The Chronic Kidney Disease Improvement in Research and Treatment Act (H.R. 3912)

Section-by-Section

Title I: Increasing Awareness, Expanding Preventative Services, and Improving Coordination

Section 101: 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; (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 Chronic Kidney Disease (CKD) not yet on dialysis.

Section 102: 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 103: Improving Access in Underserved Areas
This section would clarify that nephrology health professionals in underserved rural and/or urban areas may participate in the National Health Service Corps loan forgiveness program.

Section 104: Improving Care Coordination for Dialysis Patients By Requiring Hospitals to Provide Information
This section establishes a process for hospitals to provide renal dialysis facilities with health and treatment information with respect to an individual at discharge. The individual or dialysis facility may initiate the request.

Title II – Incentivizing Innovation for Truly Innovative New Drugs, Biologicals, Devices, and Other Technologies

Section 201: Maintaining an Economically Stable Dialysis Infrastructure
This section would eliminate application of co-morbid case-mix adjusters; eliminate the outlier adjustment; require the Department of Health and Human Services (HHS) to use the age adjustor from CY15; require the Centers for Medicare & Medicaid Services (CMS) to

reassess the weight adjusters; mandate an update to 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. This section also repeals the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) bad debt rule and requires the Department of Health and Human Services (HHS) to apply bad debt to the total prospective payment system (PPS), putting the ESRD payment model on par with other Medicare payment models.

This section also establishes an ESRD-specific productivity rate and limits the amount for a short period if Medicare margins are below 3 percent.

It would also promote the adoption and incorporation of innovative drugs, biologicals, and devices by establishing a pass-through period for new drugs, biologicals, and devices. The Secretary would be required to establish a process for identifying and determining appropriate payment amounts for incorporating new devices and technologies into the bundle.

Title III – Improving the Accuracy and Transparency of ESRD Quality Programs

Section 301: Improving Patient Decision Making and Transparency by Consolidating and Modernizing Quality Programs

This section eliminates the specified domains in the statute and replaces them with language requiring measures used in the ESRD Quality Incentive Program (QIP) to be selected in consultation with stakeholders to promote improvement in beneficiary outcomes and shared decision-making with beneficiaries and their caregivers; when selecting such measures, it requires HHS to take into account clinical gaps in care, underutilization that may lead to beneficiary harm, patient safety, and outcomes.

The section would require the Secretary:

- Ensure that no single measure or individual measure within a composite measure in the ESRD 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; 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.

Title IV: Empowering Patients

Section 401: 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. This section would guarantee access to Medigap policies to all ESRD Medicare beneficiaries, regardless of age.

Section 402: 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.