American Kidney Fund®

January 26, 2016

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden and Working Group Leaders Isakson and Warner:

Thank you for the opportunity to comment on the Chronic Care Working Group Policy Options Document. We applaud your work, and we commend your actions that will lead to lower costs and better health outcomes for individuals suffering from chronic disease.

The American Kidney Fund is the nation's leading nonprofit organization working on behalf of the 31 million Americans with chronic kidney disease. Since our founding in 1971, we have provided financial assistance enabling more than one million U.S. dialysis patients to obtain the health care they need to survive. We provide grants to patients with kidney failure, also known as end-stage renal disease (ESRD), to assist them in paying health insurance premiums, transportation for dialysis, medications, and other health-related necessities. We advocate for access to quality care for all patients with kidney disease, and we educate the public on prevention and treatment of kidney disease. We are submitting these comments on behalf of the individuals that we serve.

The American Kidney Fund is also a member of Kidney Care Partners (KCP). In addition to our comments below, we support the comments that KCP has submitted.

Allowing End Stage Renal Disease Beneficiaries to Choose a Medicare Advantage Plan

We support allowing ESRD patients to opt into a Medicare Advantage (MA) plan irrespective of when their condition began. As dialysis patients can have a number of comorbidities that require a high level of care, they would greatly benefit from the care coordination and disease management that MA plans provide. MA plans provide services that aim to keep their members healthier, which can result in better outcomes for patients.

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We believe that the data needed to ensure that Medicare Advantage plans are correctly reimbursed is currently available. According to the Medicare Payment Advisory Committee (MedPAC) report released in 2013, 13 percent of Medicare beneficiaries who have ESRD were enrolled in MA. The payments to MA plans for dialysis patients are already risk-adjusted, and the payments are based on costs of dialysis patients in the traditional Medicare program. Allowing ESRD patients to choose MA plans would enhance health outcomes for patients and better control costs.

Expanding Access to Home Hemodialysis Therapy

Currently, about 11 percent of dialysis patients dialyze at home, but physicians estimate that between 15 and 25 percent could dialyze at home.[1] Providing patients with choice in where they receive dialysis is an important part of a good quality of life and allows the patient more autonomy in their own care. We support the recommendation of utilizing telehealth to expand choice for ESRD patients on dialysis. Specifically, we support including freestanding renal dialysis facilities in the definition of an originating site for telehealth. Additionally, we support the provision that an in-person physician visit is required at least once every three months.

Providing Continued Access to Medicare Advantage Special Needs Plans (SNP) for Vulnerable Populations

The American Kidney Fund supports the recommendation to grant a long term extension or make Medicare Advantage Special Needs Plans (SNP) permanent. As you note, Medicare Advantage has three types of SNPs which deliver comprehensive care to individuals who are 1) institutionalized; 2) dually eligible for Medicare and Medicaid, or (3) living with severe or disabling chronic conditions. The plans are constructed to care for those individuals who are in these specific circumstances, and because the risk lies with the insurance carrier, they implement special programs. Extending the time periods gives the insurance carrier an incentive to work for better outcomes, as they understand the higher health costs will be their responsibility. More importantly, the change would allow carriers time to implement long-term and consistent health initiatives.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

Literature has told us that "dialysis patients' depression and anxiety levels are closely tied to their physiological status"[2] and depression may be a "modifiable risk factor for poor outcomes".[3] In order to improve health outcomes and control costs, it is important to understand the role that behavioral health can play in treating chronic diseases. It is an area where data would be extremely helpful. Hence, we support the recommendation that the Government Accountability Office (GAO) conduct a study on the integration of behavioral health and primary care.

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[1] United States Government Accountability Office. (2015, October) *End-Stage Renal Disease: Medicare Payment Refinements Could Promote Increased Use of Home Dialysis. (*GAO-16-125).

[2] Kutner, Fair, Kutner. *Assessing Depression and Anxiety in Chronic Dialysis Patients.* Journal of Psychosomatic Research 29 (1) 23-31, 1985.

[3] Kimmel P, Peterson R. Clinical Journal *Depression in Patients with End Stage Renal Disease Treated with Dialysis: Has the Time to Treat Arrived?* American Society of Nephrology 1:349-352, 2006

Once again, we thank you for the opportunity to comment on the Chronic Care Working Group Policy Options Document. We applaud your work on behalf of Americans with chronic diseases, and we look forward to working with you in the future.

Sincerely,

LaVarne A. Burton
President and CEO