January 25, 2016

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

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

Dear Senators Isakson and Warner:

The Alliance for Home Dialysis (Alliance) appreciates the opportunity to provide the Senate Finance Committee's Chronic Care Working Group with comments on its document outlining policy options for improving the care and treatment of Medicare beneficiaries with multiple chronic conditions.

Thank you for your consideration of our comments submitted in June of 2015, and your incorporation of our top recommendations into your policy options document. The Alliance, a coalition of kidney dialysis stakeholders, representing patients, clinicians, providers, and industry, supports policies that facilitate treatment choice for individuals in need of dialysis and to address systemic barriers that limit access for patients and their families to the many benefits of home dialysis. We appreciate your recognition of these barriers and your efforts to overcome them.

Home dialysis—which takes the form of either peritoneal dialysis or home hemodialysis —is a vital treatment option that offers end-stage renal disease (ESRD) patients significant quality of life advantages, including clinically meaningful improvements in physical and mental health. Currently, about 11.5% of U.S. dialysis patients receive treatment at home: 9.7 % use peritoneal dialysis and 1.8% are on home hemodialysis. As you recognized in your Policy Options Document, the Government Accountability Office (GAO) recently recognized the benefits of expanding this treatment to more patients. They estimated that "15 to 25 percent of patients could realistically be on home dialysis," and realize significant benefits from doing so. [1] Access to treatment in the home can significantly improve patients' health-related quality of life, including faster recovery time after treatment with fewer side effects;[2] improved cardiac status[3] and survival rates;[4] and increased likelihood for transplantation[5] and opportunity for rehabilitation.[6]

We are pleased to offer a few specific comments on your policy options.

[1] Government Accountability Office, "End Stage Renal Disease: Medicare Payment Refinements Could Promote Increased Use of Home Dialysis," Oct 2015. http://www.gao.gov/assets/680/673140.pdf
[2] 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.
[3] Culleton, B et al. Effect of Frequent NHD vs.CHD on Left Ventricular Mass and Quality of Life. JAMA 2007;11
[4] Pauley, R.P. Survival comparison between intensive hemodialysis and transplantation in the context of the existing literature surrounding nocturnal and short-daily hemodialysis. Nephrol Dial Transplant. 2013 28: 44-47.
[5] ibid
[6] 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.

Expanding Access to Home Dialysis Therapies

The Alliance strongly supports the Chronic Care Working Group's proposal to expand Medicare's qualified originating site definition to include free-standing renal dialysis facilities in any geographic area. Being able to receive a monthly visit in the dialysis facility saves a potentially longer trip to the physician's office, and may facilitate home dialysis as a treatment choice. In addition, we would recommend the inclusion of hospital-based outpatient dialysis programs as originating sites, as many of these operate robust home dialysis programs, and would benefit from inclusion in a telehealth model.

An even more vital policy change, however, would be to allow a patient's home to be a qualifying site for telehealth. Permitting patients and their physicians the option to participate in telehealth visits in some months – with in-person visits at least quarterly (every three calendar months) — may incentivize patients to adopt home dialysis as a treatment option. Such telehealth interactions are appropriate when they 1) include a video interaction, 2) are supported by the transmission of clinical data that facilitates physician review and evaluation of patient treatment, and 3) are compliant with federal and state laws protecting privacy of patient health information.

Not only would this policy help to promote choice of modalities, but it has the potential to benefit current patients on home dialysis. Travel to a physician's office or a dialysis facility to see their doctor is oftentimes difficult for those patients for whom travel would require medical transportation, such as patients on ventilators. Eliminating the need for patients to travel to a hospital or facility-qualifying site to see their doctor also would support those actively employed or seeking employment without sacrificing the appropriate level of clinical interaction. Pediatric patients often need to travel long distances for clinic, and telehealth would permit children to minimize school absences, decrease transportation costs, and decrease lost work days for parents. We fully appreciate the concern regarding clinical equipment; however, in the experience of Alliance members, providers are able to work with patients to use iPads and other technologies to allow for video interactions and the transmission of clinical data in strict compliance with federal and state privacy laws. We do not anticipate any significant costs associated with this policy change, as the vast majority of the infrastructure required for telehealth is already available.

We appreciate your solicitation of feedback on patient safeguards, which we believe are essential for a patient population that requires ongoing, intensive treatment. First and foremost, providers and patients should retain full discretion to choose to conduct their monthly clinical assessment visit via telehealth. A telehealth encounter should be made with the concurrence of both parties that it is in their best interest. Second, if patients are able to participate in telehealth visits with authorized providers, the interval for a required in-person interaction should be at minimum quarterly; that is, patients should see their physician or other provider in person at least once every three calendar months. Finally, while we expect that a telehealth visit with a physician would meet Medicare's current requirements for patient consultation and monitoring within a given month, such a visit should not preclude a patient from seeing their dialysis facility-based interdisciplinary care team to address emergent issues.

We'd like to make the important clarification that your section is titled "Expanding Access to Home Hemodialysis Therapy," but we believe that access to telehealth services will expand access to all home modalities, which includes peritoneal dialysis as well as home hemodialysis. Peritoneal dialysis is an important treatment option for many, especially pediatric dialysis patients.

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

The Alliance supports choice for all ESRD beneficiaries, from treatment modality to insurance coverage. We support the Working Group's proposal to support access to Medicare Advantage plans for individuals with kidney failure. Medicare Advantage plans offer the potential for improved care coordination for ESRD beneficiaries, because these plans are wholly responsible for better patient outcomes and reduced costs. We have seen evidence of this in the private market; for example, recognizing the health and

financial benefits of home dialysis, private plans such as Kaiser Permanente[7] cover the equipment and medical supplies required to dialyze at home at no cost to their insured patients.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

The Alliance commends the Chronic Care Working Group for its recognition of the efforts required to deliver high quality care for patients with chronic conditions. The Alliance strongly supports the ongoing dialogue between providers and insurers around more accurate reimbursement for the time and professional investment required to care for our nation's sickest patients, which include those managing chronic kidney disease and ESRD. These patients, who typically manage many co-morbidities, benefit from physicians' thoughtful attention to strategizing how best to implement their care plan. Developing a high severity Chronic Care Management (CCM) code may help to recognize and encourage this important work. It may be of interest to the Working Group that, under current CMS regulations, physicians are not reimbursed for providing CCM services to an ESRD patient if they have provided monthly assessment to that patient in the preceding 90 days.

We greatly appreciate the opportunity to provide this feedback, and would be glad to discuss further if it would be helpful. If you have any questions, please contact Brian Beaty at brian@homedialysisalliance.org or 202-466-8700.

Sincerely,

Stephanie Silverman
Executive Director

Cc: The Honorable Orrin Hatch, Chairman
The Honorable Ron Wyden, Ranking Member

7 2015 Individual Plan Membership Agreement and Evidence of Coverage for Kaiser Permanente for Individuals and Families. Northern and Southern California Regions: Kaiser Permanente, 15 June 2014. PDF.