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Nonprofit Kidney Care Alliance

December 19, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW, Room 445-G
Washington, DC 20201

Re: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models- CMS-5517-FC

Dear Administrator Slavitt:

On behalf of the Nonprofit Kidney Care Alliance (NKCA), I write to offer comments and recommendations on the Centers for Medicare and Medicaid Services' (CMS) Final Rule regarding the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. NKCA represents five nonprofit dialysis providers: Centers for Dialysis Care; Dialysis Clinic, Inc.; 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 4,500 patients with chronic kidney disease (CKD), with the goal of avoiding, or at least delaying, onset of end stage renal disease (ESRD). Approximately 85 percent of our patients are covered by Medicare, including Medicare Advantage plans.

NKCA members have been very active in the development of the Center for Medicare and Medicaid Innovation (CMMI) Comprehensive ESRD Care (CEC) model. Two of our members, Dialysis Clinic, Inc. and The Rogosin Institute, launched ESRD Seamless Care Organizations (ESCOs) on October 1, 2015, and we were pleased to see a second round of ESCO applications accepted earlier this year. If our applications are approved, we anticipate that as many as four members of the NKCA could operate as many as nine ESCOs in 2017. We see ESCOs as the primary model of integrated care for patients with ESRD, and hope that this model will continue to be expanded in order to better serve patients with CKD and patients who have received a kidney transplant. We appreciate the collaborative approach and willingness to listen that CMMI has brought to the work on the CEC model and look forward to expanding the program in the future.

Our goal in providing the best care for dialysis patients and others with kidney disease is to improve patients' quality of life, reduce the risk and slow the progression of kidney disease, and increase the

number of patients who can benefit from kidney transplants. We believe that, on balance, the ESRD prospective payment bundle has allowed us to provide better care to our patients while achieving efficiencies in our delivery of care. It has also removed financial incentives that were not aligned with patient care.

As implementation of the Quality Payment Program (QPP) continues, we appreciate the continued opportunity to provide feedback to ensure efficient and effective application of the law. In particular, we have focused our comments on participation in APMs, including the CEC model, based on our current experience and future interest in growing the model to better coordinate care in order to provide improved outcomes for patients and lower costs for the Medicare program.

ESCO as an Advanced APM

We appreciate and support that the Final Rule indicates that the two-sided CEC model would be considered an Advanced APM and therefore eligible for Qualifying APM Participant (QP) status. We are very pleased that CMMI has allowed for both large dialysis organizations (LDOs) and non-LDOs to have the option of taking on two-sided risk in the model in order to participate in the Advanced APM track of the QPP.

As an Advanced APM, the CEC model has an opportunity to attract additional entities and clinicians into the ESCO by providing the opportunity to receive the QP bonus incentive payment under MACRA. This incentive can mean a great deal to participants in the ESCO since each participating nephrologist is also an owner, directly accepting the financial risk if the ESCO has chosen a two-sided shared savings model. We believe that this will continue to grow the model for new participants and continue the success already seen in the first year of the model.

Certified Electronic Health Records Technology Requirements (CEHRT)

NKCA understands the need to require the use of CEHRT for Advanced APM models to better track and coordinate care, and increase electronic health records adoption. We do, however, want to ensure that these requirements are focused on the individual clinicians and will not be placed on the dialysis provider, who has not been required to adopt the technology under the current EHR meaningful use requirements. Currently, the provider types listed in the Health Information Technology for Economic and Clinical Health (HITECH) Act (i.e., PHSA §3000(3)) as eligible for incentives under HITECH do not include dialysis facilities and vascular access centers, along with nursing homes and a variety of other venues of care. Only hospitals and "eligible professionals" such as doctors, dentists, podiatrists, optometrists and chiropractors can participate in the program and should be subject to these requirements.

Attribution-Eligible Beneficiaries

Patient attribution in the ESCO is based on the dialysis clinic in which a patient receives dialysis care, rather than what has been applied to the broader primary care attribution model with other accountable care organizations (ACOs). This requires a different approach from that of the standard ACO. Unlike traditional ACOs, in which patients are attributed according to the primary care physician who provides a plurality of services to a beneficiary, ESCO patients are attributed based on whether they

are receiving dialysis services in a given facility. In addition, the ESCO only includes patients on dialysis and excludes patients with CKD and those with a kidney transplant. NKCA appreciates the recognition of this difference in the Final Rule and the intent to provide a model-specific definition, but urges CMMI to quickly clarify the definition of an *attribution-eligible beneficiary* in the CEC model for planning purposes as new models ramp up in 2017. We believe that the definition of an attribution-eligible beneficiary should be a beneficiary's receipt of maintenance dialysis services during the year. We believe the same definition should be used for all clinicians in the model, regardless of specialty, in order to appropriately hold clinicians accountable for only the beneficiaries that could practically be attributed to the ESCO.

In addition, based on experience with the CEC model thus far, we would also recommend an opportunity for ESCOs and their nephrologist owners to review and appeal the list of attributed patients.

MIPS APM Standard

NKCA appreciates the flexibility provided in the Final Rule for those eligible clinicians who participate in an APM such as the CEC model but do not meet the necessary thresholds to achieve QP status. In this case, we believe this means that many of our participants in both LDO and non-LDO ESCOs would default to the proposed MIPS APM standard. We believe that the standard laid out in the Final Rule eliminates additional reporting burdens and provides incentives for eligible clinicians to continue to participate in an APM despite not achieving QP status. We support CMS in including this standard and believe CMS should look for additional ways to provide a path to QP status over time.

Determination

We appreciate the process laid out in the Final Rule to determine QP status at three snapshot dates in order to inform clinicians of QP status as soon as they are eligible. While we understand the intent, NKCA would like CMS to consider various situations that may arise for both large dialysis organizations (LDOs) and non-LDOs that may prevent an entity from reaching the annual threshold score. Our members have seen great success recruiting nephrologists into the model, as well as partnering with primary care clinicians in order to better coordinate care for patients and expose clinicians to APMs. In some cases, these clinicians may receive a small portion of their total Medicare Part B dialysis payments or patients, through beneficiaries attributed to the ESCO. We are concerned that, in these cases, this could pull down the aggregate of the entity and keep the entity from meeting the necessary threshold score. In this case, it would mean that the entire entity and its clinicians would miss out on the advanced APM incentive payment because they sought to expand their reach to other clinicians to better coordinate care. We ask CMS to look at these scenarios as it makes these determinations, and consider other means of determining the calculation if there is an outlier in an entity pulling down the aggregate score. NKCA believes that engaging with many partners is critical and beneficial to providing the best care for beneficiaries in the model, but cautions that this may impact QP threshold status in certain scenarios. We encourage CMS to work with CEC model participants to craft an appropriate means to capture the aggregate attribution threshold score.

Conclusion

Thank you for the continued opportunity to comment on the MACRA Final Rule. The NKCA appreciates the opportunity to provide input to ensure that the implementation of this law continues to support the highest 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