Congress of the United States
Washington, DC 20515

March 21, 2013

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

**RE: FY 2014 Home Hemodialysis Training Payment**

Dear Secretary Sebelius:

As you update your payment system for the Medicare end-stage renal disease (ESRD) program for FY 2014, we urge you to pay close attention to home hemodialysis training payments that CMS pays to outpatient dialysis centers. We are concerned that these payments are set too low, thus discouraging the use of home hemodialysis (HHD)—a treatment modality for patients with ESRD that in many cases enhances patient quality of life and can reduce costs to Medicare and society.

Home dialysis creates substantial benefits for dialysis patients and their families. Observational studies confirm that patients who dialyze at home generally have better survival rates and a better quality of life. Home dialyzers often have the freedom to continue working a steady job, creating economic and other benefits to both patient and family. Because home dialyzers do so more often and for longer periods of time (for example while sleeping) than patients in dialysis centers, they generally report better wellness outcomes.

The FY2013 rate of $33.44 per training session (adjusted based on geography) barely covers the cost for one hour of a nurse's time in most markets—much less the 4-5 hours required for a nurse to conduct such a training. Because as many as 25 training sessions are required for patients to be ready to perform HHD, outpatient dialysis centers are in the position of providing dozens of hours of uncompensated care for a single Medicare patient who wishes to get trained for HHD.

According to a study in the *American Journal of Kidney Disease*, a survey of nephrologists demonstrated that they believe that 11 to 14 percent of patients are fit to be HHD users. Nonetheless, only 2 percent of ESRD patients currently use HHD, and fewer than a quarter of dialysis centers are certified to offer HHD. We believe that the training payment plays a role in this imbalance.

As you perform the important work of updating the MIPPA payment bundle for FY 2014 and, in particular, the sensitive task of making reductions to reflect your estimate of the change in the utilization of certain drugs and biologicals, we urge CMS to revisit training payments for HHD with an eye toward adequately reimbursing providers to encourage them to have robust HHD programs for those ESRD patients for whom such treatment is appropriate.



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Sincerely,

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