The Dialysis PATIENTS Demonstration Act

The Dialysis PATIENTS Demonstration Act (DPDA) has been the subject of considerable enthusiasm and controversy within the kidney and transplant communities since its introduction in September 2016. The most recent iteration of the legislation, introduced in the U.S. House of Representatives and Senate by a bipartisan group of lawmakers, has garnered substantial support in both chambers, with 185 House co-sponsors and 8 Senate co-sponsors at press time. Yet the legislation remains a focal point of division within the broader kidney and transplant communities.

At the most basic level, DPDA proposes a Medicare demonstration project that would test a dialysis-focused integrated care model. In the model, dialysis providers and potentially others would assume the full risk of administering all care to dialysis patients enrolled in the model in an open or preferred network setting. By providing integrated care for dialysis patients centered on the dialysis organization, the model seeks to either improve care or generate savings by reducing hospitalizations.

Proponents of the legislation point to the success of integrated care models—such as Accountable Care Organizations (ACO) and ESRD Seamless Care Organizations (ESCO)—in streamlining care and improving outcomes. According to proponents, this legislation would let dialysis centers serve as the primary point of care for dialysis patients, increasing access to comprehensive care for the hundreds of thousands of dialysis patients already receiving care in these settings. Opponents of the bill have raised concerns about the possibility of increased consolidation in the dialysis market and establishment of perverse incentives that would reduce access to transplantation.

In one provision of the bill, dialysis providers with adequate capitalization can provide plans that resemble Medicare Advantage (MA) for dialysis patients. Some critics maintain that, unlike other MA plans, these plans for dialysis patients would start at dialysis initiation and end at dialysis termination, potentially reinforcing existing silos of care, reducing emphasis on prevention, and providing potential financial disincentives for patients to be referred for transplantation.

Opponents have suggested that only two dialysis organizations would likely be financially capable of assuming the full risk of insuring dialysis patients and claim this would prohibit smaller organizations from participation in the model, further reducing patient choice.
The move toward a value-based comprehensive care system from the current fee-for-service system is in line with broader trends in healthcare, and similar efforts are supported by ASN. However, as outlined in a letter sent by ASN and the American Association of Kidney Patients (AAKP) to the bill’s cosponsors, several provisions of potential concern in the legislation outweigh the potential benefits patients would receive were the bill to be enacted. As described in the letter (see excerpts below), these potential risks include: restriction of patient choice, exacerbation of existing silos of care, exclusion of transplanted patients from the model, and an infringement on the patient-physician relationship and disruption of care.

In a January 31, 2018, statement supporting the legislation, the Renal Physicians Association (RPA) asserted the PATIENTS Act “builds on RPA’s commitment to the use of integrated care models in kidney disease. . . . RPA has supported the ESRD Seamless Care Organization (ESCO) payment model and developed an Incident ESRD Payment Model proposal recently recommended for implementation by the Physician Focused Payment Model Technical Advisory Committee (PTAC).” These integrated care models “offer tremendous potential to improve patient care via reduced hospitalizations, enhanced care coordination, increased availability to social support and nutritional staff, and transportation to care when necessary,” RPA added in its statement.

“With integrated care, patients undergo fewer duplicative and wasteful tests, and they receive holistic care that focuses on the whole patient, not just their disease,” wrote Dialysis Patient Citizens CEO Hrant Jamgochian, JD, on December 5, 2017, in a Real Clear Politics article urging Congress to advance the legislation. “The Dialysis PATIENTS Act seeks to build on the successes of the Comprehensive ESRD Care Model and Medicare Advantage ESRD Chronic Special Needs Plans, while expanding dialysis patients’ access to integrated care,” Jamgochian stated.

For the treatment of iron deficiency anemia in adult patients with chronic kidney disease (CKD) not on dialysis

Designed to be different

AURYXIA is the only oral iron tablet approved by the FDA for the treatment of iron deficiency anemia specifically in adult patients with CKD not on dialysis

- Proven effective in patients who were previously intolerant of or had an inadequate therapeutic response to traditional oral iron supplements
- Patients in the Phase III pivotal trial achieved results without the use of ESAs or IV iron
- 52% of patients achieved the primary endpoint of a hemoglobin increase of ≥1.0 g/dL by Week 16
- 18 percentage-point increase in mean TSAT at Week 16 from baseline
- Discontinuation rates due to adverse reactions were similar between AURYXIA and placebo (10% vs 9%)
- Convenient mealtime dosing
- Each tablet contains 210 mg of elemental iron

Please see Brief Summary including patient counseling information on following page

ESAs = erythropoiesis stimulating agents
**Indication and Usage**

**Auryxia** (ferum carboxylate) tablets are for oral use containing 210 mg of ferum carboxylate equivalent to 1 g Auryxia for oral use.

**Contraindications**

**Iron Overload:** Iron absorption from Auryxia may lead to excessive iron stores. Increases in serum ferritin and transferrin saturation (TSAT) levels were observed in clinical trials. In a 58-week safety and efficacy trial evaluating the control of serum ferritin in patients with chronic kidney disease on dialysis in which concomitant use of intravenous iron was permitted, 35% of patients treated with AURYXIA had a ferritin level >1500 μg/mL as compared to 13% (9.9%) of patients treated with active control. Assess iron parameters (e.g., serum ferritin and TSAT) prior to initiating AURYXIA and monitor iron parameters while on therapy. Patients receiving intravenous iron may require a reduction in dose or discontinuation of intravenous iron therapy.

**Risk of Overdose in Children Due to Accidental Ingestion:** Accidental ingestion of Auryxia should be considered a potential cause of fatal poisoning in children under 6 years of age. Advise patients of the risk to children and to keep AURYXIA out of the reach of children.

**Adverse Reactions**

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to adverse reaction rates in the clinical trials of another drug and may not reflect the rates observed in practice.

**Iron Deficiency Anemia in Chronic Kidney Disease Not on Dialysis:** Across two trials, 190 unique patients with CKD-NDD were treated with AURYXIA. This included a study of 117 patients treated with AURYXIA and 116 patients treated with placebo in a 12-week, randomized, double-blind period and a study of 75 patients treated with AURYXIA and 73 treated with placebo in a 12-week, randomized, double-blind period. Regimen changes in these trials ranged from 210 mg to 2520 mg of feric iron per day, equivalent to 1 to 12 tablets of AURYXIA.

Adverse reactions reported in at least 5% of patients treated with AURYXIA in these trials are listed in Table 1.

**Table 1: Adverse Reactions Reported in Two Clinical Trials in at least 5% of patients receiving AURYXIA**

<table>
<thead>
<tr>
<th>Body System</th>
<th>Adverse Reaction</th>
<th>AURYXIA % (N=190)</th>
<th>Placebo % (N=188)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Adverse Reaction</td>
<td>70</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Metabolism and Nutrition Disorders</td>
<td>5/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypersensitivity</td>
<td>5/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>5/2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

During the 16-week, placebo-controlled trial, 12 patients (10%) on AURYXIA discontinued study drug because of an adverse reaction, as compared to 10 patients (9%) in the placebo control arm. Diarrhea was the most common adverse reaction leading to discontinuation of AURYXIA (2.5%).

**Drug Interactions**

Orally administered desferrioxamine has to be taken at least 1 hour before or after AURYXIA. CYP3A4 inhibitors may be administered concomitantly with AURYXIA: are: amiodarone, asparagine, ketoconazole, clarithromycin, dexamethasone, diltiazem, elavil, fluoxetine, griseofulvin, lovastatin, metoclopramide, propranolol, statins, and warfarin.

Oral medications not listed above

There are no empirical data on avoiding drug interactions between AURYXIA and most biocompatible adsorbents. For oral medications where a reduction in the bioavailability of that medication would have a clinically significant effect on its safety or efficacy, consider separation of the timing of the administration of the two drugs. The duration of separation depends upon the absorption characteristics of the medication concomitantly administered, such as the time to reach peak plasma levels or fraction of dose absorbed.

**Use in Specific Populations**

**Pregnancy:**

**Risk Summary:**

There are no adequate and well-controlled studies in pregnant women. There are no data on use in pregnancy. In animal reproduction studies, no adverse effects on the developing fetus occurred. Auryxia is not expected to be teratogenic.

**Lactation:**

The effects of AURYXIA on the breastfed child from AURYXIA or from the underlying maternal disease are not known. Oral medications that can be administered concomitantly with AURYXIA are: amlodipine, aspirin, atorvastatin, calcitriol, clopidogrel, and warfarin.

**Geriatric Use:**

The safety and efficacy of AURYXIA have not been established in patients 65 years of age and older.

**Pediatric Use:**

The safety and efficacy of AURYXIA have not been established in pediatric patients.

**Clinical Considerations**

The expected background risk of major birth defects and miscarriage for the indicated population is unknown. Auryxia in pregnancy occurs predominantly in the 1st trimester due to the use of medications. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies are 2 to 4% and 15 to 20% respectively.

**Clinical Adverse Events:**

Adverse reactions reported in at least 5% of patients treated with AURYXIA in these trials are listed in Table 1.