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years

first in the world

April 13, 2012

Renee Fenton
Communication Manager
Duals Project Team
PO Box 45600
Olympia, WA 98504-5600

Via Facsimile: (360) 438-8633

Re: Pathways to Health: Medicare and Medicaid Integration in Washington State

Dear Ms. Fenton:

The non-profit Northwest Kidney Centers (NKC) is the oldest dialysis program in the world, with operations in King and Clallam counties in Washington State. We are pleased with the manner in which the Washington State Health Care Authority (HCA) and the Department of Social & Health Services (DSHS) have approached the implementation of the Affordable Care Act, and the open communication the agencies have had with the community related to specific aspects thereof. We generally support many of the ideas and proposals described in Washington's draft proposal "Pathways to Health: Medicare and Medicaid Integration in Washington State" (Pathways). However we have specific suggestions and questions that will hopefully improve the proposal in its final form.

BACKGROUND

Last year in our 14 facilities, 11 local hospitals where we provide services, and in over 200 patient homes, NKC provided more than 226,000 dialysis treatments. Today we serve nearly 1500 individuals with kidney failure. We work closely with over 40 nephrologists who practice in small and large group practices and academic settings. For the last four years we have been providing free education to individuals in the community with Chronic Kidney Disease (CKD). Last year we provided such education to over 1000 individuals and family members.

NKC is committed to reducing the costs associated with the essential care we provide to our patients. In 2010, NKC elected to waive transition into Medicare's End-Stage Renal Disease Prospective Payment System (PPS). In doing so, we agreed to a "Bundled" payment for the services that we provide to Medicare beneficiaries. Over 1000 of NKC's patients have Medicare as their primary insurance. Approximately 29%, 435 of our 1,500 patients, are dually eligible for both Medicare and Medicaid benefits.

Our comments to you are submitted with the assumption that DSHS and HCA share our mission to promote the optimal health, quality of life and independence of beneficiaries who require dialysis. And as a non-profit community owned organization, we seek to fulfill our mission in a cost effective, high quality manner in service to the public.

Northwest Kidney Centers, Seattle, WA – Comments on Pathways to Health Proposal, Washington State

STRATEGY 1: Implement health homes for all high cost/high risk dual beneficiaries under Managed Fee for Service where financial integrated capitation model does not exist
(beginning January 1, 2013)

NKC agrees with the proposal's statement that *"Care coordination will be most successful in engaging a beneficiary when it is provided locally by an entity that already has established care relationships with the beneficiary."* NKC patients typically dialyze at least three times a week for over four hours at clinics located throughout King and Clallam counties, typically close to their homes. Medicare regulations require that each of our patients receive a Comprehensive Assessment and Plan of Care (CAPC) within 30 days of the initiation of their treatment, following a change in the manner in which patients receive treatment, or monthly if patients have been deemed clinically "unstable." Following the initial assessment, stable patients continue to receive annual CAPC. Each Comprehensive Assessment is completed by an interdisciplinary care team consisting of the patient's Nephrologist, Nurse Case Manager, Dietitian, and Social Worker. Issues covered range from patient suitability for transplant to issues that may be impeding care or outcomes. NKC follows the same clinical processes for all of its patients, regardless of their payer or their ability to pay.

RECOMMENDATION

The proposal suggests, *"A health home is not a place, but a list of services and functions provided by an entity that will be qualified by the state."* We ask that health home program developers consider how providers of dialysis services may be integrated into the health home model.

Participating Entities - Additional clarity regarding the qualifications and expectations for participating health home entities would be helpful. As an entity that provides a number of services listed in the proposal, it might make sense for dialysis centers to be considered as candidates to become participating health home entities. Further clarification regarding system requirements would assist organizations such as ours in knowing if this was indeed the case.

Coordinating Entities - Additional clarity regarding selection criteria for the qualified coordinating entity would also be helpful. If these entities are intended to also be providers, what specific qualifications would demonstrate that they would be able to administer the program and what would their specific responsibilities be as coordinating entities? For example, would there be minimum claims processing standards to ensure that participating (non-coordinating) members of the health home would receive prompt payment for the services that they deliver to the beneficiaries?

Disqualification of Entities - Additional clarity regarding the expected minimum composition of the participating entities within the health home would also be helpful. For example, what provisions are either stated or are anticipated in the program design to mitigate the effects of a coordinator losing a key participant in a qualified health home? What would the process of disqualifying a health home or participating member look like and how might this effect the care of a beneficiary?

Northwest Kidney Centers, Seattle, WA – Comments on Pathways to Health Proposal, Washington State

STRATEGY 2: Implement full financially integrated model purchased through health plans (beginning January 1, 2013)

NKC agrees with the proposal's intent to include medical, mental health, chemical dependency, and long term services within capitation.

NKC has recent experience with how a capitated payment model can produce beneficial financial outcomes for payers of dialysis services. In 2011, NKC agreed to begin receiving a bundled payment from Medicare for dialysis services provided to their beneficiaries. Under bundling, providers of dialysis services receive a per-treatment payment for dialysis treatments, including specified lab tests and administered medications. Prior to bundling, Medicare paid separately for dialysis treatments, administered drugs, and lab tests that fell outside a narrowly-defined list.

To ensure that payers continued to focus on quality, and didn't, for example, simply stop providing (or unreasonably restrict) necessary therapy to their patients, Medicare also put into place the End-Stage Renal Disease Quality Incentive Program (QIP). QIP ties two percent of a facility's Medicare reimbursement their patient's clinical outcomes.

RECOMMENDATION

Generally Preserve Patient Access to Care - NKC strongly urges that Pathways developers consider access to care when designing their plans. Because the vast majority of dialysis patients receive treatment at service locations three times a week for over four hours at a time, it is essential that these services be available in centers as close to where beneficiaries live as possible.

Establish Clear Patient Access Standards - NKC would urge that minimum standards for patient access like maximum drive times be articulated within the program design documents so that beneficiary needs can be sufficiently met and program participation can be more easily achieved.

Follow Established Industry Quality Standards - It would also be helpful to understand the manner in which incentives are to be applied to health plan outcomes to preserve and improve quality in the delivery of services to beneficiaries. Where existing CMS quality programs such as the ESRD QIP (based on National Quality Forum approved measures) exist, we would strongly urge that Pathways program incentives mirror the existing quality standards, and guard against creating separate, potentially competing goals.

Northwest Kidney Centers, Seattle, WA – Comments on Pathways to Health Proposal, Washington State

STRATEGY 3: Modernize current service delivery system, implement three-way contracting and capitation of Medicare Payments and Medicaid medical payments coupled with the use of performance measures and incentive pools to improve integration and financial alignment across medical, behavioral health, and long term services and supports systems (beginning January 1, 2014)

We note that in the Pathways proposal, strategy 3 describes a number of plan features that would help with integration and alignment of incentives. NKC has specific recommendations relating to two such features described below.

RECOMMENDATION

“Provides medical care through a health plan with strong financial incentives to reduce inpatient medical admissions and avoidable ER/ED utilization”

NKC works hard to reduce inpatient medical admissions and avoidable ER/ED utilization. Our hospital admission rates are lower than the national average, and of patients hospitalized, a large percentage of those hospitalizations are related to a need for dialysis (e.g. CHF, fluid overload, cardiac issues including chest pain). Many of these conditions can be resolved by simply providing patients with more dialysis. Often, if a patient fails to show up for a treatment, they present at the hospital exhibiting the symptoms described above. In a more tightly coordinated care model, NKC could reach out to a coordinator if the patient failed to show up at the dialysis center, and the coordinator could pay a visit to the patient’s home to investigate their status. NKC, because it has a number of locations in the Seattle area, could reschedule the patient for a dialysis treatment and potentially save the cost of a hospital admission.

Another reason for hospital admissions of our patients is catheter infections. Patients with End-Stage Renal Disease (ESRD) clean their blood by running it through a filter outside of their body. To access the blood, patients have three options: Arteriovenous Fistula (AVF), Arteriovenous Graft (AVG) or Catheter. The industry standard is for patients to have an AVF at the time of their first dialysis treatment. Because an AVF can take as long as 8 weeks to mature, patients will sometimes also get a temporary catheter while the AVF matures. In other cases, a catheter will be placed while an access surgeon who will perform the AVF procedure is identified.

Industry insiders suggest that the relatively low Medicare and Medicaid reimbursement for AVF placement exacerbates the access problem.

Clearly Describe Shared Savings - NKC strongly recommends that more effort be paid to coordinating care between access surgeons, nephrologists, the dialysis care team and patients, with an eye toward reducing hospital admissions related to access infections. While we see conceptual support for this in the Pathways proposal, we would recommend that the process of creating incentives to cooperate within the community be made more explicit. If it is the program’s intent, for example, to create financial incentives for cooperation across beneficiaries’ interdisciplinary care teams, then we would recommend that the mechanism for achieving the redistribution be at least partially described in the Pathways proposal.

Northwest Kidney Centers, Seattle, WA – Comments on Pathways to Health Proposal, Washington State

“Creates incentives for the health plan to achieve quality metrics – including metrics tied to retention and engagement of high-risk clients with serious mental illness, substance use disorders, and/or significant functional impairments;”

Include Dialysis Patients as “High Risk” Clients - NKC believes that quality incentives are essential to preserve and improve patient outcomes. Nevertheless, it is unclear in the Pathways proposal who would preside over the development of such metrics, and to which beneficiaries they would apply. NKC would respectfully suggest that beneficiaries with ESRD be included in or considered part of the above list, and that where available, existing, industry standard quality metrics like ESRD QIP be applied instead of Pathways-specific quality goals.

We urge that as the Pathways program moves from draft to final version, simplification of performance measures or alignment with pre-existing national performance measures be considered a top priority.

We appreciate the opportunity to comment on the Pathways draft proposal, and look forward to participating in the process of shaping the future of care for nearly one in three of all of the patients to whom we provide services. I welcome your contact to discuss any aspects of this letter.

Sincerely,



Joyce F. Jackson
President and CEO
Northwest Kidney Centers
700 Broadway
Seattle, WA 98122

(206) 720-8500
Joyce.Jackson@nwkidney.org