



The Dialysis P.A.T.I.E.N.T. Act: Expanding Integrated Care for End Stage Renal Disease

The Dialysis PATIENT Act (Patient Access to Integrated-care, Empowerment, Nephrologists, and Treatment, H.R. 5506/S.3090) will establish an End Stage Renal Disease (ESRD) Integrated Care Demonstration Program within Medicare to expand coordinated care for this complex population. This demonstration adds a new capitated payment model to promote use of innovative care techniques and hold providers accountable for costs and quality.

Care Coordination Programs Improve Outcomes for ESRD Patients.

ESRD patients are some of the most complex and costly Medicare beneficiaries. Through previous pilot projects, techniques have been developed that improve some of the most important quality indicators including: fewer patients using catheters; more patients using home modalities; and reduced hospitalizations. Kidney failure usually results from co-morbidities such as hypertension and diabetes that continue to afflict the patient. In coordinated care programs, these conditions can be treated by the ESRD care team.

Access to Care Coordination Programs for ESRD Patients is Extremely Limited.

The Dialysis PATIENT Act will scale up activities currently unavailable to most patients. ESRD patients are not permitted to enroll in Medicare Advantage (MA) so usually must navigate their own rigorous treatment regimens in the fee-for-service Medicare system without the help of case managers or “health coaches” that managed care organizations often deploy. Only a few have access to care coordination- Medicare beneficiaries who enroll in MA after turning 65 but before kidney failure may stay in their health plans, and certain regions are served by Special Needs Plans (SNP) specifically for ESRD patients. The ESRD Seamless Care Organization demonstration, an Accountable Care Organization for dialysis patients created by the CMS Innovation Center, now operates at 13 sites. These patients receive services that are NOT reimbursed in fee-for-service Medicare, including:

- *Intervening to prevent complications.*
- *Transitions from the hospital to the community.*
- *Managing co-morbidities.*
- *Medication reconciliation.*
- *Increased engagement of patients in their care. **

The Dialysis PATIENT Act Preserves Current Patient/Provider Relationships.

- Unlike managed care in the MA program, patients would not be bound to a network and would retain their freedom of choice to see any provider. Patients would be permitted to opt out if they so desired.
- Restriction on auto-enrollment and marketing only through the patient’s current dialysis clinic prevents any “poaching” of beneficiaries by large dialysis organizations with greater resources.

Some Highlights of Integrated Care in Special Needs Plans and ESRD Seamless Care Organizations:

Intervening to prevent complications:

In fee-for-service Medicare, dialysis clinics are not reimbursed or staffed to provide services beyond those specified in the Conditions for Coverage. But when dialysis providers are at risk for the costs of hospitalizations, they will undertake additional activities, even administering extra dialysis treatments when necessary, at their own expense.

Transitions from the hospital to the community:

Nurse practitioners determine why a patient was hospitalized and intervene to prevent another stay. They obtain discharge summaries and work through each action item with patients—matters like changes to current medications, prescriptions of new medications, and referrals to new specialists that can take hours and often overwhelm patients. Case managers are able to explain the new medication regimen to the patient, make sure new prescriptions are filled, identify specialists who are taking new Medicare patients, make appointments, and arrange for transportation.

Managing co-morbidities:

Many patients whose kidney care is stable neglect managing their diabetes. ESRD patients receive kidney care regularly but do not always visit their primary care physicians. Care managers coordinate care of comorbidities like diabetes, when necessary providing referral options for primary care physicians experienced with ESRD, or nudging patients to get eye and foot examinations.

Medication reconciliation:

A pharmacist is part of many ESCO teams and is available to consult on issues of “polypharmacy”—too many medications that may have interactions or serious side effects. With the help of pharmacists, care teams are often able to eliminate prescriptions from a patient’s regimen.

Increased engagement of patients in their care:

Dialysis patients assigned to an ESCO are informed by a letter, telling them that “The goal of an ESCO is for your dialysis facilities, nephrologists, and other health care providers to communicate closely with your other health care providers, so they can deliver high-quality care that meets your individual needs and preferences.” Patients are told they will now have a specially trained nurse available to them who “will work with you, your family, dialysis team, doctors and care partners, both inside and outside of the dialysis center, to help you better understand and manage your ESRD.” Patients are also reminded that they can still choose any dialysis facility, doctor, or hospital. The letter is followed by an individual consultation with the nurse practitioner.