

November 26, 2019

The Honorable Richard Neal
Chairman
House Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable Kevin Brady
Ranking Member
House Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

RE: Rural and Underserved Communities Health Task Force Request for Information

Dear Chairman Neal and Ranking Member Brady:

The National Renal Administrators Association (NRAA) wishes to thank you for your bipartisan efforts to support and foster patient access to high-quality healthcare in rural and underserved urban communities. We very much appreciate your leadership in working on this critically important issue that impacts so many Americans every day.

The NRAA is a voluntary organization representing dialysis providers throughout the United States. Our membership primarily includes small and independent for-profit and not-for-profit providers serving patients in urban, rural, and suburban areas in both free-standing and hospital-based facilities. We strongly support efforts by the Committee to improve patient quality of care and health outcomes for Medicare beneficiaries with Chronic Kidney Disease (CKD) of all stages, including End-Stage Renal Disease (ESRD). We appreciate the ongoing recognition by the Committee of the unique challenges posed to small and medium dialysis facilities providing high quality care to these highly vulnerable pediatric and adult patient populations.

The NRAA thanks the Committee for the opportunity to comment on the Rural and Underserved Communities Health Care Task Force Request for Information. Given that dialysis is life-sustaining for ESRD patients, our comments center on ensuring that these patients residing in rural and underserved urban communities have adequate and appropriate access to treatment. In this light, we respond to specific questions in the RFI:

- I. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?
- II. What should the Committee consider with respect to patient volume adequacy in rural areas?
- III. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

The NRAA's comments reflect our desire to continue working effectively with the Committee to improve patient quality of care and health outcomes for adult and pediatric patients with CKD. We very much appreciate the Committee's efforts to ensure that patients in rural and underserved communities

maintain access to high-quality care and therefore welcome the opportunity to suggest methods to support and advance this vitally important goal.

I. Factors Outside of the Health Care Industry that Influence Health Outcomes in Rural and Urban Underserved Areas

In addition to health factors, socioeconomic (SES) challenges significantly impact care access and health outcomes for CKD patients in rural and urban underserved areas.

- **In-center dialysis:** ESRD beneficiaries with transportation challenges cannot necessarily attend all prescribed in-center dialysis sessions, leading to unnecessary, avoidable, and costly hospitalizations, ED visits, and medical complications. This occurs both in rural areas where patients may have to travel significant distances to dialysis facilities, as well as urban areas where public transportation challenges can lead to significant patient travel times.
- **Home dialysis:** ESRD patients preferring home dialysis in certain cases cannot elect this modality due to housing insecurity, limited storage space for equipment (especially in urban areas), and relatively infrequent supply replenishment (particularly in rural areas). Without full security and access to these care elements, home dialysis simply is not a treatment option for ESRD patients.
- **Kidney transplant:** Several non-health factors strongly influence the availability of kidney transplant, including:
 - Significant patient travel times and distances for transplant assessment and procedure, especially for those patients facing transportation challenges in rural areas where transplant centers can be more than four hours from the patient's home;
 - Stability level of the patient's home, caregiver availability, access to nutritious food, and access to social services supports – all of which are critical to post-transplant success;
 - Patient financial limitations and lack of secondary payer health insurance coverage to mitigate the significant pre- and post-out-of-pocket transplant-related costs; and
 - Lack of Medicare coverage for immunosuppressive therapies beyond three years, particularly for limited income beneficiaries with no secondary insurance.

II. Patient Volume Adequacy in Rural Areas

A Dobson DaVanzo analysis performed on behalf of NRAA suggests that the current low-volume and rural payment adjusters in the ESRD Prospective Payment System (PPS) do not effectively target rural facilities with low patient volumes most in need of additional support. In particular:

- The low-volume adjustment generally does not cover low-volume facility costs. When applied to the 2016 base rate of \$230.39, the adjustment yielded Medicare payment of \$285.45, which barely covered the median cost of large dialysis organizations (\$279.91) and was far below the median non-LDO cost (\$338.12) before other payment adjustments were applied.

- The low-volume adjustment captured only about one-third of facilities reporting fewer than 4,000 treatments in 2016.¹ Facilities with less than 4,000 treatments not receiving the adjustment (about 8 percent) had higher average costs per treatment than facilities receiving the adjustment – a 13 percent differential based on the median.

This analysis supports NRAA’s recommendation to implement a single payment adjuster for rural, relatively low-volume facilities (e.g., less than 6,000 treatments) so they can remain open for patients. Notably, the Medicare Payment Advisory Commission (MedPAC) recently considered a similar refinement – a “Low-Volume and Isolated” (LVI) adjustment – because: (1) rural facilities have lower Medicare margins on average than urban facilities (-5.5 percent versus -0.4 percent in 2017, respectively); and (2) facilities in the lowest volume quintiles have significantly lower Medicare margins than those in the highest quintiles (-21.3 percent versus +5.4 percent in 2017, respectively).^{2 3}

III. Policy and Programmatic Efforts to Strengthen Healthcare Quality for Rural and Underserved Populations

ESRD Treatment Choices (ETC) Mandatory Model

The NRAA broadly supports the President’s initiative to Advance American Kidney Health, but is extremely concerned that the ETC Model could severely jeopardize patient access to dialysis – especially for beneficiaries in rural and underserved communities treated by small and independent facilities that simply cannot absorb the enormity of the Model’s potential reimbursement cuts (-13 percent).

Particularly concerning is that low-volume and rural facilities disproportionately currently do not offer home dialysis relative to other facility types – indicating their ability to perform well on the home dialysis rate in the Model and remain open will be very challenging, if not impossible.⁴ Specifically, 70 percent of low-volume facilities did not provide home dialysis and 75 percent of facilities considered both low-volume and rural did not offer home dialysis in 2018.⁵ **Therefore, the NRAA urges exclusion of low-volume and rural facilities in organizations with 35 or less clinics from the Model unless they voluntarily opt to participate so that these facilities are not subject to the substantial payment cuts that will force them to close.**

Medicare Advantage

The NRAA seeks to ensure successful and smooth implementation of the 2021 MA ESRD benefit expansion. Asking ESRD beneficiaries typically with multiple chronic conditions and complex social

¹ Dialysis facilities eligible for the ESRD PPS low-volume payment adjustment must provide less than 4,000 treatments for each of the three years prior to the current payment year.

² MedPAC. [March 2019 Report to Congress](#), page 174.

³ MedPAC. [“Improving Medicare payment for low-volume and isolated outpatient dialysis facilities.”](#) October 3, 2019.

⁴ Dobson DaVanzo analysis of 2018 Medicare data performed on behalf of NRAA.

⁵ A low-volume facility meets the ESRD PPS definition of 4,000 treatments in *each of the 3 years* preceding the payment year.

needs to travel for prolonged time periods to receive dialysis from an in-network provider both in rural and underserved urban communities places unnecessary and undue burden on patients and their families. **Therefore, we urge the Committee to work with the Centers for Medicare and Medicaid Services (CMS) to enhance MA network adequacy standards for ESRD-related care particularly during MA benefit expansion transition period; any disruptions in access to life-sustaining dialysis could lead to severe adverse patient health outcomes, including mortality.**

Conclusion

In conclusion, the NRAA again wishes to thank the Committee for the opportunity to comment on the Rural and Underserved Communities Health Task Force Request for Information. We look forward to our continued work with the Committee to ensure access to high-quality care that improves quality of life and health outcomes for patients with CKD, including those patients residing in rural and underserved urban areas. If you have any questions concerning our comments, please do not hesitate to call Marc Chow at (215) 564-3484.

Sincerely,

Maria Regnier, RN, MSN, CNN
NRAA President