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Dear Drs. Mangione, Nicholson and Barry:

The American Kidney Fund (AKF) is writing to urge the U.S. Preventive Services Task Force (USPSTF) to develop a chronic kidney disease (CKD) screening recommendation.

AKF fights kidney disease on all fronts as the nation's leading kidney nonprofit. We work on behalf of the 37 million Americans living with kidney disease, and the millions more at risk, with an unmatched scope of programs that support people wherever they are in their fight against kidney disease—from prevention through transplant. Through programs of prevention, early detection, financial support, disease management, clinical research, innovation and advocacy, no kidney organization impacts more lives than AKF. AKF is one of the nation's top-rated nonprofits, investing 97 cents of every donated dollar in programs, and holds the highest 4-Star rating from Charity Navigator and the Platinum Seal of Transparency from Candid.

Our support for CKD screening recommendation stems from concerns about the growing number of people who experience kidney failure and need dialysis or transplantation, the health disparities associated with kidney disease and the need for a clinical assessment tool for physician use by primary care physicians and other providers when screening for chronic kidney disease. The last time the USPSTF considered kidney screening guidelines was 2012 and much has changed since then. For example, there are at least two classes of drugs today to slow the progression of CKD that did not exist in 2012 (SGLT2 inhibitors and GLP-1 receptor agonists).

Dramatic Increase in Kidney Failure Patients

Thirty-seven million people in the United States have kidney disease, and most do not know that they have it. [More than 780,000](#) people in the United States, or 1 in 500 people, are currently living with end-

stage kidney disease (ESKD, or kidney failure).¹ Unfortunately, the numbers are growing. From 2009-2019, the number of people with ESKD increased by more than 41%.² In 2009, there were 574,000 people with kidney failure; that number increased to 809,103 in 2019. Studies project that 971,000 to 1,259,000 individuals will be living with ESKD in 2030.³

People with CKD cost taxpayers a great deal of money: total Medicare fee-for-service spending for beneficiaries with CKD who did not have ESKD was \$87.2 billion in 2019, representing 23% of total Medicare fee-for-service expenditures. Medicare beneficiaries with ESKD and receiving maintenance dialysis make up 1% of the Medicare population, but 7% of the costs⁴, which was just over \$50 billion in 2019. Screening people for CKD and helping them manage the disease once it is diagnosed could save the federal government billions of dollars.

Kidney failure radically changes a person's life and lifestyle, including an inability to work for most patients because of the need for ongoing dialysis. Allowing patients to find out early that they have kidney disease provides the opportunity for lifestyle changes and the opportunity to slow or halt the progression of the disease and possibly prevent renal failure. Seventy-five percent of new kidney failure cases are due to diabetes and hypertension, largely modifiable risk factors.

Recommendation Suggestion

Screenings for CKD should be done for every patient known to be at higher risk for kidney disease, and specifically populations that have been diagnosed with high blood pressure, diabetes or cardiovascular disease.

Health Disparities

Early stages of CKD are similar across people of different socioeconomic status, race and ethnicity, but in stage five kidney disease and kidney failure there are higher proportions of people of color.⁵ Black Americans make up just 13% of the U.S. population, but they account for 35% of Americans on dialysis. Compared to white Americans, Black Americans are 3.4 times more likely to develop kidney failure. Native Americans are 1.9 times and Asian Americans are 1.3 times more likely than white Americans to develop kidney failure. People of Hispanic ethnicity are 1.5 times more likely to develop kidney failure than non-Hispanics.⁶

The reasons for these differences are multi-factorial, but one reason for the disparate impact on these communities could be less access to affordable and high quality health insurance. A study that compared Medicaid expansion states to non-expansion states found that people living in expansion states had lower mortality rates after going on dialysis and more patients were preemptively placed on the transplant

¹ Centers for Disease Control and Prevention. Chronic Kidney Disease Surveillance System website. <https://nccd.cdc.gov/CKD>. Accessed 2/19/2021. <https://www.cdc.gov/kidneydisease/pdf/Chronic-Kidney-Disease-in-the-US-2021-h.pdf>

² <https://adr.usrds.org/2021/end-stage-renal-disease/1-incidence-prevalence-patient-characteristics-and-treatment-modalities>

³ Keith P. McCullough, Hal Morgenstern, Rajiv Saran, William H. Herman, & Bruce M. Robinson(2019). Projecting ESKD Incidence and Prevalence in the United States through 2030. JASN, 30 (1) 127-135. <https://jasn.asnjournals.org/content/30/1/127>

⁴ <https://adr.usrds.org/2021/end-stage-renal-disease/9-healthcare-expenditures-for-persons-with-esrd>

⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3983362/>

⁶ National Institutes of Health, National Institute for Diabetes and Digestive and Kidney Diseases (NIDDK) website. <https://www.niddk.nih.gov/health-information/kidney-disease/race-ethnicity>

list so they could be on dialysis for a shorter time.^{7,8} Over 2.2 million people fall into the Medicaid “coverage gap,” meaning they do not qualify for Medicaid or Affordable Care Act premium tax credits.⁹ Fifty-eight percent of those in the Medicaid coverage gap are racial and ethnic minorities: 28% African American/Black, 28% Hispanic/Latino, 1% American Indian or Alaska Native, 1% Asian or Pacific Islander.¹⁰ People without access to health insurance often rely on community health clinics that provide free care or have sliding scale fees. Sometimes they receive no care at all. The same groups that have difficulty accessing care also have higher rates of kidney failure.

The estimated glomerular filtration rate (eGFR) is a clinical support tool used by primary care physicians to measure kidney function. Prior to September of 2021, there were two measurements of eGFR: one for Black Americans and another for everyone else. Recommendations to change the measure were put forth in September 2021 by the *NKF-ASN Task Force on Reassessing the Inclusion of Race in Diagnosing Kidney Disease* and race is no longer included. This historic change is expected to result in reducing disparities in transplant listing in Black Americans and earlier referrals to nephrology. The USPSTF should utilize this change to provide primary care physicians a recommendation on when to screen all patients, including those of color, for CKD. While these high-risk patients should be prioritized, screening all patients for CKD would be an essential tool to identify and treat the disease in its earlier states.

Recommendation Suggestion

A recommendation to include all racial and ethnic minorities in CKD screenings will focus screenings on the communities more likely to suffer kidney failure. Additionally, a recommendation that all people who utilize community health centers or federally qualified health centers (FQHCs) should be screened when they visit on an annual basis.

Need for Clinical Assessment Tools

AKF recently completed a survey of 300 clinicians in primary care, nephrology, and endocrinology that showed some concerning trends on kidney disease testing and late referrals. This survey was part of AKF’s Unknown Causes of Kidney Disease (UCKD) project. The survey found that urinalysis, an important test in order to detect the earliest stages of kidney disease, is used as frequently as metabolic panels, which tend to catch kidney disease in later stages. Nearly half of patients were found not to be referred to a nephrologist until they had reached stages 4 or 5 of kidney disease, and these late referrals were attributed to a variety of reasons: difficulty accessing nephrology care in rural areas, lack of early detection, and confusion about what next steps to use and who to refer patients to on the part of primary care providers. A recommendation from the USPSTF to screen high-risk populations for both urine albumin to creatinine ratio (ACR) and eGFR would help guide primary care providers on who should be

⁷ Shailender Swaminathan, Benjamin D. Sommers, Rebecca Thorsness (2018). Association of Medicaid Expansion With 1-Year Mortality Among Patients With End-Stage Renal Disease. *JAMA*, 2018;320(21):2242-2250. <https://jamanetwork.com/journals/jama/fullarticle/2710505>

⁸ Weiner, Janet. “Addressing Kidney Transplant Waiting List Disparities Through Medicaid Expansion,” *University of Pennsylvania Leonard Davis Institute of Health Economics, Health Care Access & Coverage, Health Equity, Blog Post*, 18 June 2018 <https://ldi.upenn.edu/our-work/research-updates/addressing-kidney-transplant-waiting-list-disparities-through-medicaid-expansion/>

⁹ Rudowitz R, Garfield R, Levitt L. “Filling the Coverage Gap: Policy Options and Considerations,” Kaiser Family Foundation, 22 April 2021. <https://www.kff.org/medicaid/issue-brief/filling-the-coverage-gap-policy-options-and-considerations/>

¹⁰ Lukens G, Sharer B. “Closing Medicaid Coverage Gap Would Help Diverse Group and Narrow Racial Disparities,” Center on Budget and Policy Priorities (CBPP), 14 June 2021. <https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-group-and-narrow-racial>

screened and what to do if someone is diagnosed with CKD, ultimately to support early detection prior to near end-stage disease, and afford a better opportunity to slow or stop worsening to renal failure.

Recommendation Suggestion

To help catch many CKD patients when early interventions (such as SGLT2i and GLP-1 medicine classes) can be effectively implemented, we suggest two recommendations: First, a recommendation that all patients at risk for CKD have an annual eGFR test and ACR test. Second, a recommendation that primary care providers should refer a patient to a nephrologist when that patient reaches stage 4 (GFR <30) or severely increased albuminuria (> 300 mg/g).

It is AKF's sincere hope that the USPSTF will provide recommendations CKD screening. If you have any questions about this letter, please contact Holly Bode, Vice President of Government Affairs at hbode@kidneyfund.org.

Sincerely,



LaVarne A. Burton
President & CEO