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Nonprofit Kidney Care Alliance

September 2, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Re: CMS-1654-P: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model, July 15, 2016.

Dear Administrator Slavitt:

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/kidney care 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 end stage renal disease (ESRD) patients at more than 280 facilities 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, the onset of ESRD. As nonprofit providers, approximately 85 percent of our patients are covered by Medicare, including Medicare Advantage plans. Two of our members also have experience participating in a current Center for Medicare and Medicaid Innovation (CMMI) alternative payment model, the Comprehensive ESRD Care (CEC) model.

Comments Regarding Specific Aspects of the Medicare PFS Proposed Rule:

II. Provisions of the Proposed Rule

C. Medicare Telehealth Services

NKCA commends CMS for including additional ESRD services (CPT codes 90967-90970) on the telehealth list. Dialyzing at home allows more independence and better patient satisfaction with cost savings to Medicare. The proposed rule's addition of four codes to those which were added in the 2015 Final Rule helps reduce potential barriers to patients starting and continuing on home dialysis and enables them to stay in contact with their care providers at a distance. Many patients must travel long distances for their monthly visit. If a patient were able to have a portion of those

visits by telehealth, this would substantially decrease the burden on patients, as well as their families and caregivers, who would otherwise need to travel to a dialysis clinic to accompany them.

We are aware that a dialysis facility and a patient's home are both not authorized as originating sites for telehealth yet. We encourage CMS to work with Congress to make this important change. There are currently several bi-partisan pieces of legislation that include provisions which would designate the home or dialysis facility as the originating site. In addition, the Senate Finance Committee's Chronic Care Working Group has indicated an interest in the issue as well. We hope that CMS will be supportive of such legislative changes.

D. Potentially Misvalued Services Under the Physician Fee Schedule

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

We were pleased that CMS agrees with the Government Accountability Office (GAO)'s recommendation to review Medicare payment policies for physicians to manage the care of dialysis patients and revise them as appropriate 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.

It is good to see that CMS recognizes that home dialysis could be clinically appropriate for far more patients than are currently utilizing the modality, and that GAO specifically looked at Medicare payment issues that could change this pattern.

NKCA is supportive of CMS' proposal to identify CPT codes 90963 through 90970 as potentially misvalued codes, so that the agency can evaluate the physician services under these codes and adjust the Medicare payment as needed. In carrying out its review, we urge CMS 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, that 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 maximum extent possible.

E. Primary Care Management Services and Patient Centered Services

4. Reducing Administrative Burden and Improving Payment Accuracy for Chronic Care Management Services

Kidney disease (both chronic kidney disease and ESRD) is really the prime model of chronic illness. Several factors underscore this. First, both CKD and ESRD don't exist alone—they are accompanied by multiple co-morbidities, including diabetes, congestive heart failure, high blood pressure, etc. Secondly, kidney disease, including and especially ESRD, can exist over many years and is therefore the epitome of chronic illness that demands multimodal, highly coordinated care.

Many NKCA members have seen the benefit of improved care coordination with CKD and ESRD patients. Importantly, much of this care coordination can be accomplished through the work of health professionals other than physicians. Not only do we see a measurable clinical benefit, but we also anticipate that we'll see significant cost savings. Under CMS' current policy for billing under CPT code 99490, a patient must have two or more chronic conditions, among many other requirements. There must also be a comprehensive care plan in place. Importantly, CMS rules provide not only for non-physician professionals, such as nurse practitioners, to provide services directly, but also permit time spent by clinical staff, under general supervision, to provide chronic care management (CCM) services to count toward the current 20 minute/month limit. However, as CMS notes, 99490 has been underutilized, which seems to be a function of both the payment level and the burden of the requirements.

We commend CMS for proposing to recognize and reimburse for an additional two CPT codes for complex CCM, as well as to add an additional G code which can be added to the required initiating visit code when physician-patient face to face time is more extensive.

- CPT code 99487: Complex care management services, with described required elements, including 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month and;

- CPT code 99489: Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

Currently, our members utilize nurses, dietitians, and social workers to provide care coordination. Nephrologists and primary care providers are stretched thin in their daily schedules. Having clinical staff, depending on the situation, be able to serve in care management roles could greatly assist in improving the quality of patient care, as well as reduce cost.

Conclusion:

Thank you for the opportunity to comment on the Medicare Physician Fee Schedule Proposed Rule. The 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, these changes impact us 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