N K
C A
*Nonprofit Kidney Care Alliance*

September 22, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW, Room 445–G
Washington, DC 20201

**Re: CMS—6074—NC, Request for Information: Inappropriate Steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans**

Dear Administrator Slavitt:

The Nonprofit Kidney Care Alliance (NKCA) appreciates this opportunity to comment on the Request for Information (RFI) regarding inappropriate steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans. The 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 5,000 patients with chronic kidney disease with the goal of avoiding, or at least delaying onset of end stage renal disease (ESRD). As nonprofit providers, approximately 85% of our patients are covered by Medicare or Medicare Advantage plans. Two of our members also have experience participating in current Center for Medicare and Medicaid Innovation (CMMI) alternative payment models, the Comprehensive ESRD Care (CEC) model.

Beyond the immediate questions raised in the RFI, is the issue of what payers and providers, are doing to address chronic kidney disease in order to reduce the number of patients whose health deteriorates until they require dialysis. Unfortunately, the incentives are simply to let kidney disease take its course until patients qualify for Medicare ESRD coverage and are no longer a cost to other payers. The Centers for Medicare and Medicaid Services' (CMS') recent RFI on the future of the Comprehensive ESRD Care Model was a step in the right direction, which we hope CMS will build upon not just for Medicare fee-for-service, but also for Medicare Advantage, Medicaid, and plans in the Marketplace.

Turning to the issues raised in the RFI, CMS' posting of the RFI was accompanied by a letter to every dialysis provider in the country indicating CMS' concern that there may be steering and/or inappropriate use of third party payment in the enrollment of some ESRD patients in Marketplace health insurance plans. CMS appears to be responding to the concerns expressed by some payers that some number of ESRD providers are steering Medicare and Medicaid-eligible individuals to Marketplace Qualified Health Plans (QHPs) thereby threatening the stability of the individual health insurance market. Clearly, to the extent that there may be abusive behavior, it should be halted. But

the substance and tenor of CMS' questions seems to presume that there is a widespread problem which points to the need for new and sweeping remedies.

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 patient. To the extent that these two principles are being compromised, CMS should first assess the extent that it is occurring, rather than rely on complaints from a handful of payers; focus its attention on the small minority of entities that may be doing so; employ the remedies which it has at its disposal; and then, if necessary, provide additional guidance and regulatory remedies after notice and opportunity for comment.

CMS should 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. However, if CMS provides for robust risk adjustment in the Marketplace plans as well as Medicare Advantage, plans should be adequately reimbursed for the high cost of caring for dialysis patients.

Dialysis patients face enormous healthcare, social and financial challenges. Their financial challenges are not limited to an acute episode, but for the rest of their life unless they are fortunate to receive a transplant. It is not steering if a patient, after understanding the financial choices they face, chooses to enroll, or stay enrolled, in a Marketplace plan, rather than Medicare or Medicaid. In some cases they may also prefer enrollment in a private plan if the provider network, including their physician(s) or the plan's drug formulary, is more robust. In other cases, the individual may choose to enroll in Medicare, in which case they may well need third party assistance with premiums and Part B coinsurance.

Consider the following example. Assuming Medicare reimbursement rates, the cost of monthly dialysis treatment alone—not including care for other conditions—would be around $3,000/month ($2995.07).[1] Thus for the first 90 days prior to becoming Medicare eligible, the patient incurs almost $9,000 in ESRD payments.

- If the patient qualifies for Medicaid, their dialysis payments may be largely, if not fully covered. However, given the often limited provider networks and low reimbursement rates, they may not have access to 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.

[1] CY 2016 ESRD PPS

At this point, a dialysis provider's financial counselors, often a social worker, assist a patient with information on the available options to cover their annual dialysis treatment costs. They may examine plan options where the cost of the monthly premium is less or has lower out-of-pocket costs. They may consider the plan they or their family members currently hold coverage or what cost-sharing subsidies may be available.

After reviewing all the available options for both financial and provider network issues, it is not unreasonable to recommend whatever option is in the best interest of the patient. In some states, there are robust public assistance programs for those who are above Medicaid eligibility to help with their costs. Fifteen states have some sort of public assistance.[2] Where there are not, or are inadequate to cover the need, properly structured private third- party payment assistance plays an important role.

In addition, we are pleased to provide further input regarding the questions CMS posed in the request for information:

**What impact is there to the single risk pool and to rates when people enter the single risk pool who might not otherwise have been in the pool because they would normally be covered under another government program? Are issuers accounting for this uncertainty when they are setting rates?**

ESRD is an essential health benefit in Qualified Health Plans. We are now entering 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. In Medicare, the annual cost of care for an ESRD patient can be up to $76,185, compared to $9,756[3] for the average Medicare patient. This underscores the necessity that the Marketplace risk adjustment system be robust so that no single plan be disadvantaged. We recognize that in some areas plans may confront a highly concentrated market, reflecting the concentration in the national dialysis market. We do not believe that should affect the ability of patients to choose the best plan, public or private, that best serves their needs.

**Are there examples of steering practices that specifically target people eligible for or receiving Medicare and /or Medicaid benefits to enroll in individual market plans? In what ways are people eligible for or receiving Medicare and/or Medicaid benefits particularly vulnerable to steering? To what extent, if any, are providers steering people eligible for or receiving Medicare and/or Medicaid to individual market plans because they are prohibited from billing the Medicare and Medicaid programs, through exclusion by the HHS Office of inspector General, termination from State Medicaid plans or the revocation of Medicare billing privileges?**

We are not aware of specific steering practices. With respect to entities that are prohibited from billing for Medicare and Medicaid because they are on the OIG's exclusion list, this may be an area where CMS should consider additional guidance for issuers to check.

---

[2] Peace L, Funk W. Kidney programs—Are they surviving? *Nephrology News & Issues*. October 11, 2014. http://www.nephrologynews.com/kidney-programs-are-they-surviving/

[3] MedPAC June 2016 Data Book

**Is the payment of premiums and cost-sharing commonly used to steer individuals to individual market plans, or are other methods leading to Medicare and Medicaid eligible individuals being enrolled in individual market plans? Specifically, how often are issuers receiving payments directly from health care providers and /or provider affiliated organizations? Are issuers capable of determining when third party payments are made directly to a beneficiary and then transferred to the issuer? What actions could CMS consider to add transparency to third party payments?**

We do not believe that third party payments are commonly used to steer individuals. As we note above, individuals may prefer to enroll in private plans rather than Medicare or Medicaid, due to lower out-of-pocket costs and/or better benefits. Third party payment, or assistance with premiums and cost sharing, in the dialysis sector has been in existence for many years, predating the launch of the Marketplaces. Federal law does not prohibit properly constructed third party payment, which can assist individuals to secure coverage that is affordable and meets the care needs of the individual and their families.

Issuers should be able to identify whether they are receiving payment from third parties, if issuers are required to accept payment directly. Here, CMS can help promote greater transparency. Currently, issuers are only required to accept direct third party payment form Ryan White programs, governmental programs (or their grantees) and Indian tribes and tribal organizations. Requiring issuers to accept third party premiums by private third party assistance programs would address the need for greater transparency.

**What remedies could effectively deter health care providers or provider-affiliated organizations from steering people eligible for or enrolled in Medicare and/or Medicaid to individual market plans and paying premiums for the provider's financial gain? CMS is considering modifying regulations regarding civil monetary penalties and authority related to individual market plans.**

As with the preceding questions, the premise seems to be that if a Medicare or Medicaid eligible individual enrolls in a private plan in the Market place it is because they were steered. If there is inappropriate behavior going on, it should not be tolerated. Under current law, CMS can impose civil monetary penalties (CMPs) on entities that knowingly and willfully report false information on a Marketplace applications and may impose CMPs and corrective action plans on those who assist with enrollment (Navigators, non-Navigator assistance personnel, and Certified Application Counselors) that violate conflicts of interest requirements or the best interests of applicants.

But, as we outlined at the outset of our letter, it is entirely reasonable for some individuals to enroll in a private plan, with or without third party assistance to secure lower costs and/or better provider networks. The vast majority of ESRD patients are eligible for Medicare after 90 days. Yet, the monthly Part B premiums and uncapped Part B co-insurance can be very burdensome, driving some patients to seek alternative coverage. We believe the test should not be based on the payment to the provider, but rather what is in the best interest of the patient based on their needs.

Before taking action, we recommend that CMS quantify the scope of any problem, identify the entities or market segments that are involved in improper steerage, and consider the use of existing remedies to

address. By taking action on all providers based on the actions of a few, patient choice will be limited and critical financial assistance will leave many ESRD patients at a loss for coverage.

**Conclusion**

Thank you again for the opportunity to comment. We would be pleased 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