



August 22, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS–1782–P: End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals With Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, and End-Stage Renal Disease Treatment Choices Model

Dear Administrator Brooks-LaSure,

On behalf of the more than 30 organizations working together to advance kidney care through Kidney Care Partners (KCP), I want to thank you for the opportunity to provide comments on the “End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals With Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, and End-Stage Renal Disease Treatment Choices Model” (Proposed Rule). This letter focuses on request for information related to the low-volume adjuster and the proposed modifications to the current low-volume adjuster. We have filed our comments on other sections of the Proposed Rule in separate letters.

Kidney Care Partners is a non-profit, non-partisan coalition of more than 30 organizations comprising patients, physicians, nurses, dialysis professionals, researchers, therapeutic innovators, transplant coordinators, and manufacturers dedicated to working together to improve the quality of care for individuals living with kidney disease.

I. KCP supports the Proposal for an Exemption Attestation Process for Disaster and Other Emergencies.

KCP supports both proposed changes to the current LVPA process related to administrative flexibilities during disasters or other emergencies. We appreciate the exception to the attestation process that would allow ESRD facilities to receive the LVPA even if they exceed the threshold because they have treated patients displaced by a disaster or other emergency. We also support the flexibility that would allow low-volume facilities to close and reopen in response to a disaster or other emergency and still receive the LVPA.

II. KCP Appreciates the Opportunity to Respond to the Request for Information and Reiterates Our Support for Refining the Low-Volume Payment Adjustment (LVPA) and Eliminating the Rural Adjustment.

KCP appreciates that CMS has requested comments on refining the LVPA to better target remote or isolated facilities¹ and its general request for “potential approaches to refine the ESRD PPS methodology.”² KCP supports the purpose of adopting an adjuster to compensate small facilities that are providing important access to care and because of their size cannot take advantage of efficiencies associated with greater scale. We agree with MedPAC that the current structure does not target dollars to the facilities that need them the most.³ KCP has raised similar concerns over several years of comment letters. The Moran Company analyses have also shown that the current dual model results in double payments to facilities and inadequate recognition of other facilities that need the adjustment. The problem these analyses highlight is that facilities with only a small number of patients experience unsustainable per patient treatment costs and margins that place them on the nearly constant brink of closure. The issue is not that isolated low-volume facilities have higher costs than other low-volume facilities, as CMS describe the concern,⁴ but rather that such isolated facilities are likely the only provider for patients in those areas and experience unsustainable margins to cover their costs because their costs are spread over fewer patients. When they are the only facility available for dialysis patients within a reasonable distance from their home, it is important that the federal government increase their reimbursement rates (as the Congress mandated in the authorizing statute⁵) to maintain patient access.

We are concerned that the Local Dialysis Need (LDN) methodology outlined in the RFI would not only fail to address the underlying concern with the current LVPA and rural adjusters, but would also disrupt access for those patients who rely upon low-volume facilities. As discussed below, CMS has reviewed only part of the equation (cost) rather than reviewing the per patient treatment cost and facility Medicare margins as well. While cost is a factor, it should not be examined in isolation as the TEP contractor did. Both MedPAC and The Moran Company focused their analyses on the per patient treatment cost and margins to identify the cut points where facility margins no longer supported keeping a facility open and establish those as the thresholds for obtaining the adjuster. The misplaced emphasis on cost alone is understandable, but it is essential that before CMS proposed changes to the current LVPA, it recognize that the issue is not cost, but how many patients over which those costs are divided and how those cost are covered, or not as may be the case, by the current reimbursement rates.

¹Display Copy page 40.

²Display Copy page 40.

³MedPAC. *Report to the Congress*. 192 (June 2020).

⁴Display Copy 38.

⁵42 USC § 1395rr(b)(14)(D).

Moreover, this focus on cost alone fails to address the second part of both MedPAC and KCP's ongoing recommendations to protect patient access to dialysis care in underserved areas. The second part of the recommend would eliminate the rural adjuster and fold those dollars into a revised low-volume adjuster to better target the money to facilities that actually need it to remain open and serve patients. Rural facilities do not inherently experience higher costs than urban facilities. In fact cost inputs, such as rent, labor, and locally sourced supplies, may be less expensive than those incurred by non-rural facilities. However, the reason so many facilities located in rural areas struggle to remain open is that they serve a small number of patients and so these fixed costs are allocated over a smaller number of claims. When the revenue does not support those higher per patient costs, the result is chronic negative margins that threaten patient access. Medicare has historically relied on rural ZIP codes as a proxy to identify such facilities. However, as MedPAC and The Moran Company have demonstrated through their analyses, many facilities in rural areas actually have a greater number of patients and experience positive margins suggesting that the adjuster based on ZIP codes no longer serves as an adequate proxy. As a result, a better defined low-volume adjuster that incorporates historic funding for the rural adjuster would meet the goals the Congress had in establishing the low-volume adjuster now that the data clearly show the problems inherent in the dialysis rural adjuster.

We have speculated that one reason why the contractor had not reviewed the MedPAC or KCP proposals during the TEP and why CMS has not sought comment on them in the RFI may be because CMS has misunderstood the concerns expressed about the current adjusters and the problem that these adjusters are trying to address. As noted above, the purpose of both of the LVPA and rural adjusters is to protect access for patients by subsidizing facilities serving a small number of patients and that as a result of that small population experience consistently negative margins that threaten their ability to remain open.

When designing an adjuster to address that purpose, questions about potential "gaming" and eligibility thresholds creating unfair cliffs arise. The concept of gaming is not really accurate; the vast majority of providers do not set out to "game" a system, but rather to maximize the reimbursement they can receive under the rules. Thus, it is appropriate for CMS to consider ways to design their policies to avoid creating situations the agency does not intend to happen. This need to have a targeted policy is one of the reason MedPAC also recommended that CMS adopt an isolation criterion when implementing a low-volume adjuster. We do not agree with the suggestion in the preamble that isolation should not be a criteria for the LVPA.⁶ Targeting a significant adjustment toward isolated low-volume facilities would also address the concerns about other facilities being built nearby as the number of individuals who require dialysis grows in an effort to maintain the low-volume adjuster.

⁶Display Copy page 38.

KCP also disagrees with the statement in the preamble that there are significant concerns about a cliff such that a multi-tiered or continuous adjuster would be warranted. We acknowledge that during some of MedPAC's public meeting a couple of MedPAC Commissions several years ago asked questions about the feasibility of such models, but as the final MedPAC recommendations demonstrate, a simple, transparent two-tiered approach is the right method to address the problem of patients losing access to dialysis services. Given that the purpose of the adjustment is to provide a federal subsidy to facilities that otherwise could not remain open and serve the critical role of providing dialysis treatments in their communities, CMS should not propose or adopt policies that seek to redistribute all dialysis payments based on the volume of patients.

In sum, KCP supports a single low-volume facility adjuster that incorporates the funding for the historical rural adjuster. This single low-volume adjuster would better target payments for facilities providing fewer than 4,000 treatments per year (the current criteria) and expand the adjuster to a second tier of facilities providing between 4,001 and 6,000 treatments per year. (As discussed below, these thresholds are based on the analyses that identified the number of treatments that would create challenges for a facility to remain open). This revised low-volume adjuster would take the place of the LVPA and rural adjuster. The new adjuster could be funded by the current dollars allocated to the low volume and rural adjusters so the amount would not result in a substantial reduction to current LVPA's percentage. It also would not result in a further reduction to the base rate. The second-tier acts as a transition so that facilities that experience patient growth would not immediately lose access to the entire subsidy, but they would receive a lower amount than facilities in the first tier. (Given that there are approximately 156 treatments each year, the transition period would allow a facility to provide treatments for an additional 12 patients on average before losing access to the subsidy entirely. Based on the MedPAC and The Moran Company analyses after that point, facility revenues should support returning to the current base rate). This recommendation is consistent with the MedPAC recommendation. We would welcome a dialogue to address any questions the contractor or CMS might have about this proposal.

Of the three options CMS describes in the RFI – (1) maintain a single adjustment;⁷ (2) establish multiple adjustment tiers;⁸ or (3) establish a continuous function adjustment⁹ -- KCP favors a two-tiered adjustment, as described in the previous paragraph. We believe the four and eight tier options are not appropriately targeted to serve the purpose of the low-volume adjuster, lack transparency,¹⁰ and overly complicate the issue based on the data shared by MedPAC and the previous analyses by The Moran Company. Moreover, we ask CMS to specifically evaluate and seek public comment on the two-tiered approach outlined by KCP and MedPAC. We also believe that if CMS were to eliminate the duplicative payments for the current

⁷Display Copy 41.

⁸Display Copy 42.

⁹ Display Copy page 44.

¹⁰Display Copy page 39.

overlap between the rural and the LVPA adjustments, the value of the new low-volume would be more tailored to the needs of facilities and still be budget neutral.

Our responses to CMS's specific questions follow below.

A. Comment Solicitation for Modifications to LVPA Methodology

1. Addressing Concerns about Payment Cliffs

- a. Request for Comment: Please comment on which payment structure would be more appropriate: single threshold as currently employed, tiered structure, or continuous function, and provide the reasoning behind your recommendation.***

As noted in the introduction to this section, KCP favors a two-tiered threshold that balances the need for ease of administration with the desire to avoid potential cliffs. The practical nature of any adjustment is that there are treatment thresholds above which a facility will not qualify. However, as KCP has recommended in previous comment letters and meeting materials, CMS's current qualifying criteria related to number of treatments threshold in each of the three years before the payment year in question for the LVPA helps to eliminate cliff by ensuring that a qualifying facility is consistently treating a low-volume of patients.

To be clear, KCP is not asking to expand the current adjustment, but rather create a second transition tier for facilities with 4,001 and 6,000 treatments so that they are encouraged to provide services to additional patients without having a complete cliff. In addition, the use of the three-year rolling average also is a guardrail against gaming.

We are concerned that a continuous option would dilute the impact of the adjustment amount, be difficult to calculate, lack transparency, and create significant unpredictability in the system. The Moran Company found that facilities providing 6,001 or more treatments do not experience the same financial challenges that those with 6,000 or fewer treatments do. We also favor the two-tiered approach over the single tier system because it recognizes that facilities with 4,000 or fewer treatments require a greater amount of assistance than a provider that has between 4,001 and 6,000 treatments, which creates a more equitable adjustment. The current system leaves too many low-volume facilities without assistance. The two-tiered system based on the cut point of 6,000 treatments in a year is simply to understand, easy for providers to calculate, and consistent with The Moran Company and MedPAC's findings of what constitutes a low-volume facility based on Medicare data. For a detailed explanation, please see the introduction of this letter.

b. Request for Comment: Please also comment on which option would be most effective in removing gaming incentives and which option would bring greater congruency between cost of providing renal dialysis services and payment.

As a threshold matter, KCP believes that a well targeted adjustment is essential to target the adjustment to those facilities with inadequate margins serving patients in areas where access issues would arise if the facilities were to close. The KCP and MedPAC recommended two-tiered approach would be the most effective option for meeting this goal. When coupled with the two guardrails already in place, the two-tiered option would also discourage gaming of the system. The first guardrail requires the facility to attest to meeting the number of treatments requirement in each of the three years before the payment year in question. This option protects against gaming the system. Including the second tier as a transition also support facilities by eliminating the cliff that the current one-tiered methodology creates to create an incentive for facilities to accept more patients.

Additionally, the requirement that the distance between a facility receiving the LVPA and the next facility under common ownership be at least 5 miles apart is also an important factor to discourage gaming. This factor eliminates any incentive to open facilities near one another to reduce the overall number of treatments each individual facility provides. We believe that it is this factor and the concern about gaming that has led MedPAC to recommend the adoption of a distance standard when applying a low-volume adjustment. The concern is not that isolated low-volume facilities have higher input costs than other low-volume facilities, but rather bad actors could game the system if the LVPA were available without a distance requirement.

In contrast, the multi-tier and continuous options in the RFI would promote gaming because they are not targeted to those facilities that truly require the adjustment and do not provide adequate payment increases. As a result, KCP members are concerned that if CMS were to adopt one of the approaches set forth in the RFI, it would be making the situation for those facilities that need this adjustment worse. While we continue to encourage CMS to adopt the long-standing recommendations of the community, it would be better to leave in place the current problematic system than to adopt one of the options CMS has outlined in the RFI.

Based on MedPAC's 2019 analysis, we believe a two-tiered system that applies the guardrails noted above and eliminates the rural adjuster at the same time brings the greatest congruency between cost and providing renal dialysis services and payments.

2. Basing the treatment threshold for eligibility based on the median treatment count among all ESRD facilities.

- a. *Request for Comment. What factors should be evaluated to best determine the treatment count threshold, as well as the tiering structure? Specifically, comment on the treatment volume beneath which per-treatment costs begin to increase.***

As noted above, KCP believes that CMS should not base the threshold for eligibility on the median number of treatments by all facilities. Nor should it look only at input cost. Consistent with the analysis MedPAC conducted, KCP recommends that CMS identify the cut points where facility margins no longer support keeping a facility open and establish those as the thresholds for obtaining the adjuster. Based on The Moran Company analysis, the current 4,000 cut point is appropriate for a first-tier with a higher adjustment amount, while the 6,000 treatments is appropriate for a lower amount adjustment. Given the purpose of the Congress in establishing the low-volume adjustment, the threshold for eligibility should be determined based on how many patients over which those input costs are divided and how those cost are covered, or not as may be the case, by the current reimbursement rates.

- b. *Request for Comment. Please enumerate any concerns you might have should the implementation of a tiered or continuous adjustment result in an expanded set of eligible ESRD facilities, and payment redistribution.***

KCP is concerned that implementing any of the three RFI options would result in a significant reduction in the base rate for other facilities without appropriately targeting the facilities who need the financial assistance. The 4-tier, 8-tier, or continuous options create too many fluctuations and encourage gaming among the various tiers. They are also administratively burdensome.

Specifically, the multi-tiered options set forth in the RFI are less targeted because they provide a larger adjustment than what is needed for many facilities. For example, The Moran Company analyzed the 8-tier design and found that the scaling suggests that the current LVPA addresses only one-third of the actual need of facilities by suggesting that all facilities with fewer than 8,000 treatments should be able to receive some adjustment. CMS has relied on the 8,000 treatments because it is the median treatment count among all dialysis facilities.¹¹ KCP does not believe that the median is the appropriate basis for the threshold. As noted previously, the threshold should be based on the per patient treatment and facility margins. As a result of the threshold not being based on data identifying facilities at-risk of closure, this design would create an adjustment that is three times larger than the total adjustment for the current methodology. At the same time it would be overpaying many facilities, it would not

¹¹Display Copy page 46.

deliver an adequate adjustment for nearly all of the facilities with smaller treatment volumes. The 4-tier design appears simply to rescale the current system and substantially reduce the total adjustment amount. The continuous function option assumes that all facilities need a volume adjustment, which is inconsistent with the purpose and intent of the statutory provision authorizing the adjustment. Moreover, none of these options accounts for the overlap with the rural adjustment, which both KCP and MedPAC recommend be taken into account in the redesigned methodology.

3. Administrative Burden

KCP members are concerned that the options set forth in the RFI are administratively complex and would not provide the support that low-volume facilities whom the Congress sought to protect.

- a. ***Request for Comment. Please comment on the extent to which this change would alleviate burden, and if there are other administrative changes that could be made to simplify this process.***

KCP supports maintaining the three-year attestation data to determine eligibility for the low-volume adjustment because it is an important safeguard.

- b. ***Request for Comment. Please describe any anticipated effects of decreasing the amount of treatment volume data used to determine LVPA eligibility.***

Decreasing the number of years will not provide relief to the administrative burden of the options outlined in the RFI.

- c. ***Response for Comment. Please describe the ways that simplifying the attestation process could help ESRD facilities with fewer resources to promote health equity by improving their ability to serve vulnerable and underserved communities.***

To lessen the burden on facilities, CMS should be able to calculate the treatment volume and let facilities know if they meet the requirement, rather than have the facility attest to information CMS already possesses. To ensure accuracy, CMS could provide a preview of the outcome and allow facilities that do not qualify to present data to demonstrate they meet the threshold.

B. Comment Solicitation on the Development of a New Payment Adjustment Based on Geographic Isolation.

As KCP noted during the previous TEP, our members strongly oppose the local dialysis need (LDN) methodology. It is complicated and lacks the transparency that the current methodology and the two-tiered methodology that KCP recommends provide. Under the KCP recommended option, facilities would be able to predict their eligibility, which they would not be able to do under the LDN methodology. Without predictability, it is difficult for facilities to plan and invest; thus, we also believe the LDN methodology would undermine the intent of the Congress. Moreover, there are no analytics demonstrating that the LDN methodology would be stable over time. It is not likely that identifying patients' locations at a specific point-in-time will remain constant over even a short time period given current geographic migration. The LDN methodology may be attractive in an academic discussion, but is not an appropriate methodology to support low-volume facilities in a practical sense. We reiterate that the methodology should be based on actual facility need and not geographic areas.

1. Request for Comment. What factors should be considered in formulating a payment adjustment for ESRD facilities in isolated geographical areas or areas for which there is a low need for renal dialysis services?

As noted in our earlier response, KCP suggests that CMS should base the adjustment on the ability of the facility to spread the costs over the number of total treatments. As The Moran Company showed in its previous analyses, the margins of smaller facilities suggests that the thresholds for the first-tier eligibility should be 4,000 treatments annually. The second-tier eligibility should be between 4,001 and 6,000 treatments annually. We do not believe geography should be taken into account nor did the Congress. The total amount spent today on the LVPA and the rural adjusters could be combined to fund this new two-tiered adjuster so that no additional dollars are removed from the base rate for other facilities. The only other factor to consider would be the location of the nearest dialysis facility to ensure that this significant adjustment amount is applied to those facilities that truly require it to protect beneficiary access to dialysis services.

2. Request for Comment. What are the best ways to incentivize renal dialysis service provision in isolated geographic areas?

The best way to protect beneficiary access to dialysis services is to make sure that there is a well-targeted, transparent, and predictable adjustment that provides adequate funding to allow facilities to continue serving a small number of patients who are at risk of losing access to dialysis services. The two-tiered approach outlined previously in this letter would be the best way to make sure patients retain access in these areas.

- 3. Request for Comment. Our analysis of the LDN methodology has shown that low LDN census tracts intersect with areas designated as HPSAs. What impact would a payment adjustment based on geographic isolation have on the ability of ESRD facilities in isolated areas to recruit and retain health care professionals?**

KCP does not support the LDN methodology for the reasons set forth above. Moreover, the cost of staffing is not the only challenge that low-volume facilities face, so the adjustment methodology needs to focus more broadly than that issue. In fact, the ability to recruit and retain health care professionals is linked more to the inability of the market basket methodology to recognize the increasing cost of labor. We believe implementing the forecast error adjustment is an important first step toward supporting the recruitment and retention of health care professionals. We also reiterate our request for CMS and the Office of the Actuary to work with KCP to identify how the market basket might also be adjusted to better capture inflationary costs.

- 4. Request for Comments. Please comment on the appropriateness of maintaining the rural facility adjustment under § 413.233, if we were to establish an LDN payment adjustment in conjunction with a modified LVPA.**

As noted in the introduction of this letter, KCP supports MedPAC's recommendation to eliminate the rural adjuster and fold those dollars into a revised low-volume adjuster to better target the money to facilities that actually need it to remain open and serve patients. As MedPAC notes:

Yet dialysis treatment volume is highly correlated with dialysis facilities' costs. The greater the facility's service volume, the lower its costs per treatment. Some rural facilities thus receive an upward adjustment to their payments even when they realize significant economies of scale. Indeed, after controlling for treatment volume, the difference in the cost per treatment between urban and rural facilities narrows considerably.¹²

Rural facilities do not inherently experience higher costs than urban facilities. In fact cost inputs, such as rent, labor, and locally sourced supplies, may be less expensive than those incurred by non-rural facilities. As such, an adjuster based on ZIP codes no longer serves as an adequate proxy. A better defined low-volume adjuster that incorporates historic funding for the rural adjuster would meet the goals the Congress had in establishing the low-volume adjuster now that the data clearly show the problems inherent in the dialysis rural adjuster.

¹²*Id.*

5. Request for Comments. Please comment on the relationship between geographic isolation and cost. Please provide any data that could further inform CMS's understanding of the relationship between geographic isolation and cost for low volume facilities.

We encourage CMS to review the MedPAC June 2020 report that provides an overview of the issue generally. We suggest that the contractor has misinterpreted the reference to geographic isolation. The issue of higher per treatment costs is related solely to treatment volume. As we understand the term, "geographic isolation" means that dialysis patients are dependent on a particular facility because there is no other facility nearby. If such facilities have a high volume of patients, then they would not need an adjuster. MedPAC has pointed this out in its 2020 report, which found that about half of "rural" dialysis facilities are high volume.¹³ It is the low-volume facilities that require the adjustment because their per treatment cost will be higher since the costs are spread over fewer patients. The criterion for a facility to be isolated is to prevent multiple facilities being built in a single location to allow each facility to maintain a smaller volume of patients. While dialysis facilities do not locate facilities based upon the LVPA, it is reasonable to suggest that an adjustment of the size of the LVPA be limited to facilities that are not near other facilities. Thus, the MedPAC recommendation focuses first on identifying facilities with a low-volume and then asking whether those facilities are "isolated" or located near another facility. If a low-volume facility is located close to another facility, then the adjuster would not be applied.

6. Request for Comments. Please comment on the appropriateness of utilizing driving time between current beneficiary address and treatment location as the appropriate metric for travel time.

KCP does not support incorporating a travel metric into the low-volume adjuster. It would be difficult to assess, would vary based on urban and rural areas, and would create a complex and burdensome approach that would be difficult to predict. Similarly, it assumes that patients rely on their own vehicle. Driving time has a completely different meaning for individuals who rely on public transportation or family members and friends. Adding such a metric would not be helpful and could undermine the Congressional intent behind the adjuster.

7. Request for Comments. Are there ways in which the suggested methodology for this potential payment adjustment could fail in targeting isolated ESRD facilities, or ESRD facilities in areas with low LDN?

As noted throughout our answers to the previous questions, we believe the LDN would fail in targeting isolated ESRD facilities because it does not address the central issue of the

¹³MedPAC. Report to the Congress. 195. (June 2020).

volume of patients actually being served or include the isolation criteria to address potential gaming.

8. Request for Comments. Are there ways in which the determination of LDN might be subject to gaming?

The LDN methodology entire fails to address the concerns that led the Congress to mandate a low-volume adjuster. We do not restate the concerns already mentioned here, but together these concerns lead KCP to recommend that CMS not continue considering the LDN methodology.

9. Request for Comments. Would a payment adjustment for ESRD facilities in areas with low LDN improve health equity? Are there specific recommendations to change the LDN methodology described above to promote quality access to care for all ESRD beneficiaries?

No, a payment adjustment for ESRD facilities in areas with low LDN will not improve health equity; in fact, KCP believes it would make health inequities worse. As we noted, there is no evidence that this methodology is stable. It would not be predictable, so facilities could not count on it to make financial decisions. Thus, it would not help those facilities that are serving communities where access to health care services are already limited. These can include urban areas serving minority populations. In addition, focusing on metrics, like drive time, would reinforce the structures that create inequities for those individuals who may technically have short drive-times, but because they do not own a car experience significantly longer travel time to their facilities. We reiterate our recommendation that focusing on patient volume and the nearness to other facilities in the vicinity is the best way to protect patient access to dialysis services by supporting low-volume facilities.

10. Request for Comments. Please comment on the favorability of CMS's implementation of a new payment adjustment for ESRD facilities in areas with low LDN as described above.

Please see the comments in the introduction to this section for the details on KCP's opposition to the LCD methodology.

11. Request for Comments. Are there any other considerations we should keep in mind when considering proposing a new payment adjustment based on an LDN methodology?

KCP has provided the basic concerns in previous sections of this letter.

III. Conclusion

Thank you again for the opportunity to provide comments on the Proposed Rule. Please do not hesitate to reach out to our counsel in Washington, Kathy Lester, if you have any questions. She can be reached at klester@lesterhealthlaw.com or 202-534-1773.

Sincerely,

A handwritten signature in black ink, appearing to read "John Butler", with a long horizontal flourish extending to the right.

John Butler
Chairman

cc: Meena Seshamani, MD, PhD, Deputy Administrator and Director
Elizabeth Richter, Deputy Director
Jason Bennett, Director, Technology, Coding, and Pricing Group
Ing Jye Cheng, Director, Chronic Care Policy Group

Appendix A: KCP Members

Akebia Therapeutics
American Kidney Fund
American Nephrology Nurses' Association
American Society of Nephrology
American Society of Pediatric Nephrology
Ardelyx
AstraZeneca
Atlantic Dialysis
Baxter
Cara Therapeutics
Centers for Dialysis Care
Cormedix
CSL Vifor
DaVita
Dialysis Care Center
Dialysis Patient Citizens
DialyzeDirect
Dialysis Vascular Access Coalition
Fresenius Medical Care
Greenfield Health Systems
Kidney Care Council
NATCO
Nephrology Nursing Certification Commission
Renal Healthcare Association
Renal Physicians Association
Renal Support Network
Rockwell Medical
Rogosin Institute
Satellite Healthcare
U.S. Renal Care
Unicycive