



# DIALYSIS CLINIC, INC.

A Non-Profit Corporation

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July 18, 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 Dialysis Clinic, Inc. (DCI), I truly want to thank both of you and your staff for your dedication to better integrated care for dialysis patients. The thoughtful process in which you listened to stakeholders meant a lot and we appreciated the ability to have open dialogues. We do value your improvements made to the legislative draft over the months of drafting, however we still have some concerns with S. 3090, the Dialysis PATIENT Demonstration Act of 2016 and unfortunately we cannot support the legislation at this time.

DCI is the largest nonprofit provider of care for patients with kidney disease in the country and was founded forty-five years ago (two years before Medicare covered dialysis services) to save the lives of five patients in Nashville, TN. We currently care for more than 15,000 patients in more than 230 clinics in 28 states – including Nevada and Florida. In addition, we run three Organ Procurement Organizations, located in Tennessee, New Mexico and Northern California. Because of the hard work of the staff of DCI Donor Services, 546 people received a kidney transplant in 2015.

Over the last four years, we have looked at opportunities to improve care for patients with kidney disease and have learned that if we really want to improve care for patients with kidney disease, and decrease the cost of care, we need to go upstream and work with them before they need to receive dialysis. Currently we provide chronic kidney disease (CKD) care coordination for 3,700 patients in 28 different communities. Our primary goal for managing these patients is to keep them off dialysis. If we are unable to keep these patients off dialysis, we would like to at least push back the start of dialysis, allow them to be better prepared for dialysis so that their first dialysis is not in a hospital, as well as increase their likelihood of being a candidate for transplant. We note that we are currently managing more than 600 patients with stage 5 kidney disease *and are keeping them off dialysis*. We have learned that we can safely and efficiently manage these patients and keep them off dialysis until the point that it is necessary for them to transition to their next step in care.

We also strongly support the need to improve the overall care for patients with ESRD and currently operate three ESRD Seamless Care Organizations (ESCOs) through the Center for Medicare and Medicaid Innovation's (CMMI) Comprehensive ESRD Care (CEC) model. On Friday, July 15, we submitted applications for three more ESCOs. If our applications are approved, we will be operating

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six ESCOs on January 1, 2017 and approximately 20% of our patients on dialysis will be in an ESCO. We support the ESCO because it provides the opportunity to share in savings from beneficial interventions. It also allows for different payment tracks allowing smaller providers to participate in the model and accept more risk as they develop the capability to accept increased risk. Although we only care for 3% of patients on dialysis in the United States, we currently operate 20% of the ESCOs.

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

First and foremost, we are concerned that your legislation could further increase consolidation. Our goal is for patients to have a choice in their dialysis provider. If we can continue to have a broad range of providers caring for patients, patients on dialysis can benefit from the different innovative approaches from each provider. We see no reason that beneficiaries be involuntarily enrolled in a plan and then required to opt-out, in order to preserve their freedom of choice. Currently only two dialysis providers have the expertise to implement the integrated care model envisioned in S. 3090. We are concerned that an unintended effect of implementing the terms of S. 3090 would be further increasing consolidation in care of patients on dialysis.

Second, your legislation relates only to ESRD patients, where there are already two models in place: the Comprehensive ESRD Care model and the 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 CMMI, launched the CEC model in October 2015. This model was intentionally created to allow providers of different sizes to be able to participate. There are also limits on the size of ESCOs, so that large dialysis organizations (LDOs) cannot use the demonstration to expand their markets. We strongly believe we should wait and see how the first few years of the ESCO progress, instead of introducing a new, competing model.

In addition, there already exists an ESRD-focused health plan in the form of Medicare Advantage C-SNPs. In contrast with S. 3090, MA C-SNPs include strong beneficiary and provider protections including 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 millions of patients with CKD so that fewer of them end up on dialysis.

Third, rather than focus on ESRD, we believe it is imperative that Congress and CMS focus on reducing the number of beneficiaries who need dialysis by addressing CKD and transplant options. 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 we currently care for more than 3,700 patients with CKD in 28 communities, with the primary goal of keeping them off dialysis.

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Since we see transplantation as the optimal care, we are actively working to increase the likelihood that a person with kidney failure can benefit from a transplant instead of being on dialysis. Last month we made a commitment to the White House at the White House Transplant Summit to expand our CKD program and formalize our transplant education and navigation services, for more than 2,500 patients with CKD and less than 30% of their kidney function remaining. Our goal is that 11% of patients with kidney failure will receive a transplant and avoid dialysis, quadruple the current rate of pre-emptive transplantation.

Lastly, we want to improve the transition to end of life for patients with kidney disease, both patients with CKD and patients on dialysis. In our most developed CKD program in Spartanburg, SC, we are seeing that more than 15% of patients are deciding that dialysis is not the right choice for them and are instead choosing medical management without dialysis. In our ESCOs, we are seeing that we can improve the transition to end of life for patients for whom the burden of treatment outweighs its benefit by offering palliative care and hospice services for these patients. According to a recent review of more than 55,000 patients who died in the Veteran Affairs health system, more than twice as many patients with ESRD (32.3%) died in the ICU, compared to patients with cancer (13.4%) and dementia (8.9%).<sup>1</sup> We can do better. Our patients and their families deserve a better transition to end of life.

We are pleased that you have dedicated so much time and interest into ESRD patients. We are more than willing to make ourselves available as a resource to you and your staffs at any time, if you wish to do further policy around CKD and transplant. As a nonprofit provider, 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 me at 615-342-0435 or [Doug.Johnson@dcinc.org](mailto:Doug.Johnson@dcinc.org).

Sincerely,



Doug Johnson, MD  
Vice Chairman of the Board

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<sup>1</sup> Wachterman et al. Quality of End of Life Provided To Patients With Different Serious Illnesses. JAMA. Published online June 26, 2016.