Congress of the United States
Washington, DC 20515

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Karina W. Davidson, PhD, M.A.Sc.
Chairperson, U.S. Preventive Services Task Force
North Shore University Hospital
350 Community Drive
Manhasset, NY 11030

Michael J. Barry, MD
Vice-Chair, U.S. Preventive Services Task Force
Internal Medicine Associates Team 2
15 Parkman Street
Boston, MA 02114-3117

Dear Drs. Davidson and Barry,

We write today to urge the U.S. Preventive Services Task Force (USPSTF) to develop a chronic kidney disease (CKD) screening recommendation. As you know, when USPSTF last evaluated the literature on CKD screening in 2012, the Task Force found insufficient evidence to support routine CKD screening for asymptomatic individuals. The Task Force generally updates topics every five years, however, declined to update its CKD recommendation. As a result, there is no current guidance from USPSTF on CKD screening. The absence of a CKD recommendation exacerbates the public health emergency posed by kidney disease and contributes to the low rates of CKD diagnosis in the primary care setting.

CKD is an epidemic in this country, affecting an estimated 37 million Americans. Astonishingly, 90 percent of those affected are unaware of their condition. CKD is the ninth leading cause of death in the United States, causing more deaths than common cancers such as breast cancer. CKD is more common in the elderly and among non-Hispanic Black populations, coinciding with some of the communities most vulnerable to COVID-19. Preliminary Medicare claims and observational data show that the COVID-19 pandemic has worsened the existing disparities among CKD populations.[1] Acute kidney injuries from COVID-19 can cause or exacerbate CKD.[2] Further, as you are undoubtedly aware, the cost of treating kidney-related care is simply unsustainable. The Medicare program spends more than $130 billion – more than 24 percent of total spending in fee-for-service – on patients with kidney disease. End-stage kidney disease, which affects only 1 percent of Medicare beneficiaries, accounts for 7 percent of traditional Medicare spending. It is imperative that we do all we can to diagnose and treat kidney disease at its earliest, most manageable stages.

In the decade since USPSTF provided its CKD screening recommendation, the body of evidence supporting CKD testing for individuals at risk for CKD has grown. Rather than general

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7309916/
[2] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0244779

population or mass screening, current evidence support screening individuals at high risk for CKD, including individuals with diabetes, hypertension, cardiovascular disease, family history of kidney disease, and individuals with a history of acute kidney injury (AKI), as recommended by clinical practice guidelines from the American Diabetes Association, the Kidney Diseases Improving Global Outcomes and the Kidney Disease Outcomes Quality Initiative.

In addition, since 2012, more treatment options for CKD have been developed. The drug class of sodium-glucose co-transporter-2 (SGLT-2) inhibitors show efficacy in slowing CKD progression and reducing the risk of cardiovascular disease and heart failure in patients with Type-2 Diabetes Mellitus (T2DM) and CKD, as well as in patients with CKD without diabetes. There are several interventions that have no effect on CKD progression, but reduce risk of cardiovascular disease, including statin-based therapies and the glucagon-like peptide receptor agonists (GLP-1 RA) drug class for T2DM. Observational studies have shown multidisciplinary care that may include a dietitian, pharmacist and, nephrologist is also associated with improved outcomes for T2DM with CKD. Finally, the presence of CKD may guide preventive care decisions, such as the appropriate blood pressures to target. Kidney disease does not usually have symptoms, so unless patients are screened, they may never be diagnosed and treated.

The body of evidence supporting CKD screening in patients with risk factors and new advances in slowing CKD progression underscores the need for USPSTF to revisit its CKD screening recommendation. As the nation reinvigorates the conversation about health disparities, we note that Black Americans are more likely to have diabetes, the leading cause of CKD, and more likely to suffer its consequences, including subsequent kidney failure and death.[3] Sitting at the intersection of public health need, novel science, and health equity, CKD screening has never been more important.

We urge USPSTF to again consider a CKD screening recommendation so that we can more effectively ease some of the enormous public health burden posed by kidney disease.

Thank you for your consideration of this request.

Sincerely,

Suzan K. DelBene
Member of Congress

Larry Bucshon, M.D.
Member of Congress

[3] https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18

/s/

Jaime Herrera Beutler
Member of Congress

/s/

Danny K. Davis
Member of Congress

/s/

Donald S. Beyer Jr.
Member of Congress

/s/

Brian Fitzpatrick
Member of Congress

/s/

Earl Blumenauer
Member of Congress

/s/

Josh Gottheimer
Member of Congress

/s/

Vern Buchanan
Member of Congress

/s/

Henry C. "Hank" Johnson, Jr.
Member of Congress

/s/

Earl L. "Buddy" Carter
Member of Congress

/s/

John B. Larson
Member of Congress

/s/

Barbara Lee
Member of Congress

/s/

Terri A. Sewell
Member of Congress

/s/

Gregory F. Murphy, M.D.
Member of Congress

/s/

Thomas R. Suozzi
Member of Congress

/s/

Tom O'Halleran
Member of Congress

/s/

Nydia M. Velázquez
Member of Congress

/s/

Donald M. Payne, Jr.
Member of Congress

/s/

Brad R. Wenstrup, D.P.M.
Member of Congress

/s/

Bobby L. Rush
Member of Congress

/s/

Kim Schrier, M.D
Member of Congress