ASN Launches Grassroots Campaign to Protect Medical Research Funding

By Grant Olan

Despite shrinking funding for kidney research and a record low grant application success rate at the National Institutes of Health (NIH), more cuts are set to take effect in 2014 unless Congress takes action to prevent them.

As part of ASN’s response to this continued threat to research, the society asks members to meet with congressional offices in their home districts in November and December to highlight the value and importance of continued investments in medical research. This district-level advocacy is a crucial corollary to the society’s advocacy work.

ASN recently surveyed in U.S. members to collect feedback on the impact of budget cuts on their research laboratories, institutions, and patients. Nearly 70 members responded. This feedback has been invaluable in helping ASN build the case in Congress that cuts have, and will continue to have, a negative effect on the United States’ position as the global leader in research.

Through congressional briefings, office visits, and community sign-on letters to Congress, ASN is aiming to ensure Congress hears the message about cuts to research funding. ASN also supports six coalitions committed to protecting federal investments in medical research, including NDD United, which represents 3200 organizations advocating for a balanced approach to deficit reduction. For more information, visit http://www.nddunited.org/.

ASN members can access all the directions and tools necessary to meet with local congressional offices, including talking points and fact sheets, at http://www.asn-online.org/policy/. It is important for members of Congress to hear from those on the ground, their own constituents who have been affected or will be affected by budget cuts.

“Doesn’t make sense to cut investments like medical research that grow the economy,” ASN Research Advocacy Committee Chairman John R. Sedot, MD, said. “Discretionary programs have already sustained significant cuts and there is no more fat to trim. Even eliminating all federal discretionary funding won’t eliminate the deficit. Congress needs to find a balanced approach to debt reduction, and your elected representatives need to hear from you this November and December. Please help yourself by helping ASN. Visit http://www.asn-online.org/policy/ today to take action.”

Proposed Cuts to ESRD Program: ASN Responds

By Mark Lukaszewski

A proposal to cut the End-Stage Renal Disease (ESRD) Program by nearly 10 percent may have unintended consequences for people on dialysis. This was ASN’s key message to the Centers for Medicare & Medicaid Services (CMS) in comments on the proposed rule regarding the Medicare ESRD Prospective Payment System (PPS) and Quality Incentive Program (QIP). ASN’s Quality Metrics Task Force, Public Policy Board, and Dialysis Advisory Group assessed the proposed rule to determine what effects it could have on patient care and access to dialysis before the society submitted feedback to CMS.

Previous ASN comment letters have focused on the quality portion of the proposed rule instead of the payment component. But given the magnitude of the proposed cuts, ASN leadership felt strongly that the society should focus on both sections of the rule, highlighting the effect the potential cuts could have on patient access to care. This article summarizes ASN’s main recommendations to CMS (Table 1).

This year Congress directed CMS to reexamine the ESRD base rate based on changes in drug utilization. In response to this mandate CMS proposed to decrease total payments to ESRD dialysis facilities by 9.4 percent. ASN is concerned about the potential serious adverse effects on the quality of care and patient access to dialysis that the proposed reduction in payment for ESRD services would have, especially if implemented at once.

“It’s troubling that Congress mandated a payment reduction at the same time that CMS is using the ESRD program as a model for bundled payment, a quality-incentive program, and a specialty-specific integrated care delivery model,” noted Thomas H. Hostetter, MD, chair of the ASN Public Policy Board. “The kidney community is working diligently on achieving the goals of the Quality Incentive Program (QIP), which was also mandated by Congress and implemented by CMS, in order to avoid further cuts in reimbursement.”

According to a 2012 Medicare Payment Advisory Commission’s report, the two largest dialysis providers saw Medicare margins of 3.4 percent on nearly 70 percent of spending, compared with 0.1 percent for 31 percent of spending for all other providers. In 2010, rural facilities operated on a –3.7 percent Medicare margin. This suggests that from you this November and December. Please help yourself by helping ASN. Visit http://www.asn-online.org/policy/ today to take action.”

In Their Own Words

Kidney professionals describe the impact of budget cuts

I am a practicing nephrologist with a small clinical research program in autosomal dominant polycystic kidney disease (ADPKD), a rare genetic disease. One of my key collaborators may no longer be able to run his laboratory. He has spent decades amassing expertise in this disease. Once he is gone our ability to address innovative questions is dramatically reduced. – Neera Dahl, MD, PhD, Yale University School of Medicine

Diabetes is the number one cause of progressive kidney injury and ESRD, and increases the risk of heart disease, heart attacks, and strokes. Cuts in my federal funding will mean losing staff members whose work is critical to our ability to find ways to slow or reverse the progression of kidney disease in diabetes. – Raymond Harris, MD, Vanderbilt University Medical Center

My laboratory supports work that advances treatment for a number of diseases of glomerular function. These diseases affect young and old, have no therapies, and often result in the need for life-saving dialysis. The cost to American taxpayers is more than $30 billion a year. Brilliant young scientists in our training program are turning away from a career in science because they view this career as too risky. The future of kidney research and patient care is being seriously and rapidly eroded. – Lawrence Holtzman, MD, University of Pennsylvania

Our research focuses on understanding polycystic kidney disease and glomerular disease. Our present grants have been cut back, decreasing our ability to pursue this research and the potential treatments that may result. We are facing a time when prominent scientists in the field of nephrology are unsure how and if they will be able to maintain their laboratories. The field was already in crisis before the sequester. Now it is in uncharted territory. – Jordan Kreidberg, MD, PhD, Boston Children’s Hospital and Harvard Medical School

We develop therapies to treat people with food-borne infections that cause acute kidney injury and coagulation problems, organ damage, and increased risk for kidney complications. We have had to reduce one technician, move another to part time, and cannot bring in new graduate students and the new knowledge they bring. As a result, our work developing better treatments has slowed significantly. – DJ Stearns-Kurosawa, PhD, Boston University School of Medicine
CMS also recommended a “holdback” policy for home dialysis training, in which dialysis facilities would not be reimbursed for training patients who are unsuccessful in transitioning to home dialysis. ASN strongly recommended CMS eliminate this proposed policy. The society is concerned that the proposal would discourage attempts at home dialysis dissemination to more infirm individuals, who, if they are able to successfully perform home dialysis, may derive greater benefits. Moreover, the holdback appears to conflict with CMS’ stated goal of using the PPS as a mechanism to promote increased home dialysis utilization.

Evaluating quality of care as well as patient access to dialysis services and medications is of utmost importance within a bundled payment system, and is especially necessary in light of proposed changes to the base rate. Nonetheless, given the limited scientific evidence currently available regarding what comprises optimal care for patients on dialysis, the society expressed reservations about some aspects of the proposed modifications to the QIP program.

ASN noted existing and proposed QIP measures are not as relevant as others. Some are focused on processes—monitoring and collecting data—rather than on outcomes. Ample evidence shows most providers meet or exceed quality standards for several measures, such as hemoglobin. ASN plans to work with stakeholders and CMS to strengthen the QIP and expand the evidence base for meaningful new measures.

The proposed clinical hypercalcemia measure was of greatest concern. CMS would penalize facilities if a percentage of patients don’t meet the serum calcium target of 10.2 mg/dL or below. However, ASN believes there is insufficient scientific evidence to substantiate this target. No hypercalcemia performance gap currently exists and calcium management is the care standard. ASN recommended CMS not finalize the hypercalcemia measure, stating that it would create a reporting burden without benefiting patients.

CMS will likely release a final rule in early November, and ASN, with other kidney stakeholders, will continue to advocate to CMS and Congress until then. “More than 20 million Americans have kidney disease, and the Medicare ESRD program provides lifesaving care to nearly 400,000 beneficiaries with kidney failure,” said ASN President Bruce A. Molitoris, MD, FASN. “People with kidney disease, among the most vulnerable patients, are disproportionately underrepresented minorities, and such a large cut may reduce access to care and quality of treatment. ASN, the kidney community, and CMS must work together to provide the highest quality care possible to the millions of Americans with kidney disease, including those on dialysis whose lives are saved daily by the Medicare ESRD Program.” ASN’s comment letter is available at http://bit.ly/18en5BA.

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Table 1
Key ASN recommendations to CMS

- Assess the significant negative effect a cut of the proposed magnitude would likely generate on patient access to quality care.
- Provide the option to phase in any PPS bundle rebase over a 4-year period in equal parts.
- Implement and publicly describe a comprehensive monitoring program to identify any unintended consequences that could arise as a result of any PPS bundle rebase, including consolidation of the dialysis market.
- Eliminate the concept of a “holdback” for home dialysis training.
- Maintain a reporting-only hypercalcemia measure instead of transitioning it to a clinical measure.
- Collaborate with ASN and other stakeholders in the kidney care community to update the 2728 form and corresponding annual comorbidity reporting list.

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