

April 16, 2010

Robert C. McFetridge
Director, Regulations Management (00REG1)
Department of Veterans Affairs, 810 Vermont Ave., NW., Room 1068
Washington, DC 20420

RE: RIN 2900– AN37—Payment for Inpatient and Outpatient Health Care Professional Services at Non-Departmental Facilities and Other Medical Charges Associated with Non-VA Outpatient Care.

Dear Mr. McFetridge,

Dialysis Patient Citizens (DPC) is pleased to provide comments to the Department of Veterans Affairs (VA) on the proposed rule regarding payment for inpatient and outpatient health care professional services at non-departmental facilities and other medical charges associated with non-VA outpatient care. As America's largest dialysis patient organization, DPC has generated a membership of over 22,000 pre-dialysis and dialysis patients and their families nationwide. We seek to ensure that the patient's point of view is heard and considered by policy makers on a wide variety of issues, so continued progress may be made in the quality of care and life for all dialysis patients.

DPC understands the VA must improve cost predictions in order to provide veterans with more efficient care. However, we are concerned the current proposal will actually harm veterans' access to care. The proposed rule may result in many veterans, who are suffering from End Stage Renal Disease (ESRD) or kidney failure, having to spend more money out of pocket or utilize other Federal and State dollars to continue receiving life-saving dialysis treatments. As noted in the proposed rule, approximately 10,500 Veterans receive dialysis treatments at non-VA facilities with the treatments currently paid for by the VA. These patients typically choose to receive dialysis at a non-VA facility because they do not live within reasonable proximity to a VA health care facility that can provide them with dialysis treatments. Patients with ESRD normally receive dialysis treatments at least three times per week for four hours per treatment. Without dialysis or a kidney transplant, these individuals would die. Due to the frequency and duration ESRD patients must undergo treatment, extending their commute to a VA health care facility that would provide dialysis services is not feasible for many patients; hence, dialysis patients relying on VA benefits would be severely impacted by the VA's proposal to reduce payment to non-VA dialysis providers.

Dialysis Facility Economics and the Impact on Patients' Access to Care

The economics of dialysis centers are unique when compared to most health care facilities. Medicare payments fall short of what it costs to provide dialysis care to patients. In order to remain viable, facilities may need to make up the loss by treating patients who have private insurance coverage that reimburses above Medicare rates. However, private insurance

coverage for non-VA patients is only temporary because Medicare becomes the primary insurance provider after a patient's first 30 months as a Medicare ESRD beneficiary. Many facilities with a high ratio of Medicare patients are operating at or near a loss. For facilities that serve primarily Medicare and VA patients a reduction in reimbursement could render those facilities unable to remain open or continue to serve VA beneficiaries. While it may be true for large dialysis providers "... that VA patient workload in dialysis centers does not represent a substantial source of income for these businesses,"¹ it cannot be concluded providers will continue to keep facilities open that already operate at or near a loss. Closure of a facility could pose a great hardship for patients, particularly those residing in a rural area with limited options available for dialysis care.

At an underfunded Medicare reimbursement rate, dialysis providers face the choice of keeping their doors open and taking a loss or closing the facility. As a result, dialysis facilities could decide to stop contracting with the VA or be unable to admit new veterans. Patients not living near a VA facility that provides dialysis would then find it much more difficult to receive treatment. In many cases, patients may have no choice except to apply for Medicare coverage, which comes with the burden of extra premiums, deductibles and co-pays. Medicare Part B only pays 80 percent of doctor visits and other outpatient health care costs leaving veterans to either pay 20 percent out-of-pocket or find another insurance provider – which would likely come with another set of premiums. In the end, this scenario may save VA dollars, but it will hurt veterans and shift additional costs to Medicare and, in some cases, Medicaid. The VA has a responsibility to ensure eligible veterans receive affordable quality health care, and particularly for dialysis patients, this care should be reasonably accessible to them.

Alternative Options that Protect Veterans with ESRD

There are other reasonable solutions the VA should further explore that would result in better predictability of costs, save tax-payer dollars and ensure veterans receive continued access to quality care at a facility that is convenient for them.

Integrate Care with Non-VA Dialysis Providers

The VA is well recognized for being our nation's most advanced and integrated health care system. The VA could continue its established tradition of leadership and serve as a role model for the nation by taking the next step and integrating care with non-VA dialysis providers. Since the primary point of care for most dialysis patients are their nephrologists and dialysis facilities, it would make sense for the VA to work with dialysis providers to establish an integrated care system in which health information from non-VA providers is easily exchanged with the VA. Veterans who are able to utilize a VA health care facility already benefit from this integration of care. All veterans, regardless of their geographic region or the availability of certain health services at the nearest VA facility, should have access to this arrangement. Integrating care would provide additional resources and more efficient care to veterans needing to utilize non-VA care. It would allow them to better manage co-morbid conditions that are frequent among

¹ Federal Register Vol. 75, No. 32, Thursday, February 18, 2010 , Proposed Rules, Page 7225.

dialysis patients and reduce costly hospitalizations.

Explore a National Rate Not Tied to Medicare Reimbursement

The VA should also explore the savings potential of creating a viable national rate. Currently, VA reimbursement to non-VA dialysis providers varies throughout the country with some rates below Medicare and others greatly exceeding Medicare rates. While regional variability in health care costs should be taken into account, the VA should work with dialysis providers to determine a mutually agreeable national rate for dialysis care that could be modified to account for regional cost variability as the Medicare rate currently does.

If the VA follows through with the proposed rule, there is a serious concern thousands of veterans will be forced to pay additional coverage premiums, co-pays or seek state assistance through Medicaid in order to continue receiving care. In addition, with the loss in VA reimbursement and a shift in some facilities to a higher number of patients with Medicare coverage, many facilities may become financially unsustainable and decide to close, forcing patients to seek treatment at other clinics and creating a barrier for access to care for veterans and other dialysis patients. DPC encourages the VA to abandon its current proposal and work with dialysis providers and the patient community to find a solution to ensure veterans do not lose access to high quality care.

DPC appreciates the opportunity to submit these comments on behalf of veterans needing life-saving dialysis treatment.

Sincerely,



Chad Lennox
Executive Director