



February 9, 2017

Mark Miller, Ph.D.  
Executive Director  
Medical Payment Advisory Commission  
425 I Street NW  
Suite 701  
Washington, D.C. 20001

Dear Dr. Miller:

The Alliance for Home Dialysis appreciates the time you and your colleagues took to meet with our members recently. We found the conversation very productive and thank you for your willingness to engage with us on common interests related to serving ESRD patients, improving outcomes and identifying important cost-saving opportunities in the area of telehealth.

Below, we have detailed the follow-up items that you and other MedPAC staff requested during our meeting.

**I. Modification of Adequacy Criteria to Include Access to Dialysis Services by Modality**

The Alliance appreciates MedPAC staff members' receptiveness to our suggestion that you consider modifying current criteria for payment adequacy to include access to dialysis services by modality. MedPAC's current analysis of payment adequacy by beneficiary focuses on access to care, change in the quality of care, providers' access to capital, and payments and costs. But in all of these approaches, the beneficiary access criteria are limited to access to a facility; not access to a modality. The Alliance believes that modifying these criteria to assess both access to a facility *and* access by dialysis modality, so that MedPAC can then base its adequacy recommendations on both criteria, would more accurately represent what is actually occurring in home dialysis uptake and payment adequacy.

**II. Home Dialysis Data Collection and Release: Round 1 of the Health Care Innovation Awards**

As we noted during our meeting, the Alliance is encouraged by CMS's forward-looking efforts regarding data collection on home dialysis. However, we have also been disappointed in the lack

of information available 18 months after the completion of the first Health Care Innovation Awards telemedicine pilot project (July 2012-July 2015) on peritoneal dialysis at the George Washington University. The Alliance has contacted the CMMI Project Officers for an update, however we have yet to receive a response. Anything you can do to help us make this connection and secure the needed information would be greatly appreciated. The Project Officers are Donelle McKenna ([donelle.mckenna@cms.hhs.gov](mailto:donelle.mckenna@cms.hhs.gov)) and Sherard McKie ([sherard.mckie@cms.hhs.gov](mailto:sherard.mckie@cms.hhs.gov)).

### **III. Telehealth and Cost Analysis of Home Dialysis**

As we discussed, the Alliance strongly believes that both home and dialysis facility should be qualifying “originating sites” for home dialysis patients’ clinical assessment via telehealth. With this change, patients would be able to receive regular consultations with their approved practitioner by using telehealth capabilities already available in the marketplace.

Currently, providers are required to conduct one face-to face patient interaction each month in order to receive the Monthly Capitation Payment for the care of home dialysis patients. The Alliance acknowledges the importance of the required monthly clinical assessment for home dialysis patients. However, we believe that a telehealth visit should be allowed to meet this face-to-face requirement in some situations, such as for those patients who are medically stable. We believe that the interval for a required in-person interaction could be adjusted to a quarterly basis if patients were able to participate in telehealth visits with authorized providers in the intervening months. Given the very serious mobility issues facing ESRD patients, and the fact that many of them must otherwise travel long distances, expanding the designation of originating sites for home dialysis telehealth services will create tremendous value for patients and clinicians alike.

We are confident that there are also real economic savings to be gained from taking this step. You asked for more information to understand the economic dynamic of home telehealth for dialysis patients, and we would offer that – while the costs of telehealth equipment are *de minimis* (including oftentimes just the use of a laptop in a dialysis facility or an iPad in someone’s home), telehealth services for home dialysis patients can provide these and other cost savings to Medicare:

- 1) Home dialysis patients have fewer Emergency Room visits and hospitalizations<sup>1</sup> compared to in-center dialysis patients.<sup>2</sup> Both home dialysis modalities (peritoneal dialysis, or “PD,” and home hemodialysis, or “HHD”) have been shown to offer clinically meaningful improvements in physical as well as mental health. Studies have demonstrated that more frequent HHD results in faster recovery time after treatment and fewer side

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<sup>1</sup> 2016 United States Renal Data System Data Report, Chapter 5: Hospitalizations, Figure 5.5, <https://www.usrds.org/2016/view/Default.aspx>; explaining that over the past ten years, hospital admission rates for peritoneal patients fell by approximately 24%.

<sup>2</sup> Suri, R.S. et. al.,. The risk of hospitalization and modality failure with home dialysis, 2 Kidney International 88, pages 360-368, March 2015, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4526768/>. This study found that home hemodialysis patients spent approximately 5.2 days per patient-year in the hospital compared to 7 days per patient-year in the hospital for in-center hemodialysis patients.

effects<sup>3</sup>; improved cardiac status<sup>4</sup> and survival rates<sup>5</sup>; and increased opportunity for rehabilitation.<sup>6</sup> PD patients often experience fewer negative side effects, such as nausea, and dietary restrictions than in-center patients.<sup>7</sup> In addition, a chart from Northwest Kidney Centers tracking home patient ER visits can be found in the Appendix to this letter.

- 2) Home dialysis patients do not require the expensive transportation that many in-center patients incur, especially those in nursing facilities. A recent study found \$310.1 million in Medicare payments for ambulance services for dialysis patients in one year, based on data from the United States Renal Data System 2012 report.<sup>8</sup> Increased adoption of home dialysis could reduce these transportation related Medicare expenditures further. A copy of the abstract from this study can be found in the Appendix to this letter.
- 3) Home dialysis patients are more likely to work part-time or full-time than in-center patients. Lengthy trips to a facility multiple times a week have the potential to interfere with a patient's work and personal life. Research shows that, after six months of in-center hemodialysis, only 43 percent of people are able to maintain the same level of employment as before they began treatment. This means that over half of all in-center dialysis patients are unable to maintain the same level of employment.<sup>9</sup>

In addition, our members do not anticipate significant costs from the integration of telehealth platforms into home dialysis modalities. For example, DaVita has shared that they do not expect that CMS will significantly alter the reimbursement rates for home dialysis as new/next generations of telehealth technologies become available, nor do they believe that incremental reimbursement is necessary.

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<sup>3</sup> Heidenheim AP, Muirhead N, Moist L, et al. Patient Quality of Life on Quotidian Hemodialysis. *Am J Kidney Dis.* 2003 Jul; 42(1 Suppl):36-41.

<sup>4</sup> Culleton, B et al. Effect of Frequent NHD vs. CHD on Left Ventricular Mass and Quality of Life. *JAMA* 2007;11

<sup>5</sup> Foley, R.N, D.T. Gilbertson et al. Long interdialytic interval and mortality among patients receiving hemodialysis. *New England Journal of Medicine.* 2011 365, no.12:1099-1107

<sup>6</sup> Blagg, Christopher. "It's Time to Look at Home Hemodialysis in a New Light." Hemodialysis Horizons: Patient Safety & Approaches to Reducing Errors. (2006): 22- 28. Web. 12 Apr 2012.

<http://www.aami.org/publications/HH/Home.Blagg.pdf>.

<sup>7</sup> "A Brief Overview of Peritoneal Dialysis." DaVita, Inc., Web. 16 Jul 2012. <http://www.davita.com/treatment-options/home-peritoneal-dialysis/what-is-peritoneal-disease/-a-brief-overview-of-peritoneal-dialysis/t/5483>.

<sup>8</sup> United States Renal Data Systems 2012 Atlas of CKD and ESRD, <https://www.usrds.org/atlas12.aspx>

<sup>9</sup> Rebecca J. Muehrer, Dori Schatell, Beth Witten, Ronald Gangnon, Bryan N. Becker, and R. Michael Hofmann, "Factors Affecting Employment at Initiation of Dialysis," *Clinical Journal of the American Society of Nephrology* 6, no. 3 (March 2011)

We hope that we can continue to discuss these and other areas with you where there are opportunities to promote the broader utilization of home dialysis, and would welcome any follow-up questions or information requests on the above or related topics you may have. I can be reached at 202-466-4724 or by email at [ssilverman@vennstrategies.com](mailto:ssilverman@vennstrategies.com). Many thanks again for your time and your interest.

Sincerely,

A handwritten signature in cursive script that reads "Stephanie Silverman". The signature is written in black ink and includes a long horizontal flourish extending to the right.

Stephanie Silverman  
Executive Director