October 7, 2017

The Honorable Kevin Brady
Chairman
Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Bldg.
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member
Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Bldg.
Washington, D.C. 20515

The Honorable Greg Walden
Chairman
Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Bldg.
Washington, D.C. 20515

The Honorable Frank Pallone
Ranking Member
Energy and Commerce
U.S. House of Representatives
2322A Rayburn House Office Bldg.
Washington, D.C. 20515

Dear Chairmen Brady and Walden and Ranking Members Neal and Pallone:

On behalf of the undersigned organizations, we are writing to you to urge you to consider enacting legislation that would require the Centers for Medicare and Medicaid Services (CMS) to conduct a voluntary demonstration project designed to encourage transplant centers, dialysis facilities, Organ Procurement Organizations (OPOs), community hospitals, nephrologists, non-profit patient organizations, and others to work collaboratively and on a local basis to increase transplantation rates in their area.

Kidney transplantation is often the best treatment option for Medicare patients with End Stage Renal Disease (ESRD) and certain medically eligible Medicare patients with late stage Chronic Kidney Disease (CKD). Kidney transplantation has been widely demonstrated to be the most cost-effective treatment for such patients, resulting in marked savings when compared to a lifetime of dialysis treatment, a concern shared both by patients and taxpayers. However, under current Medicare policy, dialysis is the usual treatment for these patients, and transplantation is the exception. Rather than continue with the status quo, transplantation should be considered first line renal replacement treatment, with dialysis available for those patients for whom transplantation is contraindicated or those for whom a suitable organ is unavailable.

The Medicare program includes a number of financial and regulatory disincentives for providers to maximize the use of transplantation as the treatment of first choice for ESRD and late stage CKD patients.

The Medicare system fails to incentivize timely referral of appropriate patients for early transplantation, as dialysis reimbursement is markedly higher than post-transplant care. Medicare payment rates for transplant admissions are not sufficient to compensate transplant centers or the transplant team for the additional resources needed to make transplantation accessible to medically complex patients. Finally, current Medicare regulations do not encourage – and in some ways inadvertently discourage – increased transplantation by, for example, imposing outcome requirements on transplant centers that are perceived to discourage the acceptance of higher risk organs for transplantation. These regulations focus exclusively on early post-transplant outcomes rather than the survival of the 100,000 patients currently waiting for a lifesaving organ.

The CMS Innovation Center's Comprehensive ESRD Care Model currently underway, as well as legislation currently under consideration by Congress (the "PATIENT Act"), encourage dialysis facilities and others to maintain patients on dialysis rather than referring appropriate patients for transplant evaluation. Under these programs, shared savings (in the case of the CEC demonstration program) or capitated payments (in the case of legislation currently under consideration) would cease if a patient receives a transplant. As transplant candidates are often healthier, and thus less costly, than general dialysis patients, the undersigned parties are concerned that entities covered under the PATIENT Act or the CEC demonstration project may seek to delay referral of these more profitable patients. In addition, there is little incentive to pursue pre-emptive transplant which occurs prior to the start of dialysis and is the most effective modality for patients with advanced CKD. As a deliberative body of both patients and medical professionals, we the undersigned are also intensely concerned that the current system has witnessed racial and socioeconomic disparities in access to transplantation – and we believe that the time is now for greater innovation and experimentation in the program to address this issue. The current demonstration projects do not support the development of community-wide innovations which advance access to transplant for all parties.

We support an alternative approach designed to facilitate, rather than discourage, timely referral of all interested patients for transplantation evaluation, increase organ availability, and expand access to transplantation of those for whom transplantation is clinically appropriate. Under this approach, Congress would enact legislation that requires CMS to conduct a voluntary demonstration project which provides financial incentives and regulatory relief to coordinated networks that include transplant centers, dialysis facilities, OPOs, academic and community hospitals, nephrologists and other professionals involved in the care of these vulnerable patients (Transplant Networks). Incentives to join the network would include both regulatory relief and an opportunity to share in savings achieved through increased transplantation: Network providers would be entitled to waiver of certain otherwise applicable Medicare rules that currently stand in the way of increasing transplantation and organ availability by focusing only on the outcome of the patients who are actually transplanted and not the patients who remain on the waiting list. Because transplantation is a more cost-effective treatment

option than dialysis over the lifetime of the transplant, we would anticipate that the demonstration would be conducted as a shared savings program similar to that used under the ACO program and various Centers for Medicare and Medicaid Innovation Center (CMMI) demonstration programs. Specifically, under the demonstration, CMS would determine a target number of transplants for the demonstration area using historical and other demographic data and, working with the United States Renal Data System (USRDS) would quantify (and share with the Transplant Network) the Medicare savings resulting from transplants performed in excess of the target over the life of these transplanted organs. Our organizations have substantial experience working with CMS on quality standards and metrics and are fully prepared to engage with CMS to develop the quality measures that would be applied to this proposed demonstration project.

The proposed demonstration has the potential to substantially improve the care for ESRD patients and those with late stage CKD. We strongly believe that working together and with the right regulatory environment, better operational alignment, and the removal of barriers and disincentives, the transplant community could significantly increase the availability of kidney transplantation, enhance equity for all patients, and, at the same time, produce considerable savings in the Medicare program for the American taxpayer.

Sincerely yours,

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