



March 5, 2018

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

Re: CMS-2017-0163: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter, February 1, 2018.

Dear Administrator Verma:

On behalf of the Nonprofit Kidney Care Alliance (NKCA), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Medicare Advantage (MA) and Part D Advanced Notice of Methodological Changes for 2019. 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 (ESRD), and increasing the number of patients who can benefit from kidney transplants. 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 Center for Medicare and Medicaid Innovation (CMMI). Collectively, we are responsible for nine ESRD Seamless Care Organizations (ESCOs) across the country in both one-sided and two-sided risk models.

Risk Adjustment of Chronic Kidney Disease

We appreciate CMS' acknowledgement and reintroduction of risk adjustment for Stage 3 CKD and support this proposal to address the cost of caring for CKD patients "upstream," before their condition worsens. We believe there is a need for plans to address CKD in patients earlier to prevent progression of the disease and avoid increases in their cost of care in future stages of the disease.

The cost of care for these patients is significant and, as kidney disease progresses, the cost of care increases dramatically. The following is an estimate of cost of care by CKD stage, based on an analysis of 2015 Medicare 5% claims data of Medicare fee-for-service (FFS) beneficiaries 65 and over, by United States Renal Data System (USRDS):

- Stage 1 and 2: \$19,074 per year;

- Stage 3: \$21,649 per year (or double the cost of care for a typical patient with Medicare coverage);
- Stage 4 and 5, *not on dialysis*: \$29,151 per year; and
- Stage 5, *on dialysis*: \$88,749 per year.

We note the difference in cost of care for a patient with Stage 4 or 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 an increased likelihood of a better quality of life. We would also note that many patients with CKD have comorbidities, such as diabetes, for whom the costs are even greater.

At Stage 3 CKD, most patients are not receiving care directly related to their kidney disease, which is a huge missed opportunity. According to the 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% are aware. Data suggest that earlier referral to a nephrologist can slow the rate of progression of kidney disease and better prepare a patient for transition to the next step in care. In this regard it is critically important that patients' primary care physicians diagnose CKD earlier and screen for albuminuria. 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 treatment options available to them.

In response to the 21st Century Cures Act, Section 17006(f), CMS proposes to add Chronic Kidney Disease, Moderate (Stage 3) (HCC 138) to the CMS-HCC Risk Adjustment Model. We support CMS' proposal, not only because it recognizes the higher costs attributed to Medicare beneficiaries with CKD Stage 3, but also because it will incentivize plans to better address the complex needs of these patients earlier, thereby improving their care and reducing both present and future costs.

We also note the analysis CMS provides relating to the distinction between CKD Stage 3a with a GFR of 45-59 ml/min/1.73m², and the more severe CKD Stage 3b with a GFR of 30 to 44 ml/min/1.73m², associated with higher risk for poor survival and cardiovascular outcomes. CMS also notes the presence of albuminuria in both “sub-stages” which confers higher risk as well. However, as CMS further points out, the ICD-10 diagnostic code system does not distinguish between Stages 3a and 3b, leaving no immediate recourse to address the more serious condition represented by CKD Stage 3b nor the higher risk which presence of albuminuria creates. We believe that CMS makes the right decision to include HCC 138, but also recommend that CMS continue to assess the twin distinctions between CKD Stage 3a and 3b and the presence of albuminuria, or lack thereof, for future refinement of the model. In this respect, we believe that there are a number of factors—both clinical and operational—that CMS might consider.

First, it is necessary to understand and maintain the distinction between CKD Stages 3a and 3b. At Stage 3a, a CKD patient's kidney function ranges from 45% to 59% of normal. At Stage 3b, a CKD patients' kidney function ranges from 30% to 44%, and they are higher risk patients who cost more than Stage 3a patients. If left unmanaged, Stage 3b patients have a greater risk of progressing to dialysis in the long-term and CKD Stage 4 in the short term. Once in Stage 4, patients have lost more than 70% of his/her kidney function.

Second, it is important that Medicare Advantage plans (and all payers) recognize the distinction between a Stage 3a patient and a Stage 3b patient so that his/her care can be improved. One clear way of doing so would be to refine the ICD-codes for Stage 3 patients to more precisely identify whether the patient is in Stage 3a or 3b.

Third, A critical issue that must be addressed as CMS moves forward with CKD risk adjustment is the capability of identifying patients with CKD in the claims database. Many patients are coded with other corresponding comorbidities, such as diabetes or hypertension, and are not identified as having kidney disease. In an analysis of one of our member companies, only 10 to 20 percent of patients with a GFR < 60 are coded properly. We believe CMS should look into this issue and find ways to identify these patients more readily.

Finally, over and above the introduction of an HCC code for CKD Stage 3, we believe there should be a protocol for plans that identify a patient with CKD, particularly those with albuminuria, not only at Stage 3, but even more so at more advanced stages so that he/she can be counseled on a timely basis, including, as appropriate, on his/her options for transplantation, including assistance in identifying a living donor or preparing that person for the wait list.

Conclusion

Thank you for the opportunity to comment on the Medicare Advantage Advance Notice and draft Call Letter. NKCA is pleased to provide input to ensure that the rule's impact continues to improve the quality of care of the patients we serve. 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,

A handwritten signature in blue ink that reads "Martin Corry". The signature is written in a cursive, flowing style.

Martin Corry
Executive Director