June 3, 2011

Dr. Donald Berwick
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1345-P: Medicare Program; Shared Savings Program: Accountable Care Organizations

Dear Dr. Berwick:

Kidney Care Partners appreciates the opportunity to provide the Centers for Medicare and Medicaid Services (CMS) with comments about the Proposed Rule for the Medicare Shared Savings Program: Accountable Care Organizations (ACOs) (Proposed Rule). KCP is an alliance of members of the kidney care community that includes patient advocates, dialysis care professionals, providers, and manufacturers organized to advance policies that improve the quality of care for individuals with both chronic kidney disease (CKD) and irreversible kidney failure, known as End Stage Renal Disease (ESRD).

The kidney care community strongly supports developing innovative models that better integrate care to improve the quality of care that beneficiaries receive and lower the growth of Medicare expenditures. For example, KCP led the effort to develop the first value-based purchasing (VBP) program in Medicare. We not only launched the Kidney Care Quality Alliance, which focused on developing cross-cutting quality metrics that could be used by dialysis facilities and physicians caring for beneficiaries receiving dialysis, but we also worked with the Congress and CMS to establish the outline of a structure for a VBP program within the Medicare ESRD program. In addition, we have worked closely with the Congress and CMS to implement the ESRD prospective payment system (PPS) that includes increasing efficiencies within the payment system.

Thus, KCP was disappointed that CMS did not include in the Proposed Rule a renal disease-specific ACO or include dialysis facilities and nephrologists as providers eligible to form an ACO. Given the discrete nature of the Medicare ESRD program, the focus and experience of providers who care for beneficiaries within this program, and ESRD beneficiaries’ compelling need for more coordinated care, kidney care providers should be

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1 See 76 Fed. Reg 19528 (April 7, 2011).
permitted to participate in the Medicare Shared Savings Program through a renal-specific ACO. However, we recognize that CMS may feel constrained initially to focus on hospitals and primary care physicians. In light of this concern, we strongly urge CMS through the Center for Medicare and Medicaid Innovation (Innovation Center) to establish in consultation with the kidney care community, a renal integrated care large-scale pilot program to allow dialysis facilities and nephrologists to be recognized as integrated care organizations for purposes of receiving incentive payments.

This pilot should build upon the lessons of CMS’ recently completed ESRD Disease Management Demonstration Project (DM Demonstration) to provide such incentives for dialysis facilities and nephrologists willing to be accountable for quality and cost outcomes. The pilot should test a variety of models of integrated care and shared savings options. It should be large-scale in that the number of organizations that participate in the pilot should exceed the number of facilities that were part of the DM Demonstration and represent all sizes of dialysis facilities (including for profit and not-for-profit, urban and rural), nephrology practices, and all appropriate modalities of care. We also encourage you to work with the community to eliminate barriers to and limitations on participation in ACOs and to implement the pilot as quickly as possible and no later than the establishment of ACOs.

The kidney care community is well situated to accomplish the aims of the Medicare Shared Savings Program through an integrated care model, like an ACO. First, it can assist CMS in accomplishing the goals and intent outlined in the Proposed Rule. Second, as the principle providers for patients with kidney failure, dialysis facilities and nephrologists are in the best position to determine how to establish integrated care models that improve quality and increase efficiencies for this unique patient population. Finally, the community has already demonstrated how integrated care can work through the DM Demonstration.

In the preamble to the Proposed Rule, CMS states its goals for ACOs as:

- Improving care for individuals, defined as safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity;
- Providing better health for populations with respect to educating beneficiaries about the upstream causes of ill health; and
- Lowering growth in expenditures by eliminating waste and inefficiencies while not withholding needed care that helps beneficiaries.\(^2\)

Dialysis facilities and nephrologists, not hospitals or primary care physicians, are in the best position to promote accountability for the population of patients with kidney failure, as well as coordinate Part A and B items and services for these patients. Dialysis facilities and nephrologists engage directly with beneficiaries with kidney failure much more frequently than hospitals or primary care physicians would. The vast majority of

\(^2\)Id. at 19533.
beneficiaries on dialysis receive treatment at in-center dialysis facilities at least three times a week. Nephrologists see patients between one and four times each month. This frequency of direct patient contact is fairly unique within the Medicare program. It allows providers the opportunity to work closely with their patients to educate them about their disease, co-morbidities, and treatment options. It also provides for closer monitoring to ensure that the appropriate treatment is being provided. Dialysis facilities already rely upon a foundation of multi-disciplinary, integrated care teams comprising physicians, nurses, dietitians, social workers, patient care dialysis technicians, and other health care professionals to evaluate and assess patients and develop an appropriate plan of care unique to their needs. Thus, the care provided is already patient-centered, timely, and efficient. We recognize that more can be done to improve care for individuals, but to accomplish this goal we must extend this patient-centered foundation across the silos of Parts A and B and integrate care.

The kidney care community is also well positioned to provide better health for beneficiaries with kidney disease who are not on dialysis. Our members have consistently been providing beneficiaries with better opportunities to learn about their disease and how to manage it. For example, KCP was instrumental in the establishment of the Kidney Disease Education program that Congress created in the Medicare Improvements for Patients and Providers Act (MIPPA). We continue our efforts to find ways to help slow the progression of kidney disease as well as to help those with kidney failure manage their disease.

In addition, the kidney care community has already demonstrated that it is capable of improving quality of care for individual patients and the dialysis population and while lowering the growth of expenditures through DM Demonstration. This project was a five-year demonstration project conducted by CMS between 2006 and 2010 that sought to test the impact of expanded integrated care approaches applied to the Medicare ESRD patient population. Arbor Research Collaborative for Health has evaluated the first three years of this project and presented its analysis at the American Society of Nephrology Annual Meeting in November 2010. Specifically, Arbor found:

- Higher survival at one and two years;
- Statistically significant reduction in all-cause and cardiovascular-related hospitalization, physician visits, and skilled nursing facility utilization;
- Improved processes of care, including increased preventive care (HbA1c, retinal screening, foot exams) for beneficiaries with diabetes, higher immunization rates, and more pervasive wait-listing for transplant;
- A specific process intervention (nutritional supplementation) was also directly associated with lower mortality among enrollees; and
- Patient satisfaction showed generally positive support for DM Demonstration.³

³Arbor Research Collaborative for Health, End-Stage Renal Disease (ESRD) Disease Management Demonstration Evaluation Report: Findings from 2006-2008, the First Three Years of a Five-Year Demonstration 10-11; 36; 37; 72; & 74 (December 8, 2010).
In addition, according to Arbor at least one organization participating in the demonstration achieved “considerable” cost savings relative to fee for service program based on differences in service utilization throughout all three years of the DM Demonstration evaluation. Another organization participating in the demonstration reduced catheter utilization, but the results were not included in the final report because the measure reduction program began after the initiation of the demonstration.\footnote{Id. at 5.}

Even though dialysis facilities and nephrologists already have the structure in place to implement an integrated care model, current Medicare policies do not allow these providers to move to the next level of care integration nor do they allow them to share the savings that would be obtained from doing so. They should be permitted to participate in the Medicare Share Savings Programs that encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Thus, we strongly urge CMS to implement a large-scale pilot program to allow dialysis facilities and nephrologists to establish integrated care models that improve quality and increase efficiencies for patient population with kidney failure. We look forward to working with the Innovation Center on such a program.

IV. Conclusion

We appreciate the opportunity to share our comments and recommendations with you. Please do not hesitate to contact Kathy Lester at 202-457-6562 if you would like to discuss them in detail or have any questions.

Sincerely,

Ronald Kuerbitz
Chairman
Kidney Care Partners

Abbott Laboratories
Affymax
American Kidney Fund
American Nephrology Nurses’ Association
American Society of Diagnostic and Interventional Nephrology
Amgen
Baxter Healthcare Corporation
Board of Nephrology Examiners and Technology
California Dialysis Council
Davita, Inc.
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