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Nonprofit Kidney Care Alliance

September 11, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1676-P: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program, July 13, 2017.

Dear Administrator Verma:

On behalf of the Nonprofit Kidney Care Alliance (NKCA), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Medicare Physician Fee Schedule (PFS) Proposed Rule. NKCA represents five nonprofit dialysis providers: Centers for Dialysis Care; Dialysis Clinic, Inc. (DCI); Independent Dialysis Foundation, Inc.; Northwest Kidney Centers; and The Rogosin Institute. Collectively, we serve over 20,000 patients at more than 280 clinics in 30 states. Consistent with our belief that we can do more to keep patients *off dialysis*, we also serve more than 5,000 patients with chronic kidney disease (CKD), with the goal of avoiding, or at least delaying, onset of end stage renal disease (ESRD), and increasing the number of patients who can benefit from kidney transplants. Approximately 85 percent of our patients are covered by Medicare, including Medicare Advantage plans. Four of our five members also participate in the Comprehensive ESRD Care (CEC) Model through the Centers for Medicare and Medicaid Innovation (CMMI). Collectively, we are responsible for 10 ESRD Seamless Care Organizations (ESCOs) across the country in both one-sided and two-sided risk models.

Approximately 26 million Americans suffer from kidney disease, at an estimated cost to the Medicare program of $99 billion.[1] Our goal is to improve patients' quality of life by providing the best care, not just for dialysis patients, but also for those with CKD. This letter addresses three issues in the Proposed Rule related to dialysis services: telehealth services for dialysis patients, misvalued codes as they relate to home dialysis services, and vascular access for dialysis patients.

[1] USRDS. 2014 Annual Report

Comments Regarding Specific Provisions of the Medicare PFS Proposed Rule

1. Medicare Telehealth Services

In the Proposed Rule, CMS requested information regarding effective examination of the access site using telecommunications technology. NKCA supports the use of telehealth as a clinically appropriate alternative for certain services, particularly as used to support and encourage home dialysis, making it easier for patients to experience a better quality of life without the need for three dialysis visits in the clinic weekly.

In the case of using current telecommunications technology to view the arteriovenous (AV) fistula or AV graft access site, we believe that current accepted practices and literature are consistent with CMS's assertion that a "look, listen and feel" approach is necessary in many instances to properly monitor the access site. However, we believe that for peritoneal dialysis (PD) in the home, it is reasonable and helpful to use telecommunications in between face-to-face visits to view the access site. Providing this flexibility would ensure greater monitoring for patients while offering greater convenience for those for whom it is clinically appropriate. Therefore, NKCA recommends that CMS reconsider updating the policy for use of telecommunications for PD home dialysis patients.

2. Potentially Misvalued Services under the PFS

Section 1848(c)(2)(K) requires the Secretary to periodically identify potentially misvalued codes, and review and adjust work and practice expense (PE) values as appropriate. As part of its review, CMS takes recommendations not only from the American Medical Association's (AMA) Relative Value Scale Updated Committee (RUC), but also from other public commenters on revised work and PE values.

We were pleased that in last year's Proposed Rule, CMS recognized that the CPT codes related to home dialysis were misvalued. We were also glad to see CMS reiterate its finding from last year's rule that CPT codes 90963 through 90970 are misvalued, but we would prefer to see an outline for reevaluation of these codes.

The Government Accountability Office (GAO) recommended reviewing and revising Medicare payment policies for physicians to manage the care of dialysis patients to ensure that these policies are consistent with CMS' goal of encouraging the use of home dialysis among patients for whom it is appropriate. We see both home hemodialysis and PD as important options in dialysis care. Any opportunity to remove barriers to a patient starting home dialysis should be pursued.

NKCA is supportive of CMS' proposal to identify CPT codes 90963 through 90970 as potentially misvalued codes. We urge CMS in carrying out its review to pay close attention to GAO's findings that physician visits with home patients are often longer and more comprehensive. It is also important that, in setting payment, CMS take into account the practical difference between home visits and in-clinic visits where visits with multiple patients on the same day are possible. While we recognize that CMS must still conduct its review, we urge CMS to use its authority to increase the current rates for managing home patients to the greatest extent possible.

3. Vascular Access Codes

In the CY 2017 PFS Final Rule, CMS implemented changes that reduced reimbursement for dialysis vascular access as the result of newly established codes, CPT 36901 through 36909. Reimbursement for most of these codes is more than 30 percent less than for codes they replaced. In the CY 2018 PFS Proposed Rule, CMS requested comments regarding these codes and their valuation. We are very concerned about the significant cuts that were imposed on January 1, 2017, for two critical reasons: 1) adverse clinical impact for our patients as a result of reduced access to these services in the physician office setting, and 2) higher ultimate costs for both patients and Medicare as patients migrate to higher-cost sites of service.

We are aware of physicians who already have ceased providing vascular access for dialysis patients as a result of the reduction in reimbursement, and we know that other practices are contemplating doing the same. With fewer community-based physicians providing this important service, patients are likely to be delayed in receiving high-quality vascular access placement services and at higher risk of infection and hospitalization.

In addition to the potential for increased costs due to infection and hospitalization, some dialysis patients may be pushed toward an ambulatory surgical center (ASC) for their vascular access services. In the ASC setting, CMS reimbursement is far greater than under the PFS. Such a transition needlessly adds to overall health care spending. We are also concerned about these unintended consequences because of the potential impact on ESCOs. As the availability of quality vascular access declines for our patients and more patients receive vascular access in an ASC or hospital setting, costs will rise and ESCOs will find it more challenging to achieve targeted savings.

NKCA urges CMS to promptly reevaluate the RVUs for these codes and carefully consider recommendations by the American Society of Diagnostic and Interventional Nephrology (ASDIN) and others in this process.

Conclusion

Thank you for the opportunity to comment on the Medicare PFS Proposed Rule. NKCA appreciates the opportunity to provide input to ensure that the rule's impact continues to support quality of care to the patients we serve. As nonprofit providers, we are affected by these changes much differently than others. We would be pleased to discuss any of these suggestions in greater detail at any time. If you have any questions, please feel free to contact Martin Corry at 202-580-7707 or info@nonprofitkidneycare.org.

Sincerely,

Martin Corry
Executive Director