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Nonprofit Kidney Care Alliance

September 10, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1693-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1693-P: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program, July 27, 2018.

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) 2019 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. Together, 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, the onset of end stage renal disease (ESRD), and increasing the number of patients who can benefit from kidney transplant. 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 & Medicaid Innovation (CMMI). Collectively, we are responsible for 9 ESRD Seamless Care Organizations (ESCOs) across the country in both one-sided and two-sided risk models.

Approximately 30 million Americans suffer from kidney disease, at an estimated cost to the Medicare program of $100 billion. 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 four issues in the proposed rule related to dialysis services: telehealth services for home dialysis patients, evaluation and management (E/M) visits, misvalued codes as they relate to home dialysis services, and the ESRD facility based measurement proposal.

Comments Regarding Specific Provisions of the Medicare PFS Proposed Rule

1. **Expanding Access to Home Dialysis Therapy under the Bipartisan Budget Act of 2018**

NKCA has always supported the use of telehealth as a clinically appropriate alternative for certain services, particularly to encourage and support home dialysis, making it easier for patients to experience a better quality of life without the need for three dialysis visits weekly in the clinic. Therefore, we are very pleased to see CMS' implementation of the legislation that Congress enacted earlier this year, which we supported. Allowing both the home and dialysis facility to be originating sites for home dialysis patients' clinical assessment via telehealth will be beneficial for patients.

However, we ask that as technology advances over the years, that CMS obtain feedback from stakeholders on what works best for the patient and his/her physician. In addition, as this policy is being implemented, we want to make sure this benefit is not abused, for example through enticement of free at-home technologies, and that the Office of the Inspector General continues their oversight of the telemedicine benefit in Medicare.

2. **Evaluation and Management Office Visit Documentation and Payment Changes**

CMS proposes several changes to existing policy around Evaluation and Management codes. CMS proposes to consolidate payment for office visits from the current levels 2 through 5 of payment to a single payment each for new patients and established patients. Additionally, CMS proposes that the current level of documentation for a level 2, with some alternatives, would be sufficient for all payment. CMS would still require that the current CPT codes corresponding to the current levels and corresponding payment be reported; however only the single consolidated payment would be made.

CMS acknowledges that the practical effect of this twin policy will vary by specialty and practice, particularly where current level 4 and 5 constitute a large share of office visit payment, but asserts that the reduction in documentation burden will in part offset negative effects. To partially ameliorate the effect of the new single payment rate, CMS proposes additional "add-on" G-codes, each with their own additional documentation requirements, for certain primary care visits and for visits of "inherent complexity" which could be billed by certain, specifically identified specialties which tend to use the current level 4 and 5 codes, such as endocrinology, oncology, urology, and others, but not nephrology. CMS also proposes to modify its current "prolonged service" codes which require a one-hour threshold, to provide for an additional 30 minutes beyond the usual time required for an E/M code.

CMS' proposal to alleviate administrative burden is welcomed and we appreciate the effort to free up more time to devote to patients. We do, however, have concerns as to whether the net effect will be as positive as CMS suggests. First, while CMS would reduce auditable documentation requirements for Medicare claims, there is no assurance that other payers, including the many hundreds of MA plans, will follow suit. Accordingly, physician practices will still be faced with the burden of documentation for these plans. Even if other payers do come around to CMS' proposal, they will need time to change systems, modify provider agreements and educate beneficiaries on the changes they may see in coinsurance.

A second concern revolves around the proposed "add-on" codes. We recognize and appreciate CMS' intention of the potential disruptive effect on patient care and practice financial effects, however, with the additional modest additional payment for primary care, "inherent complexity" and "prolonged service" visits comes additional documentation and the add-on code results in only a small increase in reimbursement that is likely insufficient to account for the increased level of complexity and care burden.

A third concern revolves around the proposed "inherent complexity" code. Again, as noted above, we appreciate CMS' recognition of the additional resource costs that may apply in caring for patients with more complex conditions, whether acute or chronic. Currently in the proposed rule, CMS has listed specific specialties who may use this add-on code. We appreciate CMS' clarification on its August 22 Listening Session on the proposed rule that the code ***would not*** be limited to these specialties, but rather, they are being listed as examples. We believe that if CMS finalizes this policy, it is important that this be clarified in the Final Rule to ensure other specialists are able to use this code and that the regulation surrounding use are clearly delineated.

Overall, NKCA does not believe this policy aligns with, and could even disadvantage, care for individuals with chronic kidney disease as it decreases physician payment for the care of those exceptionally complex patients with advanced chronic kidney disease and kidney transplant. The entire medical system should be aligned to reduce the likelihood that these patients will need dialysis, and, in the case that dialysis is needed, to increase the likelihood of an orderly initiation of kidney replacement therapy; the current proposal adversely impacts this goal for the care of kidney patients. We encourage CMS to reconsider this policy to ensure there are no unintended consequences and to ensure that the care most valuable to patients and to the health care system, specifically preventing and delaying organ failure and its complications and costs, is promoted in any payment reform.

3. 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 Update Committee (RUC), but also from other public commenters on revised work and PE values.

We were pleased that in the CY 2017 PFS final rule, CMS recognized that the CPT codes related to home dialysis were misvalued. We were glad to see CMS reiterate its finding again last year and in this year's proposed rule that CPT codes 90963 through 90970 are misvalued, and recommend that CMS outline further how it plans to address the matter in a timely manner, including opportunities for stakeholder input.

In its November 2015 report entitled "End-Stage Renal Disease: Medicare Payment Refinements Could Promote Increased Use of Home Dialysis", 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

peritoneal dialysis 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.

4. **ESRD Facility Based Measurement Proposal**

In the proposal, CMS requests comment on the possibility of expanding facility-based measurement into ESRD facilities. Although we appreciate CMS looking for ways to provide flexibility in reporting and reducing reporting burden, we do not believe a facility-based measurement for clinicians practicing in dialysis facilities makes sense in current practice. The ESRD Quality Improvement Program (QIP) measures performance by dialysis facilities, not individual clinicians. While a Medical Director for a facility may be appropriately measured by the QIP, other nephrologists are not consistently present or a part of daily quality performance of the facility. Many nephrologists provide care in their own practices as well as multiple dialysis facilities. Additionally, other clinicians practicing in the dialysis facility as employees are not currently merit-based incentive payment system (MIPS) eligible clinicians including nurses, social workers and dieticians.

Based on these practice patterns, a dialysis facility's QIP performance cannot be attributed to an individual clinician and is not an appropriate measurement for nephrologists. We do, however, support further expansion and opportunities in current programs for nephrologists to participate in MIPS and Advanced Alternative Payment Models (AAPMs) through the Comprehensive ESRD Care (CEC) model.

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 Marty Corry at 202-580-7707 or info@nonprofitkidneycare.org.

Sincerely,

Martin Corry
Executive Director