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January 24, 2012

Hon. Marilyn Tavenner, Acting Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Ave SW  
Washington, D.C. 20201

Dear Acting Administrator Tavenner:

On behalf of the American Society of Pediatric Nephrology (ASPN), I write to congratulate you on your nomination as Administrator of the Centers for Medicare and Medicaid Services (CMS). We wish you well throughout the confirmation process and appreciate the opportunity to provide you with information on the ASPN's policy positions with respect to CMS' work, and look forward to working with you as you take the helm of CMS from the capable hands of Dr. Berwick.

Founded in 1969, the ASPN is a professional society composed of pediatric nephrologists whose goal is to promote optimal care for children with kidney disease and to disseminate advances in the clinical practice and basic science of pediatric nephrology. The ASPN currently has over 500 members, making it the primary representative of the pediatric nephrology community in North America.

Members of ASPN's leadership met with Dr. Berwick in March 2011, and appreciated his informed interest in discussing the unique challenges facing children with end-stage renal disease (ESRD), especially regarding dialysis payment and quality, and other issues affecting this unique Medicare population. To review, patients under the age of 18 make up less than one percent of the Medicare ESRD patient population. According to an internal ASPN survey of pediatric dialysis facilities conducted in 2010, approximately 43 percent of our dialysis patient population is covered by Medicare, with Medicaid covering 31 percent and private insurance covering 19 percent. Only 7 percent of our dialysis patient population does not have traditional insurance coverage with half of that uninsured. In addition to payer makeup, the survey also looked at patient age, as often we treat patients past their eighteenth birthday. We found that while 85 percent of patients from the reporting centers were under the age of 18, fully 15 percent of our patient population is over the age of eighteen, as pediatricians care for late adolescents through their early twenties.

Therefore, every ESRD policy that applies to “adults,” defined as patients over the age of 18, does, in fact, also apply to pediatric dialysis facilities. It is with this in mind that I write to make the following points:

- We continue to urge CMS to ensure adequate payment for pediatric dialysis facilities to address the unique needs of children with ESRD;
- We remain committed to improving the quality of care for the pediatric ESRD population; and
- We stand ready to work collaboratively with CMS in these efforts.

### **Payment for Pediatric Dialysis Facilities**

The ASPN continues to support moving forward with implementation of the ESRD prospective payment system (PPS), and is working with its membership and pediatric facilities to monitor reimbursement requirements for the provision of high quality ESRD care to children. The ASPN is currently engaged in several data collection and educational efforts designed to inform CMS as it determines the current cost of dialyzing this unique, vulnerable patient population. Concern about cognitive development and growth are unique to children receiving dialysis and therefore, identifying appropriate comorbid case mix adjustors for the pediatric and adolescent patient population is an important component of this effort, as is ensuring that these are reported to CMS via Medicare claims. Beyond this, information on higher costs due to the need for specialized equipment and greater staffing should be considered in future iterations of the pediatric facility PPS formula. Without accurate reimbursement to pediatric facilities, those who are specially trained to care for this unique patient population, and pediatric ESRD patients themselves, face an uncertain future. Our goal is to make sure that reimbursement is appropriate so that facilities and experts can continue to provide high quality services to those in need.

### **Quality Improvement Efforts**

ASPN has been involved in the development, review and endorsement of physician-level and facility-level quality measures for several years. It is our hope that CMS’ work in this area will continue, and that CMS will soon include pediatric ESRD measures in the Physician Quality Reporting System (PQRS). Doing so will ensure that those physicians who treat even the smallest proportion of the Medicare population can continue to participate in these programs, as we share the common goal of improving the quality of dialysis care.

We also strongly urge CMS to ensure that all Medicare quality programs – whether they are facility or physician-based – be harmonized as fully as possible to ensure the highest quality patient care and to make the process easier and more streamlined for both providers and health care professionals. For example, pediatric nephrologists have only one physician measure on which to report for the PQRS, but we understand that the Medicare End-Stage Renal Disease Quality Incentive Program (ESRD QIP), which applies to dialysis facilities, will in future years include a number of pediatric quality measures. CMS should make sure that all quality measures are logical and appropriate, evidence-based

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<sup>1</sup> Warady BA, Ho M: Morbidity and mortality in children with anemia at initiation of dialysis. *Pediatr Nephrol* 18:1055-1062, 2003.

<sup>2</sup> Amaral S, Hwang W, Fivush B, Neu A, Frankenfield D, Furth S. Association of mortality and hospitalization with achievement of adult hemoglobin targets in adolescents maintained on hemodialysis. *J Am Soc Nephrol*. 2006 Oct;17(10):2878-85.

<sup>3</sup> Bassi S, Montini G, Edefonti A, et al: Cardiovascular function in a chronic peritoneal dialysis pediatric population on recombinant human erythropoietin treatment. *Perit Dial Int* 13:S267-S269, 1993 (suppl 2).

<sup>4</sup> Morris KP, Skinner JR, Hunter S, Coulthard MG. Short term correction of anaemia with recombinant human erythropoietin and reduction of cardiac output in end stage renal failure. *Archives of Disease in Childhood* 68:644-8, 1993.

<sup>5</sup> Yorgin PD, Belson A, Al-Uzri AY, Alexander SR. The clinical efficacy of higher hematocrit levels in children with chronic renal insufficiency and those undergoing dialysis. *Seminars in Nephrology* 21:451-62, 2001.

<sup>6</sup> Gerson A, Hwang W, Fiorenza J, et al: Anemia and health-related quality of life in adolescents with chronic kidney disease. *Am J Kidney Dis* 44:1017-1023, 2004

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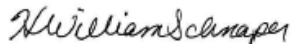
and achievable at the level for which they are intended and that physician and facility issues are addressed in parallel. We encourage those at CMS who are developing these programs to discuss with us, as the care providers, the types of measures that are included and the framework of the programs so that the measures can be optimally implemented. ASPEN members are pleased to have been involved in the technical expert panels (TEPs) tasked with developing quality measures for the ESRD QIP, and we encourage CMS to continue to use these mechanisms for future measure development, both at the physician and facility levels.

Pediatric nephrologists continue to strive to provide the best quality care to their patients, and we believe that participation in programs such as Medicare's Physician Quality Reporting System (PQRS) and the QIP is important to achieving this goal.

At the conclusion of our meeting with Dr. Berwick, we agreed to establish three internal working groups to consider the applicability of the PPS in pediatric dialysis units, the implementation of quality measures, and the potential effect of the high percentage of pediatric patients who are covered by Medicaid rather than Medicare or private insurance. These work groups have enjoyed a collaborative relationship with CMS staff, and we hope that you will be supportive of this work moving forward.

Again, congratulations on your nomination and best of luck with the confirmation process. We look forward to working closely with CMS after your confirmation. Please contact me at (312) 503-1180 or Schnaper@northwestern.edu; or our Washington Representative, Katie Schubert at (202) 484-1100 or kschubert@dc-crd.com, if we can provide additional information on the ASPEN or its policy positions.

Sincerely,



H. William Schnaper  
President