

Members

Doug Stratton, Chairperson
Sen. Vaneta Becker
Sen. Sue Landske
Sen. James Lewis
Sen. Samuel Smith
Rep. Craig Fry
Rep. Ron Herrell
Rep. Dick Dodge
Rep. Gerald Torr



INTERIM STUDY COMMITTEE ON DIALYSIS COVERAGE

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MEETING MINUTES¹

Meeting Date: August 6, 2008
Meeting Time: 10:30 A.M.
Meeting Place: State House, 200 W. Washington St., Room 233
Meeting City: Indianapolis, Indiana
Meeting Number: 1

Members Present: Doug Stratton, Chairperson; Sen. Sue Landske; Rep. Craig Fry; Rep. Ron Herrell; Rep. Dick Dodge; Rep. Gerald Torr.

Members Absent: Sen. Vaneta Becker; Sen. James Lewis; Sen. Samuel Smith.

Mr. Stratton called the meeting to order at 10:35 a.m. and asked the members to introduce themselves.

Mr. Stratton gave a brief overview of the Committee's responsibilities and provided procedural information.²

Michael Kraus, M.D., Division of Nephrology, Indiana University Medical Center, provided background information concerning dialysis, including peritoneal dialysis and hemodialysis provided at dialysis facilities and in patient homes.³

¹ Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of \$0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is <http://www.in.gov/legislative/>. No fee is charged for viewing, downloading, or printing minutes from the Internet.

²Attachment 1.

³Attachment 2.

In response to questions from Mr. Stratton and Rep. Herrell, Dr. Kraus stated that:

- (a) nephrologists typically have established relationships with dialysis providers and make referrals to those providers, however new relationships are established with different dialysis providers depending on insurance coverage requirements and geographic accessibility needs;
- (b) close geographic proximity of a dialysis provider to a patient's home is an important consideration in determining to which provider a referral is made;
- (c) determining whether to place a patient on home hemodialysis is done based on several considerations, including:
 - (1) only one device is approved for home hemodialysis;
 - (2) education of nephrologists concerning home hemodialysis;
 - (3) economic considerations; and
 - (4) overall design of the current facility based hemodialysis delivery system;
- (d) reimbursement rates under Medicaid and Medicare are too low to make a profit, so cost shifting to privately insured and private pay patients occurs;
- (e) current legal requirements do not present barriers to home hemodialysis, economic barriers do; and
- (f) the overall cost of hemodialysis per year averages \$80,000.

A handout related to the testimony of the following five individuals was provided.⁴

Barb Melo, R.N., Davita, discussed the process of hemodialysis provided in dialysis facilities. She emphasized the importance of building patient trust and difficulties in changing providers after a patient is established in a particular hemodialysis facility.

In response to questions from Mr. Stratton and Rep. Herrell, Ms. Melo stated that:

- (a) home hemodialysis requires that the patient have a partner to remain with the patient throughout the hemodialysis process and that most of the patients for whom she cares in the dialysis facility do not have such a partner, so home hemodialysis is not an option for them;
- (b) transportation and physical stress are important considerations in determining the distance that a patient should be required to travel for hemodialysis; and
- (c) home nursing care as a means of providing a hemodialysis partner for home hemodialysis may or may not be feasible.

Keith Mentz, Nephrology, Inc., provided information concerning payment for hemodialysis. He discussed the history of payment for hemodialysis since Congress' passage of a Medicare entitlement for end stage renal disease patients in 1972. Mr. Mentz stated that since 2006, insurers have changed their conditions of coverage. An example of such a change, provided by Mr. Mentz, is that private insurers require that certain medications be provided during hemodialysis as a condition of coverage, but then deny coverage for those medications. Mr. Mentz stated that 90% of his hemodialysis patients have Medicaid or Medicare as their primary payment source.

In response to questions from Rep. Fry, Rep. Torr, and Rep. Dodge, Mr. Mentz stated that:

- (a) 20% of his hemodialysis patients are home hemodialysis patients through which his dialysis facilities can make a profit, largely due to the lack of need for staff for those patients;
- (b) he has negotiated with private insurers to keep certain out of network patients at his dialysis facilities after network changes have caused insurers to notify patients that a different dialysis facility should be used;
- (c) all of his profit results from home hemodialysis and facility based hemodialysis paid for through payors other than Medicaid or Medicare;

⁴Attachment 3.

- (d) the financial problems of his dialysis facilities are caused by low payment rates under Medicaid and Medicare, and profits made through other payment sources have previously balanced those losses, but with recent changes in payment under the other payment sources, the losses under Medicaid and Medicare are no longer balanced; and
- (e) private insurance coverage frequently requires hemodialysis patients to travel a greater distance to a hemodialysis facility that is in the private insurer's network, rather than receiving hemodialysis at an out of network hemodialysis facility that is nearer the patient's home.

Matt Bassett, Davita, provided an explanation of the impact of recent changes in private insurer coverage of hemodialysis. He expressed concern that patients who are very ill are being told that they must change hemodialysis providers because their current providers are not in the insurers' networks. He provided recommendations for inclusion in legislation to assist hemodialysis patients with coverage under private insurance.

In response to questions from Mr. Stratton, Rep. Torr, and Rep. Fry, Mr. Bassett and Anthony Gabriel, M.D., Davita, stated that:

- (a) patients don't typically understand the payment conditions of their preferred provider network policies;
- (b) the changes in private insurer coverage are changes in payment with respect to out of network providers;
- (c) annual determination and implementation of facility efficiency improvement measures occurs to decrease costs of providing hemodialysis;
- (d) patients find it too difficult to use private insurance as a payment method for hemodialysis, so they often drop private insurance coverage and obtain Medicaid or Medicare coverage while still eligible for private insurance;
- (e) in 2007, private insurers decreased benefit payment amounts;
- (f) Rep. Fry's bill from the 2008 session of the General Assembly contained recommended changes and could possibly be amended based on recent legislative experience with the same issues in Kentucky.

Danielle Peters, granddaughter of a dialysis patient, provided information concerning the progression of her grandfather's physical illnesses and treatments. She emphasized the need for hemodialysis patients, particularly those with mental health conditions as well, to establish trusting relationships with their hemodialysis providers. Ms. Peters explained difficulties with direct reimbursement for hemodialysis from private insurance and requested that the General Assembly protect access to hemodialysis patients' choice of a hemodialysis provider.

In response to a question from Mr. Stratton, Ms. Peters stated that patient concerns and patient family concerns, as well as expenses, would likely be taken into account by a patient in making a choice of hemodialysis facility.

Robin Wildman M.S.W., Fresenius, discussed psychosocial issues and the increasing difficulties that hemodialysis patients have with insurance payment for hemodialysis.

In response to questions from Mr. Stratton, Ms. Wildman stated that physical stress and distance sometimes cause hemodialysis patients to make a choice of decreased time on hemodialysis so the patient will feel well enough to make it home. She recommended that affordability and patient choice of a hemodialysis facility should be provided for and stated that changes in private insurance coverage during the past year have caused patients to make potentially detrimental health choices.

Rick Warthan, hemodialysis patient, described a series of family health difficulties that have compounded his own hemodialysis related problems. He expressed great concern about financial problems related to hemodialysis, decreased access to chosen hemodialysis facilities, and lack of coverage for hemodialysis, and

requested that the General Assembly address these issues.

Mr. Stratton noted that the next meeting of the Committee will take place on Wednesday, August 20, 2008, at 10:30 a.m. in Room 233 of the State House. With no further business to discuss, the meeting was adjourned at 12:25 p.m.