



Nonprofit Kidney Care Alliance

January 26, 2016

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

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

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

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

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

On behalf of the Nonprofit Kidney Care Alliance (NKCA), I am pleased to have this opportunity to submit comments in response to your Bipartisan Chronic Care Working Group Policy Options Document. NKCA represents five nonprofit dialysis providers: Centers for Dialysis Care; Dialysis Clinic, Inc. (DCI); Independent Dialysis Foundation, Inc.; Northwest Kidney Centers; and The Rogosin Institute (Rogosin). Collectively, we serve over 20,000 end stage renal disease (ESRD) patients at more than 280 facilities in 30 states, as well as, thousands more patients with chronic kidney disease (CKD). As nonprofit providers, we receive approximately 85 percent of our payments from Medicare.

Our goal is to provide the best service possible for all patients with kidney disease, not only for patients on dialysis, but also to decrease the number of patients needing dialysis and increasing the number who can benefit from transplants. Kidney disease (both CKD and ESRD) is really the prime model of chronic illness. Several factors underscore this. First, both CKD and ESRD don't exist alone—they are accompanied by multiple co-morbidities, including diabetes, congestive heart failure, high blood pressure, etc. Secondly, kidney disease, including and especially ESRD, can exist over many years and is therefore the epitome of chronic illness that demands multimodal, highly coordinated care. Kidney disease should be a prime focus for the new care models that the Committee seeks to encourage, and we were pleased to see specific policies related to ESRD listed. Approximately 26 million Americans suffer from kidney disease, at an estimated cost to the Medicare program of \$87 billion; therefore we believe it is a very important issue that needs to be addressed.

In response to the issue areas that were listed in your policy options document, we wish to focus on the following themes. Please note that we have organized the sections according to these themes and indicated, where possible, how the subsections relate to the issues raised in the Bipartisan Chronic Care Working Group Policy Option Document.

HOME DIALYSIS:

Expanding Access to Home Hemodialysis Therapy (pg. 7 of Policy Option Document)

NKCA applauds the Working Group for the inclusion of this policy, and we support the proposal of expanding Medicare's qualified originating site definition to include freestanding dialysis facilities in any geographic area. **We, however, hope that this policy would also include home peritoneal dialysis and not just home hemodialysis.**

We see both home hemodialysis and peritoneal dialysis as important options in dialysis care. Dialyzing at home allows more independence, better patient satisfaction and costs Medicare less. Any change to remove barriers to a patient starting home dialysis should be made. Many patients must travel long distances for their monthly physician visit. If a patient were able to have a portion of those visits by telehealth at a nearby clinic, this would substantially decrease the burden on some patients who would otherwise need to travel a long distance or traverse a congested urban area.

To address your question on safeguards, we would recommend that any policy be crafted in a way to be patient-focused and where a mutually agreeable plan of care between each patient and his/her physician exists. Currently, some of our members' clinics align the monthly *physician* visit with the monthly *clinic* visit, so that the patient only has to make one trip. However, not all dialysis providers use this approach, so allowing more patients to benefit from once-a-month visits, instead of two, would be incredibly beneficial to the patient.

We also recommend that the home should be an originating site, in addition to a dialysis clinic. For healthier patients who have to drive twice a month (once for clinic visit and once for physician visit), allowing a telehealth option from the patient's home could give a patient the convenience they much need. Subject to their physician's concurrence, this could be helpful to patients whose doctor may be at a distance, whether rural or within a large urban metro area and/or during periods of winter weather.

Although not directly mentioned in your paper, we also wanted to point to the financial benefit of achieving higher levels of patients on home hemodialysis or peritoneal dialysis. The Government Accountability Office's (GAO) November 2015 report on home dialysis noted that a barrier to home dialysis is limited nephrologist reimbursement. If a nephrologist were able to have a monthly visit via telehealth instead of not being able to bill the monthly capitation payment for a patient who is doing well because the patient does not visit on a monthly basis, nephrologists would have more of an incentive to care for patients dialyzing at home.

HOSPICE:

Providing Medicare Advantage Enrollees with Hospice Benefits (pg. 8 of Policy Option Document)

NKCA supports the proposal to include the hospice benefit under Medicare Advantage (MA) plans. At the time that any patient chooses hospice, the last thing we should be doing is forcing a disruption in their care team, even if they are no longer receiving curative or chronic care. This would allow ESRD providers to continue to provide care for MA patients with CKD who have chosen medical management without dialysis and for MA patients on dialysis who choose to stop dialysis.

One of our members, Dialysis Clinic Inc., has instituted a Chronic Kidney Disease Care Coordination Program, “Reach Kidney Care”, in 28 locations, involving over 3,500 patients, to educate them on how they can stay healthier and thereby avoid, or at least delay, dialysis. One of their primary interventions is supporting a patient who chooses medical management without dialysis. However, under some current MA plans, the patient would transfer immediately to traditional fee-for-service Medicare once she/he elects hospice and any care from their Reach Kidney Care program would be suspended. This is the worst time to have an abrupt handoff in care and the most important time to continue to provide support to the patient and his/her family. If all Medicare Advantage plans were to cover hospice care, we would be able to continue to serve the kidney patient during this most critical and difficult time.

Although not listed in your paper, one important policy change that we would recommend is allowing ESRD patients who are terminally ill to stay on dialysis while concurrently enrolling in hospice, if they so wish. The symptom burden of ESRD patients is akin to those with advanced cancer, including high rates of pain, fatigue, itching, shortness of breath, nausea, constipation, cramping, and insomnia. Abruptly stopping dialysis may significantly exacerbate symptoms and may deprive patients of their true goals in their final days, including having enough symptom control through dialysis and hospice services to create meaningful memories with their loved ones. The reality is that ESRD Medicare beneficiaries enroll in hospice far less often than their Medicare counterparts with advanced cancer or advanced heart failure (20% vs. 55% and 39%), respectively. This policy is well documented in the medical literature as a barrier to hospice utilization. Furthermore, it is especially notable that the intensity of care at the end-of-life for older adults on dialysis is much higher than those with advanced cancer or advanced heart failure by every metric—hospitalization rate, intensive care unit (ICU) admissions, days in the hospital and ICU, intensive procedures, and death in hospital. Offering hospice with ESRD care to patients, regardless of their terminal illness diagnosis, will enhance the patient and family experience by providing comprehensive interdisciplinary care to relieve symptoms across all domains (physical, psychosocial, spiritual, and cultural) in an outpatient setting. In lieu of hospice eligibility, the only way for a

terminally ill patient on dialysis to obtain just-in-time symptom management is to go to the local emergency department - a far inferior, as well as more expensive, option.

MEDICARE ADAVANTAGE PLANS:

Allowing End Stage Renal Disease Beneficiaries to Choose a Medicare Advantage Plan (pg. 9 of Policy Option Document)

NKCA supports the proposal to allow all ESRD beneficiaries, regardless of when their condition began, to enroll in a Medicare Advantage plan. We feel that all ESRD patients should have a choice in all of their care, including the type of treatment and what type of insurance plan works best for him/her. High-quality MA plans can provide better care and, with additional chronic-care policy changes (as stated in your working group policy options document), there may be many more MA plans suited to serve ESRD patients.

If Congress adopts this change in policy, there will need to be a carefully constructed set of transition safeguards, particularly in the first few years, when plans would need to expand their provider networks to accommodate a larger number of ESRD beneficiaries. Also, on an ongoing basis consideration should be given as to whether a new ESRD beneficiary should be entitled to a Special Enrollment Period (SEP), or, after they have completed the first three to four months of dialysis, be eligible to apply under the next Annual Enrollment Period (AEP), when they can better compare plan costs, benefits and provider networks.

Providing Continued Access to Medicare Advantage Special Needs Plans (SNPs) for Vulnerable Populations (pg. 10 of Policy Option Document)

While traditional Medicare Advantage plans already serve ESRD patients, by virtue of their having been enrolled prior to their onset of ESRD, not all such plans are well equipped to care for these patients with their multiple, often severe chronic conditions. If greater flexibility is given to general MA plans to better serve chronically ill patients (such as those with ESRD or CKD), we would recommend a trial period to determine how well the changes are working, as was done for SNPs.

A better policy alternative than expansion of eligibility in standard MA plans may be to improve and grow the Chronic Condition Special Needs Plans (C-SNP) option. Currently, the Centers for Medicare & Medicaid Services (CMS) recognizes 15 chronic conditions in the C-SNP program. One of those is ESRD. These subsets of plans are designed around an ESRD patient and therefore can better align care for many ESRD beneficiaries. CMS also allows for C-SNPs that address multiple conditions. We would recommend that the Working Group specifically authorize C-SNPs around four, closely related conditions; CKD, diabetes mellitus, cardiovascular disease and congestive heart failure.

Medicare has been focused on treatment of beneficiaries with kidney failure, through ESRD, but has largely neglected the potential to improve beneficiary health and lower costs by going upstream to address chronic kidney disease. Medicare spending for patients with CKD age 65 and older exceeded \$50 billion in 2013, representing 20 percent of all Medicare spending in this age group. Moreover, CKD is closely associated with other comorbidities, including diabetes and congestive heart failure. Yet, only 7.7 percent of patients with Stage 3 CKD even know they have kidney disease, and only half of people with Stage 4 CKD, whose kidneys are now seriously compromised, know they have kidney disease. Left untreated or poorly managed, these patients may advance to Stage 5 and eventual end stage disease requiring dialysis. The cost to the Medicare program alone is stark, growing from \$23,680 per year at Stage 3, to \$84,645 per year on dialysis. Both an ESRD C-SNP and a CKD (and related comorbidities) C-SNP should be specifically authorized under a permanent SNP program, thereby giving plans, providers and patients, greater ability to plan and effectively implement C-SNPs for patients with chronic conditions.

Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees (pg. 13 of Policy Option Document)

Medicare Advantage plans can offer additional supplemental benefits beyond the standard, required Medicare Part A and B benefits. For example, under Enhanced Disease Management (EDM), plans can offer benefits and services focused on target groups needing specialized case management and/or educational activities. Supplemental benefits do have to be “health related,” something that CMS determines and approves on a plan-by-plan, annual basis. In general, CMS has become more inclusive of supplemental benefits and the types of professionals who can provide them. That is positive.

The provision of supplemental benefits has functioned to date on an “a la carte” basis. This provides flexibility. However, the process could be improved by also providing preapproved packaged supplemental benefits by chronic condition thereby making it more likely that plans would offer them. If Medicare Advantage plans could alter their plan design for patients with ESRD or CKD in this way, it would be extremely beneficial.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees (pg. 15 of Policy Option Document)

NKCA applauds your policy to expand supplemental benefits for chronically ill patients in MA. As nonprofits, we often go above and beyond what is covered in order to provide better care for our patients. In our daily course of care, we find that providing a nutritional supplement greatly increases the quality of care for our patients. Studies have shown a 29 percent decrease in mortality when a nutritional supplement is given during dialysis; however Medicare does not cover it. Some Medicare Advantage plans offer group, and one-on-one nutrition education, medical nutrition therapy, and even some meals, but this is only for a

limited time, typically two weeks. While this may be appropriate in the period immediately following an acute episode, it falls short of what is needed over the long-term for those with a chronic condition such as ESRD.

CARE COORDINATION:

Improving Care Management Services for Individuals with Multiple Chronic Conditions (pg. 11 of Policy Option Document)

Many NKCA members have seen the benefit of improved care coordination with CKD (and ESRD) patients. Importantly, much of this care coordination can be accomplished through the work of health professionals other than physicians. Not only do we see a measurable clinical benefit, but we also anticipate that we'll see substantial cost savings – a clear goal in your policy options paper. The potential new billing code could be any of those listed in your paper (five or more chronic conditions, one chronic condition in conjunction with Alzheimer's or a related dementia, or a chronic condition combined with impaired functional status, such as that caused by anxiety, depression, or alcohol and/or drug dependence.). Under CMS' current policy for billing under CPT code 99490, a patient must have two or more chronic conditions, among other requirements. There must also be a comprehensive care plan in place. Importantly, CMS rules provide not only for non-physician practitioners, such as nurse practitioners, to provide services directly, but also permit time spent by clinical staff to provide chronic care management (CCM) services under *general* supervision to count toward the current 20 minute/month limit. These parameters should be included specifically in the proposed new code, although the allowance for general supervision may need to be increased given the greater complexity of the conditions covered by it.

Currently, our members use nurses, dietitians, and social workers to provide care coordination. If more non-MD/DO health care providers could be considered qualified health professionals and be able to use the CCM code (99490) or be considered clinical staff, it will allow more patients to have the opportunity to participate in a care management model. Nephrologists and primary care providers are stretched thin in their daily schedules. Having nurses and other care providers, depending on the situation, be able to serve in this role could greatly assist in improving the quality of patient care, as well as reduce cost.

We commend the Working Group's efforts on improving care management for those with multiple chronic conditions. As you move forward in creating policy, we hope a continued dialogue on the best ways to reimburse and increase the quality of care will involve providers, patients, and payers.

Encouraging Beneficiary Use of Chronic Care Management Services (pg. 23 of Policy Option Document)

As discussed above, the use of the current CCM code and a proposed higher-level code can improve care. Both codes would still be subject to the beneficiary 20 percent coinsurance that could remain a barrier, particularly a high level code with a higher payment level. Therefore NKCA supports waiving the beneficiary co-pay in these instances. Any initiative to promote chronic care management is good policy. However we hope that you would go beyond just waiving an \$8 co-pay. More needs to be done to increase patient engagement, especially in ESRD and CKD. Many patients do not even know they have kidney disease until it is too late. Others are ill prepared to transition to dialysis when it can no longer be avoided. Starting dialysis is a life-changing event, making it critical that patients be engaged in the decisions about their options, and the management of their care when starting. The members of NKCA have been working for several years with their patients to accomplish these objectives through:

- Chronic Kidney Disease Care Coordination
- Pre-Dialysis Education with Navigation Services
- Transition Care Coordinators
- Family and Community Outreach & Mobilization

Across each of these practices, the goal is to empower patients to play a greater role in managing their health and meaningfully engaging with their health care providers. NKCA members believe that the potential of having patients and families manage their own health has barely been tapped. In fact, our current system of care emphasizes the professional side almost to the exclusion of real patient involvement. Any new approach to improving the care provided to patients at risk for, or living with, chronic illness must incorporate this potential, if meaningful improvements in the incidence and prevalence of these disease states, the quality of care provided, and the cost of care are to be made. This belief is based on the many years of experience that NKCA members have had with their care of patients with renal disease, not just those with ESRD. For example, one of our members, The Rogosin Institute, has more than thirty years of experience in mobilizing individuals, families and whole communities in thirty-two countries, as well as work here in the United States in the Mississippi Delta, Houston, Texas, and the U.S. Affiliated Pacific Islands. (See Problem Solving for Better Health, (Smith, Hoyt-Hudson, Fitzpatrick, Eds, Springer, New York, 2011)).

By providing one-on-one and small group in-person education, care coordinators, educators, and navigators are able to learn about a patient's life goals and circumstances, then work with the patient to help him or her achieve the life he or she wants, without having their kidney disease get in the way. It is also a means by which patients can be made aware of their options, such as home dialysis, rather than in-center care. As a result, there will be significantly higher use of home care, which can lead to a high quality of care (with decreased use of medications, hospital visits, etc.) and a better quality of life – all at lower cost.

As we noted earlier, one of our members, DCI, has instituted a CKD Care Coordination Program to start educating patients (now involving 3,500 patients and 28 locations) on how they can stay healthier and thereby avoid, or at least delay dialysis. Furthermore, if it is necessary as the condition progresses the patients learn about their options, including home dialysis, and are better prepared with hemodialysis access via fistula, rather than a catheter. They do this through one-on-one discussion with a care coordinator. During the first visit, the care coordinator talks with the patient for up to an hour and a half. During this time, the patient has the opportunity to ask any questions that he or she may have. Thereafter, a plan of care is designed and implemented. The care coordinator continues to meet with the patient until he or she is able to better manage his or her other medical conditions or until he or she selects a choice of therapy at this transition in care. For a patient choosing a therapy at the transition in care, the care coordinator will continue to work with the patient to help the patient implement his or her choice.

Another of our members, Northwest Kidney Centers, utilizes pre-dialysis “Choices” education classes. For those who attend the weekly classes, Northwest Kidney Centers finds that significantly more patients have a permanent access in place prior to the start of dialysis; more start treatment in a center, rather than a hospital; and more choose home dialysis than in-center care. The Rogosin Institute also has developed a Renal Management Clinic, which is doing the same things for patients in New York City.

Empowering patients also means mobilizing families and the larger community to promote healthy living habits. Peers, as well as healthy individuals and family members, can help patients with the many challenges they have in daily life, such as: personal hygiene, proper taking of medication, exercise, nutrition, and emotional problems, such as depression. These individuals can become “coaches,” and/or peer mentors who have the back-up of nurses and doctors by means of the many digital tools we now have at our disposal to achieve better health outcomes. We should point out that this component of the overall approach we are proposing to increase the engagement of individuals in their own health has the additional advantage of filling a great need identified by our patients, i.e. to reduce the isolation that they feel as ESRD patients. The Rogosin Institute is already developing these programs to engage family and community resources in New York City, in the Borough of Brooklyn, Queens, and Manhattan in particular, including partnerships with other non-profit social service and medical agencies in the private sector.

Eliminating Barriers to Care Coordination under Accountable Care Organization (pg. 25 of Policy Option Document)

There are two issues NKCA would like the Working Group to address in this section. First, while the Working Group’s document refers generally to Accountable Care Organizations (ACOs), we urge that it specifically include ESRD Seamless Care Organizations (ESCOs) as well. Indeed, in its most recent statement on ACOs, CMS now explicitly includes the

recently launched ESCOs as part of the broader ACO community. Second, while there are certainly situations in which two-sided risk ACOs might have more favorable terms, we see no reason why beneficiaries should be treated differently just because they are in a one-sided risk entity. It is unfair to patients in the non-large dialysis organizations (non-LDOs) in the ESCO program, since CMS does not even allow them to be in a two-sided model at this time. For our members in ESCOs, this has been an issue. If both non-LDOs and LDO ESCOs could remove or decrease standard Medicare Part A and Part B cost-sharing responsibilities, including deductibles and coinsurance payments, based on specific patient outcomes, patient engagement could greatly improve.

Regarding the question as to whether items or services should be defined through rule making or left to the discretion of an ACO, we would recommend that both options be allowed. Congress could authorize and then CMS, through notice and comment, provide a list of services. At the same time, Congress could provide authority to the Secretary to also consider ACO requests, on a case-by-case basis.

On the issue of beneficiaries with Medigap or employer-provided supplemental coverage, the Working Group points to an unfortunate irony: many beneficiaries who do not have such supplemental coverage for coinsurance, copays and deductibles, are the very beneficiaries who need them most for better care. These individuals tend to be older and have lower income. They would clearly benefit from waived copays, coinsurance and deductibles.

MENTAL and BEHAVIORAL HEALTH:

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries (pg. 12 of Policy Option Document)

Depression and Anxiety:

This year, a mental health measure was added to the ESRD Quality Incentive Program (QIP). The measure is depression. This is an extremely important addition since depression is a widespread problem among dialysis patients. All NKCA members have recognized this and are already tracking, or gearing up to better detect and track, this problem, as well as the closely related problem of anxiety. However, once a patient who is depressed is identified, there is no next step in the process. There is no adequate provision for a flexible, multi-faceted, and integrated approach to alleviating the problem. Better integration of behavioral and mental health care for those with serious chronic diseases, and especially ESRD, is necessary. We believe that, if patients who need mental health services were able to get them, they would become more engaged patients overall. Again, this means better quality of care (and life) for the patients and lower costs because medications would be taken more effectively, and there would be fewer missed dialysis and physician-nurse appointments.

There is sizeable literature on the available screening and diagnostic tools and the non-pharmacologic and pharmacologic interventions that can be used to alleviate both depression and its frequently associated anxiety. Not all of these tests and/or interventions need to be costly. They range from formal psychological and/or psychiatric interventions to the use of physical, occupational and art therapy; peer mentoring; and referrals to agencies that can assist with housing, employment and legal issues, as well as technology-based approaches that use applications that can tailor interventions that will help alleviate and/or resolve anxiety and/or depression.

Health literacy training for not only the patients, but also for the health professional staff is something that The Rogosin Institute has added to its programs to begin to help address these mental health issues. We believe that there is a great opportunity to change mental and behavioral health patterns among ESRD patients using these techniques. The reimbursement of some of these simple services, quite apart from the professional interventions, will result in not only better quality of care, but also cost-savings. The federal government can lead the way in changing the prevalence and severity of behavioral health issues among beneficiaries with chronic illness.

Behavioral and Mental Health in the ACO/ESCO:

The Centers for Medicare and Medicaid Services, through the Center for Medicare and Medicaid Innovation (CMMI), launched the Comprehensive ESRD Care Initiative (CEC) in October 2015. Two of our member companies (DCI and Rogosin) were chosen to participate among the twelve ESRD Seamless Care Organizations. ESCOs are to test new payment and service delivery options for ESRD beneficiaries. They currently screen for several aspects of behavioral health (depression, anxiety, substance abuse and alcohol abuse). Any recommendations made to GAO to conduct a study on the integration of behavioral health and primary care in Accountable Care Organizations should also include ESCOs.

TELEHEALTH:

Increasing Convenience for Medicare Advantage Enrollees through Telehealth (pg. 16 of Policy Option Document)

As stated in a previous question, dialyzing at home allows more independence and better patient satisfaction with cost savings to Medicare. Policy or rule changes resulting in the removal of potential barriers to patients starting and continuing on home dialysis are critical. Many patients must travel long distances for their monthly visit. If a patient were able to have a portion of those visits by telehealth, this would substantially decrease the burden on patients, as well as their families and caregivers, who would otherwise need to travel to a dialysis clinic to accompany them. Therefore, we support your policy to permit MA plans to include certain

telehealth services in their annual bid, and home hemodialysis and home peritoneal dialysis patients should be allowed to use such services.

QUALITY MEASURES - MOVING UPSTREAM TO CHRONIC KIDNEY DISEASE DETECTION and PREVENTION:

Developing Quality Measures for Chronic Conditions (pg. 22 of Policy Option Document)

NKCA supports the Working Group's recommendation to develop quality measures for chronic conditions and believes that such measures will benefit both CKD and ESRD patient populations. We also support collaboration with the various governmental agencies and other organizations that are actively concerned with, and working on, the development of such measures.

It should also be pointed out that Medicare has understandably been focused on treatment of beneficiaries with kidney failure, through ESRD, but has largely neglected the potential to improve beneficiary health and lower costs by going "upstream" to address chronic kidney disease, which not only leads to kidney failure, but is also strongly associated with cardiovascular disease and metabolic disorders, most especially diabetes. Beneficiaries are often unaware that they have CKD until it is well advanced. There are elements in the existing Medicare program that can help identify those at risk and promote better coordination of their care. These include the annual wellness visit along with high-risk assessment; diabetes screening; cardiovascular screening; chronic care management services; and Part D's Medication Therapy Management program. Currently, they all operate as separate and distinct payment provisions. More could be done to coordinate their delivery to focus on CKD care.

Moreover, with the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA), Medicare's current disjointed and overlapping quality and performance measures will be consolidated into a single merit-based incentive payment system (MIPS). The measures that are incorporated into MIPS can be honed to incentivize physicians and other clinicians to better identify, educate, and care for patients with CKD. NKCA members believe that overall outcome measures must be developed to assess more accurately the quality of the care provided by physicians, as well as the entire care team. Scoring highly on the MIPS' outcome measures (both quality and cost) should be the basis of incentive rewards for physicians, nurses, and the whole care team.

CONCLUSION:

We are pleased to see that so much work and dedication has characterized the efforts of the Working Group thus far. We, as NKCA, are willing to make ourselves available as a resource to

you and your staff at any time. We share with you the belief that we can make a major difference in the care of people with chronic illness and in the costs that such illness entails. We encourage the Senate Finance Committee and the Bipartisan Chronic Care Working Group to work with those who are on the front lines treating kidney disease (both CKD and ESRD), as it truly is a major health issue that needs to be addressed more effectively from both the quality and cost points of view.

We would be glad to discuss any of our suggestions above in greater detail at any time. If you have any questions, please feel free to contact Martin Corry at 202-580-7707 or info@nonprofitkidneycare.org.

Sincerely,

A handwritten signature in blue ink that reads "Martin Corry". The signature is written in a cursive style with a long, sweeping tail on the letter "y".

Martin Corry
Executive Director