



American Society of Pediatric Nephrology

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April 25, 2024

The Honorable Ron Wyden
Chair
U.S. Committee on Finance
Washington, DC

The Honorable Mike Crapo
Ranking Member
U.S. Committee on Finance
Washington, DC

Dear Chair Wyden and Ranking Member Crapo:

On behalf of the American Society of Pediatric Nephrology (ASPN) we appreciate the opportunity to provide this statement for the record on the Senate Finance Committee's April 11 hearing on "Bolstering Chronic Care through Medicare Physician Payment." Pediatric nephrologists serve as the medical home for children with kidney disease who need specialized care for this chronic condition. We would like to provide input on several of the issues raised during the hearing, including improvements to the Medicare Physician Fee Schedule (MPFS), increasing provider participation in value-based care models, and prior authorization. We also want to raise issues related to Medicaid, as one-third of pediatric patients with end-stage kidney disease (ESKD) are covered by this program.

Founded in 1969, 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. ASPN currently has over 700 members, making it the voice for pediatric kidney disease. Our members strive to ensure that affected infants, children, adolescents, and young adults receive appropriate and high-quality care. Approximately one third of pediatric patients with ESKD are covered by Medicare, making reforms to the Medicare Access and CHIP Reauthorization Act (MACRA) critical to pediatric nephrologists.

Recommended Changes to the Conversion Factor

Children with end-stage renal disease (ESRD) are automatically eligible for Medicare, and one-third of our patient population has Medicare coverage. Most of the care billed to Medicare falls under the ESRD Prospective Payment System (PPS). However, care delivered to children who receive kidney transplants as part of the Medicare program receive three years of post-transplant care under the MPFS, making the stability of the payment system a concern for our members. MACRA provided 0.5% updates to the MPFS conversion factor from 2015-2019. Since then, the lack of statutory updates to the conversion factor combined with the system's budget neutrality requirements has created significant downward pressure on payment.

Children with kidney disease, including those post-transplant, are medically complex and require high levels of care coordination to support their continued growth, development, and health that is not recognized under the MPFS. To support high-quality care for medically complex patients, the Finance Committee must first stabilize the MPFS by providing inflationary updates to the conversion factor and update the budget neutrality factor for the first time since 1992. Once these changes that benefit all

physicians are in place, the Finance Committee and the Centers for Medicare & Medicaid Services (CMS) can implement policies to provide incentives to provide high-quality coordinated care.

Increasing Provider Participation in Value-based Payment Models

As discussed, pediatric nephrologists and pediatric ESKD centers serve as the medical home for many children with kidney disease. Since only one-third of children with ESKD have Medicare coverage, the potential for reimbursement for care coordination is low and contributes to the scarcity of pediatric ESRD resources by disincentivizing programs from offering such pediatric care. This reimbursement issue must be addressed both to prevent the loss of existing ESKD resources due to ongoing financial pressures and to allow for consideration of their expansion in a cost-conscious environment. The medical home is particularly important for pediatric ESKD patients, as they also receive hypertension care, which is an important screening for this vulnerable population.

Most pediatric nephrologists practice at children's hospitals. ESKD patients at these institutions only have exposure to the Medicare program, which makes participation in value-based programs and models a challenge. To truly incentivize value-based care, quality measures and requirements should be harmonized across payers to reduce confusion and burden. It is also critical that institutions have the staff to be able to participate in data tracking and in reporting measures, which can be difficult for small practices.

The quality programs should be integrated into the existing electronic medical record (EMR) to collect data. There are multiple pain points with silos of care and integrating quality structures into EMRs that need to be addressed. It would also help to increase the number of pediatric measures if they spanned payers beyond Medicare. Measures could look at the entire pediatric ESKD population and better reflect the quality of care.

Recommendations Related to Medicaid Coverage

While the recent hearing did not address the Medicaid program, ASPN urges the Finance Committee to explore improvements to the Medicaid program to improve care coordination and chronic care delivery. As stated earlier, one-third of pediatric ESKD patients are on Medicaid, and so any policy changes must ensure that these patients are able to access the same quality of care as patients on Medicare or private insurance. Medicaid reimburses at approximately 80% of the Medicare rate and rates vary across states and services.

Many medically complex children, including those with chronic kidney disease and ESKD, are covered by Medicaid. While covered by Medicaid, medical care supports their growth and development and manages their disease. The program needs to support this complex, coordinated care. Therefore, the solutions that the Finance Committees present should not be limited to Medicare, or we risk creating health disparities based on the patient's insurance coverage.

Recommendations to Improve Prior Authorization

Children and adolescents undergoing dialysis or transplants are unique, and very different from adults. The causes for ESKD in children predominantly include congenital abnormalities, glomerular diseases and rare genetic disorders, not hypertension and diabetes as seen in adults undergoing the same treatment. Children with ESKD also suffer from impaired growth and development, including impaired neurocognitive development. They also have different drug metabolism, which changes over time as they grow to be adults.

These differences between children and adults with kidney disease, and specifically ESKD, are particularly important when considering prior authorization policies, which may delay access to medically appropriate care and therapies for pediatric patients. These children regularly require genetic testing, imaging studies, durable medical equipment, including scales and blood pressure cuffs, 24-hour ambulatory blood pressure monitoring, mental health services, special formulas and feeding tube supplies. All may require prior authorization.

One member reported that prior authorization requirements resulted in a significant delay for a four-year old patient suffering from severe hypertension who required CT vascular imaging. When the provider completed the peer-to-peer to complete the prior authorization, the approval delay was because the imaging was to examine the patient's aorta and vasculature rather than the lung parenchyma, which would be examined in adults. Because of the delay, our member considered admitting the child as an inpatient, which would have been at a significantly higher cost to the health care system, to expedite the testing, and ultimately, the necessary treatment. The delay in diagnosis and surgical treatment put the child at risk for stroke and seizure from uncontrolled hypertension. ASPN urges the Finance Committee to consider the unique needs of pediatric ESKD patients when considering prior authorization reforms. Additionally, we recommend that reviewers of prior authorization requests for pediatric patients have pediatric expertise. These vulnerable patients should not experience unnecessary, and potentially dangerous, delays in care because these requirements do not reflect the needs of these children who are commonly covered by Medicare and Medicaid.

Thank you again for the opportunity to submit this statement for the record to the Senate Finance Committee. We look forward to working with the Committee and with the Bipartisan Working Group on Physician Payment reform led by Senators Stabenow and Thune as you develop legislative solutions to improve physician payment and care for patients with chronic conditions. Please reach out to Erika Miller, ASPN's Washington Representative, at emiller@dc-crd.com with any questions or if we can provide additional information.

Sincerely,

A handwritten signature in cursive script, appearing to read "Jodi Smith".

Jodi Smith, MD, MPH
President