

Statement
of the
Alliance for Home Dialysis
for the
Committee on Finance
of the
U.S. Senate
“Bolstering Chronic Care Through Medicare Physician Payment”

April 11, 2024

The Alliance for Home Dialysis (the Alliance) appreciates the Senate Finance Committee’s focus on ensuring high-quality care for Medicare beneficiaries with chronic conditions. Our organization focuses on the chronic conditions of chronic kidney disease (CKD) and End Stage Kidney Disease (ESKD) with a focus on dialysis treatment choice. We believe that these conditions should be of particular interest to this Committee not only because of the burden to patients, but also because all ESKD patients, regardless of age, are eligible for Medicare.

As background, the Alliance is a coalition of kidney disease stakeholders including patients, clinicians, dialysis facilities, other providers, and industry who came together starting in 2012 to advocate for policies that would increase access to and uptake of home dialysis in the United States.

Improving the uptake of home dialysis matters for clinical and quality-of-life reasons. Research shows that both home dialysis modalities (peritoneal dialysis and home hemodialysis) offer quality-of-life and clinical advantages—and patients deserve access to these benefits. For example, home hemodialysis allows for tailoring the dialysis prescription to allow for more frequent or longer-lasting sessions. Such more frequent sessions can result in faster recovery and fewer side effects,¹ improved cardiac status,² improved survival rates,³ and increased rehabilitation opportunities.⁴ Peritoneal dialysis patients also

¹ 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.

² Culleton, B et al. Effect of Frequent NHD vs. CHD on Left Ventricular Mass and Quality of Life. *JAMA* 2007;11

³ 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

⁴ 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.
<https://www.aami.org/docs/defaultsource/uploadedfiles/filedownloads/horizons/home-blagg.pdf>

experience fewer side effects and have fewer dietary restrictions than in-center dialysis patients.⁵ Both home modalities also offer significant quality-of-life advantages like ease of scheduling, ability to continue to work, ability to travel, and reduced dependence on transportation to dialysis clinics.

While home dialysis has been growing in recent years, in large part due to government and provider commitment to ensuring patients have access to all modalities, it still only hovers at a little over 13% of patients doing their treatments at home. This is striking given that the Government Accountability Office (GAO) shared in 2015 that they believe up to 25% of patients could be successful on home dialysis.⁶ Furthermore, a few years ago, HHS set a far loftier goal that 80% of new ESKD patients should be receiving dialysis at home or be transplanted by 2025. While we have seen increases in uptake of home dialysis in recent years, additional policy changes, including through legislation, are needed to ensure that patients can access these important treatments and increase the overall number of patients on home dialysis in the U.S.

We appreciate all Congress has done thus far to increase access to home dialysis. Congress has been particularly impactful with regard to policy changes in telehealth; the Bipartisan Budget Act of 2018⁷ included key elements of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act of 2017 (the CHRONIC Act), including a provision that allowed home to be the originating site for a telehealth visit. In practice, this means that patients can now see their doctors for the monthly capitated payment visit from the comfort of their homes, avoiding often lengthy travel to and from the dialysis facility. Allowing this expanded access to telehealth makes home dialysis more accessible for patients and has helped increase uptake to these important therapies. Policy changes like this are key to ensuring expansion of home dialysis.

Congress has a key role in ensuring patients have choices when faced with decisions about treating their ESKD through dialysis. Specifically, Kidney Disease Education (KDE) is a policy area where the Committee could advance policy changes to positively impact the lives of patients and ensure that they have choices in their treatment. We strongly believe this policy area merits the Committee's further attention.

Medicare's current KDE benefit provides up to 6 sessions of educational services for individuals with Stage 4 chronic kidney disease. KDE covers a wide range of topics, including how to take care of your kidneys, how to manage other chronic diseases that often come alongside CKD, diet, medications, and treatment options for both dialysis and transplant.

Unfortunately, KDE is extremely underutilized with only about 2% of eligible patients taking advantage of the benefit. We believe, and the Government Accountability Office (GAO) has stated as well, that the

⁵ "A Brief Overview of Peritoneal Dialysis." DaVita, Inc., Web. 16 Jul 2012. <https://www.davita.com/treatment-services/peritonealdialysis/living-well-on-pd>

⁶ Government Accountability Office. (2015). End-Stage Renal Disease: Medicare Payment Refinements Could Promote Increased Use of Home Dialysis. (GAO Publication No. 16-125). Washington, D.C.: U.S. Government Printing Office.

⁷ Bipartisan Budget Act of 2018. Public Law 115-123. 2018.

<https://www.congress.gov/115/plaws/publ123/PLAW-115publ123.pdf>

expansion of KDE could lead to the expansion of home dialysis.⁸ The Alliance urges the Senate Finance Committee to consider the following legislative policy options for increasing access to KDE:

1. Congress should permit reimbursement for stages 3b and 5 CKD patients to receive the KDE benefit.

Currently, KDE is only permitted for patients with stage 4 CKD. The Alliance believes that reimbursement for such services should be allowed for patients with stage 3b and 5 CKD.

Stage 3b CKD means moderate to severe loss of kidney function, with kidneys working somewhere between 30-44% of what the average healthy kidneys do.⁹ In addition, health risks get higher at this stage of CKD, including the risk of developing co-occurring heart disease or high blood pressure and the stage of CKD progressing to stage 4. There is also a higher risk of complications at this stage of CKD, like anemia, bone disorders, and metabolic acidosis, which is a buildup of certain acids in the blood. Patients with CKD stage 3 are likely to need dialysis services at some point, though their disease may take some time to develop. They deserve to be educated in the same manner as patients with stage 4 CKD.

Stage 5 CKD actually refers to the first phase of ESKD, or kidney failure; these patients have kidneys that are working less than 15% of what the average healthy kidneys can do.¹⁰ Patients at stage 5 have the highest risk for comorbidities like heart disease and the CKD complications discussed above. They may also have symptoms of kidney failure like urinating less or not at all, itchy skin, feeling tired, trouble concentrating, numbness, achy muscles. Shortness of breath, nausea, loss of appetite, trouble sleeping, and foul-smelling breath. These patients require immediate dialysis or a transplant to survive; they must be educated about their options, but they are currently not allowed KDE.

Based on these realities about stages 3b and 5, we strongly believe that KDE should be allowed for both and ask the Committee to consider this change.

2. Congress should expand the providers qualified to provide KDE beyond doctors, physician assistants, nurse practitioners, and clinical nurse specialists.

Under current law, only *qualified persons* can provide kidney disease education services, which are defined as certain healthcare entities for which payment can be made under the physician fee schedule, including physicians, physician assistants, nurse practitioners, and clinical nurse specialists, or hospitals, critical access hospitals, skilled nursing facilities, home health agencies, or hospices in a rural area. Notably, this excludes home dialysis nurses, who are arguably some of the most knowledgeable professionals about kidney disease. The Alliance urges the Committee to consider expanding who can provide KDE to include home dialysis nurses.

⁸ See citation 1

⁹ Stage 3b Chronic Kidney Disease. National Kidney Foundation. <https://www.kidney.org/atoz/content/stage-3b-chronic-kidney-disease-ckd#about-stage-3b-ckd>. Accessed 11 April 2024.

¹⁰ Stage 5 Chronic Kidney Disease. National Kidney Foundation. <https://www.kidney.org/atoz/content/stage-5-chronic-kidney-disease-ckd#:~:text=Stage%205%20CKD%20means%20you,or%20they%20are%20on%20dialysis>. Accessed 11 April 2024.

In addition, current law does not allow dialysis facilities to provide KDE. We believe that dialysis facilities are an appropriate place for KDE services to occur and that they should be allowed to bill for KDE—with appropriate guardrails. In our view, these guardrails should seek to avoid so-called “patient steering” to one facility over another. Specifically, we would urge Congress, alongside allowing facilities to bill for KDE, to instruct CMS to enact requirements on what kind of information can be provided to exclude any provider-specific or advertising information. In addition, we recommend that CMS play a role in approving educational materials before they are deployed to patients.

Thank you for your work in ensuring that Americans with chronic conditions have access to the treatments they need. We appreciate your consideration of these requests related to Kidney Disease Education and look forward to continuing to work with you to improve the lives of Americans with CKD and ESKD.