The Chronic Kidney Disease Improvement in Research & Treatment Act (H.R. 2644)

Section-by-Section

Title I: Improving Patient Lives and Quality of Care Through Research and Innovation

Section 101: Identifying Barriers or Payment Disincentives for Transplant and Best Practices for Improving Donation Rates
This section would require the Secretary of Health and Human Services (HHS), not later than 18 months after enactment, to submit a report to the Congress on any disincentives in the Medicare payment systems that create barriers to kidney transplants and post-transplant care for beneficiaries with end-stage renal disease (ESRD). The study would also examine best practices on how to increase deceased and living organ donation rates.

Section 102: Enhancing Care through New Technologies
The structure of Medicare’s ESRD Prospective Payment System (PPS) has led some to question how new technologies would be adequately incorporated into dialysis treatment. This provision would require the National Academy of Sciences to evaluate the current ESRD payment system, identify barriers to adopting innovative items, services, and therapies, and make recommendations as to how to eliminate such barriers.

Section 103: Understanding Current Utilization of Palliative Care Services
The Government Accountability Office would be required to issue a report on how and to what extent palliative care is utilized and the effects of palliative care on the quality of life and treatment outcomes of individuals with ESRD.

Section 104: Understanding the Progression of Kidney Disease and Treatment of Kidney Failure in Minority Populations
The Secretary of Health and Human Services would be required, not later than one year after enactment, to submit a report to the Congress on: (1) the social, behavioral, and biological factors leading to kidney disease; (2) efforts to slow the progression of kidney disease in minority populations that are disproportionately affected by such disease; and (3) treatment patterns associated with providing care to minority populations that are disproportionately affected by kidney failure.
Title II: Empower Patient Decision Making and Choice

Section 201: Providing Individuals with Kidney Failure Earlier Access to Managed Care
The 21st Century Cures Act contained a provision that allows fee-for-service Medicare beneficiaries with ESRD to enroll in a Medicare Advantage plan starting in plan year 2021. The section would allow patients to access the care coordination that Medicare Advantage plans offer earlier by moving up the effective date of the 21st Century Cures provision to plan year 2020. The section also reauthorizes on a permanent basis the Chronic Special Needs Plan for ESRD (C-SNP). The Section also accelerates the MedPAC report on risk adjustment mandated in the 21st Century Cures Act by one year: MedPAC would issue its report by July 1, 2019.

Section 202: Medigap Access for ESRD Beneficiaries
The Social Security Act guarantees that Medicare beneficiaries over age 65 have access to Medigap plans – recognizing the role these plans have in helping patients plan and defray the cost of Medicare services. For ESRD patients, Part B’s 20 percent cost sharing and lack of annual cost sharing limits make affording care extremely difficult. This section would guarantee access to Medigap policies to all ESRD Medicare beneficiaries, regardless of age.

Section 203 Promoting Access to Home Dialysis Treatments
This section would expand access to telemedicine services for home dialysis patients by allowing dialysis facilities and the home to be approved sites of service for telemedicine for home dialysis. The proposal would not allow for origination site fee for the home.

The section would also provide a safe harbor from Stark/anti-kickback statute for equipment furnished by a practitioner for purposes of home dialysis so providers are not disincentivized or penalized for providing patients the tools for successful home dialysis.

Section 204: Allowing Individuals with Kidney Failure to Retain Access to Private Insurance
Individuals with ESRD who are covered by a group health plan and are eligible or enrolled in Medicare may keep their private health plan as their primary payor for 30 months. This section extends the Medicare Secondary Payer requirement for ESRD beneficiaries by an additional twelve months, allowing people to keep their private plan longer.

Title III – Improving Patient Care and Ensuring Quality Outcomes

Section 301: Maintaining an Economically Stable Dialysis Infrastructure
Eighty-five percent of ESRD patients rely on Medicare to pay for dialysis. Given the oversized role Medicare has in covering this population, it is critical that the Medicare bundled payment adequately and fairly reimburses the cost of providing care. This section would fix unresolved problems with the current method for calculating the PPS bundled payment amount. This section would eliminate application of co-morbid case-mix adjusters; eliminate the outlier adjustment; require HHS use the age adjustor from CY15; require the Centers for Medicare & Medicaid Services (CMS) to reassess the weight adjusters; mandate an update the standardization factor based on the most recently available data; and require CMS to consider
reasonable costs for setting the bundled rate. The Secretary would also be required to include
the network fee as an allowable cost or offset to revenue in the ESRD cost report. Taken
together, these provisions would make the bundled payment rate more accurate and stop
funding designated for dialysis payment from being inappropriately removed from the system.

Section 302: Improving Patient Decision Making and Transparency by Consolidating
and Modernizing Quality Programs

There are a great deal of inconsistencies and redundancies in the current quality programs
related to kidney disease. These redundancies and inconsistencies are costly and burdensome
without a providing additional benefit for patients. The proliferation of individual measures
leads to questions of whether the Secretary is focusing on measuring the most important
aspects of dialysis care. This section would provide more transparency to the measure
adoption process, ensure that resources are being efficiently directed at meaningful metrics,
and make sure that the measures adopted can and will influence in a positive manner the
delivery of care to improve patient outcomes.

The section would require the Secretary:

• Ensure that no single measure or individual measure within a composite measure in the
  ESRD Quality Improvement Program (QIP) is weighted less than 10 percent of the total
  performance score;

• Submit for National Quality Forum (NQF) endorsement any composite measures to be
  used in Five Star or QIP and prohibit the Secretary from adopting any measure or
  composite that has been considered, but not endorsed by the NQF or similar entity;

• Use only measures that have been shown through testing to be statistically valid and
  reliable;

• Use the ESRD QIP methodology to assign stars in the ESRD Five Star Program and
  prohibit the use of a bell curve when setting stars or rebasing the stars in the ESRD Five
  Star Program;

• Require that hospitals provide health information to dialysis facilities upon discharge of
  a patient who receives treatment at the dialysis facility; and

• Use funds collected from assessed penalties under the QIP to establish bonus payments
  for providers of service or renal dialysis facilities that exceed the attainment
  performance standards.

Section 303: Increasing Access to Medicare Kidney Disease Education Benefit

This section would expand the Medicare Kidney Disease Education program to: (1) allow
dialysis facilities to provide kidney disease education services under certain circumstances; (2)
permit physician assistants, nurse practitioners, and clinical nurse specialists, in addition to
physicians, to serve as referral sources for the benefit; and (3) to provide access to these
services to Medicare beneficiaries with Stage 5 CKD not yet on dialysis.
Section 304: Certification of New Facilities
Facilities must meet conditions or requirements to participate in the Medicare program. Under Section 1865 of the Social Security Act (SSA), most facilities can have national accrediting bodies certify that a facility meets Medicare conditions or requirements. However, dialysis facilities are prevented by the statute from using an accrediting body to certify it meets the requirements related to coverage of services for ESRD under Section 1881 of the SSA.

Dialysis facilities must use State Government accreditation bodies to certify it meets the conditions and requirements of the Act. Reliance on these bodies has slowed certification of new facilities and delayed new access points for patients. The section would delete the clause in Section 1865(a) that prohibits dialysis facilities from utilizing national accrediting bodies to certify it meets the requirements for participation, thus reducing the backlog and lag time associated with accrediting dialysis clinics.

Section 305: Improving Access in Under Served Areas
This section would clarify that nephrology health professionals in underserved rural and/or urban areas may participate in the National Health Service Corp loan forgiveness program.