Dialysis Clinic, Inc.
A Non-Profit Corporation

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The Honorable Todd Young
400 Russell Senate Office Building
Washington, DC 20510

The Honorable Bill Nelson
716 Hart Senate Office Building
Washington, DC 20510

The Honorable Dean Heller
324 Hart Senate Office Building
Washington, DC 20510

The Honorable Michael Bennet
261 Russell Senate Building
Washington, DC 20510

Dear Senators Young, Nelson, Heller, and Bennet:

On behalf of Dialysis Clinic, Inc. (DCI), I want to thank you for your dedication to better integrated care for dialysis patients. We do value the improvements made to the legislative draft over the months of drafting, however like last Congress, we still have concerns with S. 2065, the Dialysis PATIENTS Demonstration Act of 2017 and unfortunately 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-six years ago (two years before Medicare covered dialysis services) to save the lives of eight patients in Nashville, TN. We currently care for more than 15,000 patients in 240 clinics in 28 states. 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, more than 600 people received a kidney transplant in 2016.

We also provide chronic kidney disease (CKD) care coordination for 4,600 patients in 29 different communities in 16 states. 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, as well as increase their likelihood of being a candidate for transplant.

We strongly support the need to improve the overall care for patients with end stage renal disease (ESRD) and presently operate six ESRD Seamless Care Organizations (ESCOs) through the Center for Medicare and Medicaid Innovation's (CMMI) Comprehensive ESRD Care (CEC) model. Currently 2,350 DCI patients receive care in an ESCO and we plan to expand our current ESCOs to care for more than 3,200 patients in January 1, 2018. We support the ESCO because it 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.

With specific regard to ESRD patients and the Dialysis PATIENTS Demonstration Act of 2017, we offer the following comments:

First and foremost, we see no reason that beneficiaries be involuntarily enrolled in a plan and then be required to opt-out, in order to preserve their freedom of choice. 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. The reality is that only large corporations could easily be able to re-structure themselves from a provider organization into an entity that can also administer an insurance plan, with complete risk of all of the patient cost, which averages over $80,000 per year, as envisioned in S. 2065. We are concerned that your legislation could further increase consolidation in a sector which is already highly consolidated. If S. 2065 were to pass, the two large providers could have a competitive advantage over other providers and there could be a risk of further increasing consolidation in care of patients on dialysis.

Second, since your legislation was first introduced, we now have the Comprehensive ESRD Care model. 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 geographic size of ESCOs, so that large dialysis organizations cannot use the demonstration to expand their markets.

The CEC model is working. A total of seven dialysis providers, including five independent providers, are currently operating ESCOs. The financial results for the first year of operations of the ESCO were recently released and are very encouraging—every ESCO decreased the cost of care. We strongly support the current model and recommend that instead of implementing a competing model, that the ESCO be revised to add a third track with capitated payment. In this way, the largest providers can benefit from a different payment mechanism and other providers can benefit from participating in the CEC and can transition to a capitated payment track at the point that the independent provider has the capability to take on this additional risk.

Lastly, we want to improve the transition to end of life for patients with kidney disease. 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%).[1] We can do better. Our patients and their families deserve a better transition to end of life. We believe that it is critical that any model addressing improved care for patients on dialysis keeps patients in the model when they receive hospice care so that these patients will not risk being abandoned by their expanded care team at this critical time. The current CEC model includes patients on hospice and we ask that the DPDA be expanded to do the same.

We are pleased that you have dedicated so much time and interest into ESRD patients. We would be glad to discuss any of these suggestions in greater detail at any time. If you have questions, please feel free to contact me at 615-342-0435 or Doug.Johnson@dciinc.org.

Sincerely,

Doug Johnson, MD
Vice Chairman of the Board

[1] Wachterman et al. Quality of End of Life Provided To Patients With Different Serious Illnesses. JAMA. Published online June 26, 2016.