person education, care coordinators, educators, and navigators are able to learn about a patient's life goals and then work with the patient to help him or her have the life he or she wants, without having their kidney disease get in the way. It is also a means by which patients can be made aware of their options, such as home dialysis rather than in-center care. As a result, we see significantly higher use of home care, which can lead to a high quality of care (with decreased use of medications, hospital visits, etc.) and a better quality of life – when the care is not rationed.

Unfortunately, we are currently experiencing the harsh reality of only allowing some patients to receive home dialysis due to a shortage of peritoneal dialysis (PD) solution in the U.S. This situation

has arisen in the past year due to a shortage of PD solution provided by one manufacturer. We hope that the Committee can assist in getting this major issue resolved, as there appears to be no clear resolution in sight. We feel very strongly that Medicare beneficiaries should always have a choice.

One of our members, Dialysis Clinic Inc. (DCI), has instituted a CKD Care Coordination Program in 28 locations, involving 3,000 patients to start educating patients on how they can stay healthier and thereby avoid, or at least delay dialysis. And, if it is necessary, to know their options, including home dialysis, and be better prepared with access via fistula, rather than catheter. They do this by one-on-one discussion with a care coordinator. During the first visit, the care coordinator talks with the patient for up to an hour and a half. The patient has the opportunity to ask any questions that he or she may have, and a plan of care gets started. The care coordinator continues to meet with the patient until he or she is able to better manage his or her other medical conditions or until he or she selects his or her optimal choice at the transition in care. For a patient choosing a therapy at the transition in care, the care coordinator will continue to work with the patient to help the patient implement his or her choice. (DCI has filed a separate letter that describes their CKD education in greater detail.)

Another of our members, Northwest Kidney Centers, utilizes pre-dialysis “Choices” education classes. For those who attend the weekly classes, Northwest Kidney Centers finds that significantly more patients have a permanent access in place prior to start of dialysis; more start treatment in a center, rather than a hospital; and more choose home dialysis than in-center care. The Rogosin Institute also has developed a Renal Management Clinic, which is doing the same things for patients in New York City.

Empowering patients also means mobilizing families and the larger community to promote healthy living habits and to enlist individuals who can help others with similar health problems. Peers, as well as healthy individuals and family members, can help patients with the many challenges they have in daily life, such as: personal hygiene, proper taking of medication, exercise, nutrition, and emotional problems, such as depression. These individuals effectively become “coaches,” and/or peer mentors, who have the back-up of nurses and doctors by means of the many digital tools we now have at our disposal to achieve better health outcomes. We should point out that this component of the overall approach we are proposing to increase the engagement of individuals in their own health has the additional advantage of filling a great need identified by our patients, i.e. to reduce the isolation that they feel as ESRD patients. The Rogosin Institute is already developing these programs to engage family and community potential in New York City, in the Borough of Brooklyn, Queens, and Manhattan in particular, including partnerships with other non-profit social service and medical agencies in the private sector.

Technology is another means to enable patients, their families, coaches and navigators to improve chronic care, as the Committee points to in Question #5. Today, we have a range of digital measurement and communication devices enabling a nurse or physician at a place remote from that of the patient to oversee his/her care. With the coaching, peer, or buddy system outlined above, advice and care can be provided at a distance and without the patient having to come to the clinic, ER, or hospital. The ability to monitor the condition of patients more closely through digital monitoring, two-way communication, and support where patients live, can prevent small problems from becoming bigger ones and can lead to better health outcomes and lower cost. However, Medicare’s statute, and

regulations related to telemedicine, “supervision” requirements as well as state scope of practice rules have not kept pace.

In sum, NKCA believes that we have a unique and very practical opportunity to empower patients, their families, and communities to engage in the management and improvement of their health status. There are examples of this approach already being used, which employed more broadly, can make a huge difference in the American health care system.

Conclusion

We are pleased to see that so much work and dedication has been undertaken thus far, and we are willing to make ourselves available as a resource to you and your staffs at any time. We share with you the belief that we can make a major difference in the care of people with chronic illness. We encourage the Finance Committee and the bipartisan chronic care working group to work with those who are treating chronic kidney disease, as it truly is a major health issue that needs to be addressed more effectively from both the quality and cost points of view. Properly implemented, programs such as we have described above can help prevent individuals from needing dialysis, but also make them healthier with a better quality of life. In addition, they can provide a model for the better management of chronic illness more generally. As nonprofit providers, we place the patient first in all the decisions we make. We would be glad to discuss any of these suggestions 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