



January 31, 2022

Chiquita Brooks-LaSure, MPP
 Administrator
 Centers for Medicare & Medicaid Services
 Attention: CMS-3409-NC,
 P.O. Box 8010,
 Baltimore, MD 21244-8010

RE: Request for Information; Health and Safety Requirements for Transplant Programs,
 Organ Procurement Organizations, and End-Stage Renal Disease Facilities

Dear Administrator Brooks-LaSure:

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to ensure optimal care under the highest standards of medical practice for patients with kidney disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with kidney disease. Part of RPA's mission is to promote excellence in the delivery of high-quality kidney care within an environment that supports patient access to care and safety.

RPA is writing to offer responses to selected sections of the CMS RFI on Transplant Programs, Organ Procurement Organizations, and End-Stage Renal Disease Facilities, listed below:

- **Kidney Health and End-Stage Renal Disease Facilities**
- **Transition to Dialysis**
- **Home Dialysis**
- **Alternate Models of Care w/Staff Assisted Home Dialysis**
- **Nephrology Joint Ventures**

Kidney Health and End-Stage Renal Disease Facilities

Question: How can CMS increase the use of nutritional, lifestyle, and medical management interventions to improve health care and decrease progression of CKD?

RPA believes an expedient answer would be to enhance use of the kidney disease education (KDE) benefit currently existing in Medicare. It is profoundly underutilized, and while we acknowledge the legislatively created constraints on CMS' ability to modify the benefit, we urge the Agency to work with Congress to address these limitations, and to take all available administrative steps to expand its use. KDE is currently limited to persons with Stage 4 CKD, and by whatever means this should be expanded to be available to those patients with Stages 3B and 5 CKD. Further, targeted efforts to address better management of diabetes with albuminuria should occur. CMS should also consider allowing for a wider range of education options within KDE, such as virtual and/or asynchronous education (so that patients view a slide deck or take a quiz, and get responses later on), and promoting material that is tailored to the adult learner.

Additionally, the requirement to bill patients for the 20% copayment under Medicare is clearly a barrier to its increased use, in that it may erode a patient's willingness to participate in KDE, and that nephrology practices will often be disinclined to bill persons in already challenging economic circumstances for the balance. To the extent possible, CMS should explore establishing a financial incentive for individuals to seek this care, rather than it being a cost to the patient.

Finally, while RPA is reluctant to reflexively call for increased reimbursement for KDE services not only because of the self-serving appearance but also given the impact on Medicare Part B reimbursement more broadly due to budget neutrality and its impact on the conversion factor, we do believe that additional payment will obviously increase the incentive to provide these services. Physician practices are in fact small businesses, and if the opportunity to do well by doing good presents itself, they will take advantage of it. CMS is well aware of the high cost of late-stage CKD and ESRD care, in both a societal sense and fiscally for the Medicare trust fund, and RPA would posit that an incremental but meaningful increase in payment for the KDE service codes would be an investment well worth making in both regards.

Question: What are the barriers to access for routine and preventive health care? To what extent does low health literacy and cultural and attitudinal beliefs impact access to care?

While the policy prescriptions for addressing hurdles to routine and preventative health services are frequently complex, identification of the barriers themselves is not. These include:

- Lack of awareness of the availability of appropriate and accessible routine/preventative health care;
- Difficulties in obtaining transportation to these services;
- Uncertainty about the costs of these services;
- The lack of the financial means to pay whatever out-of-pocket costs are associated with this care;

- Possible duplication of services among multiple providers. Additionally, with any chronic illness time away from work for patients and family members, and associated fear of job loss, can limit an individual's willingness to get diagnosed and seek treatment.
- Lack of available health care providers in rural and/or impoverished areas;
- Difficulty in assuring the high level of coordination needed between providers, across settings of care (inpatient-outpatient), across specialties;
- Patients with limited ability to engage themselves or act as their own advocate when no one else is available.

Burdensome regulatory oversight is also a barrier. Recall that physician practices cannot even give nutritional supplements to kidney patients (absent meeting strict criteria) without running afoul of the Department of Justice (DOJ), the Office of Inspector General (OIG), or other oversight agencies. Recognizing that nutritional supplements may not be part of routine or preventative care, they are emblematic of physician practice wariness about what services can and cannot be provided to patients in a regulatorily compliant manner, and any practice taking a conservative approach to these issues will not provide the product or service.

Regarding low health literacy and kidney care, for less engaged patients on dialysis one of the most challenging problems is that they may occasionally miss treatments (and it is worth noting most of these individuals are receiving in-center dialysis, as home dialysis patients are engaged almost by definition). These missed treatments can lead to recurrent and unnecessary emergency room visits, hospitalizations, and other complications.

Finally, and beyond the treatment of kidney disease per se, the inability to sustain a primary care practice in underserved communities is a substantial barrier to the availability of routine and preventative care, as in many geographies there are literally no primary care practices in the urban environment. This adversely affects transitions of care and care coordination.

Question: How can we better educate patients about behaviors (such as diet and exercise) that may affect CKD progression? What is working? What is not working? How can pre-dialysis education and prevention programs be improved?

Increased resources should be made available with regard to diet and nutrition. These resources could be used to fund studies to determine the optimal diet(s) for CKD. Additionally, renal dieticians are a specialized group and in many situations are currently working for the large dialysis organizations (LDOs), which is positive given the reach of the LDOs but can limit the availability of the workforce for other dialysis organizations and nephrology practices. Exacerbating this situation is the low level of reimbursement under Medicare for these services; the CPT code with the highest value (97802, Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes), has a base payment unadjusted for geography of less than \$36. This is too low to allow small and mid-sized groups to hire nutritionists. Additionally, facilitating the use of virtual interactions and phone visits

would give people in smaller markets access to these specialists. RPA would also recommend that CMS encourage dietician involvement early on in the CKD journey and not just at the start of dialysis, to take every contributory step possible in delaying the onset of ESRD.

Question: How can we increase awareness of known racial, ethnic, gender, sexual orientation, and economic disparities in care for CKD?

Given the disproportionate representation of kidney disease in communities of color as well as among other disadvantaged populations, it is vitally important to address issues of disparities in healthcare delivery, and RPA commends CMS for soliciting input in this area. Broadly, and acknowledging that this issue is outside of the Agency's purview, the absence of universal broadband and internet access otherwise is a severely limiting component of raising awareness on all of the disparities listed. To the extent that CMS can exert influence on efforts to expand internet availability for communities with challenges accessing the internet, it should do so to improve population health in these communities. Further, expanding diversity in medical schools and training programs particularly in nephrology to increase trust and awareness of health care system can only help but raise awareness with regard to health care disparities.

More specific to the treatment of kidney disease and promoting the health of persons with kidney disease, elimination of the race-based estimated glomerular filtration rate (eGFR) for transplant determination through the transplant networks and establishing a requirement for race neutral reporting for labs that serve Medicare patients are concrete steps that could be taken to address disparities in the treatment of CKD.

Question: How can primary care providers (PCPs) better support their patients in prevention and slowing progression of CKD? What can be done to increase screening of at-risk individuals and how can we ensure that PCPs provide timely referrals to nephrologists for individuals with poor or declining kidney function?

RPA has long recognized the opportunity for improvement in patient care through the enhanced collaboration between primary care physicians (PCP) and nephrologists, and the use of care coordination teams. We believe that the importance of effective communication between PCP and nephrologist cannot be overemphasized in that successful care coordination as well as the potential for prevention of complications of comorbid disease hinge upon such dialogue. Toward this end, in 2009 RPA launched the Improved Identification and Co-Management of Advanced CKD Patients project in Philadelphia and Chicago.

While the research may be dated, the lessons learned are not. The pilot project focused on two nephrology practices and their eight referring primary care practices. During the pilot project, select tools from RPA's Advanced CKD Patient Management Toolkit (<https://www.renalmd.org/page/CKDToolkit>) were modified for use by PCPs in collaboration with nephrologists. These tools were utilized in an effort to achieve better patient outcomes

through improved identification, communication, and co-management. The selected tools were the: (1) CKD Screening Protocol and Recommendation on When to Refer to Nephrologist; (2) CKD Identification and Action Plan Tool; (3) Referring Clinician Fax Back Form; (4) CKD Post-Consult Letter (5) Concise Guidelines; (6) CKD Chart Flag; and (7) CKD Patient Diary.

In the course of the project, use of the toolkit was associated with:

- Enhanced awareness and identification of CKD as compared with practices prior to completion of the study;
- Increased and enhanced communication between the practices among PCPs, nephrologists, and respective staff;
- Improved co-management practices between PCP and nephrology practices;
- Increased awareness, through the project process and the use of toolkit materials, of recommended clinical guidelines, with resulting changes in care and referral patterns; and
- Individual variations in office practice, acceptance, modification, and use of communication tools, including barriers to optimal tool use.

The changes reported by the PCPs, nephrologists, and their respective site champions were directly relevant to the project goals of improving communication between PCPs and nephrologists, improving the referral process, improving co-management and CKD patient care, and enhanced satisfaction of all parties. The process of project participation heightened the awareness of participating PCPs and PCP site champions in their role in the identification and early management of CKD. After the final interviews, virtually all of the participating PCPs noted increased awareness of the risk factors for kidney disease, discussing tracking patients with previous kidney disease, diabetes, hypertensive, lipid disorders, and/or rising creatinine levels. The findings, which were published in the American Journal of Kidney Disease in 2014¹ speak to the utility of such a toolkit for empowering PCPs caring for patients with early CKD or its risk factors. To our knowledge it is still the only field-tested tool for identifying and comanaging advanced CKD patients.

Further, we would reiterate that the problem is not necessarily timely referral but rather lack of primary care. Many individuals with fewer socioeconomic resources do not seek or have access to primary care but instead get care intermittently via emergency departments (EDs). CMS may want to consider establishing a requirement that when a patient with CKD Stage 3 or higher is seen in an ED that as part of their discharge they need to be set up to see primary care and nephrology – and Medicare should also consider paying for transportation to those initial appointments, and even paying the patients or creating some other financial incentive for keeping that initial visit. The “reward” of accessing care is not enough for those who do not

¹ Haley WE, Beckrich AL, Sayre J, McNeil R, Fumo P, Rao VM, Lerma EV. Improving Care Coordination Between Nephrology and Primary Care: A Quality Improvement Initiative Using the Renal Physicians Association Toolkit. Am J Kidney Dis. 2015 Jan;65(1):67-79. doi: 10.1053/j.ajkd.2014.06.031. Epub 2014 Aug 30. PMID: 25183380.

already seek that care, and we believe the funds spent on transportation and incentives for keeping primary care appointments would be an investment that would pay dividends in delayed progression of CKD. Finally, we would recommend that education efforts about the importance of updated standards of diabetic care including SGLT2i drugs (a class of medications used to treat type 2 diabetes) that have the potential to significantly enhance the treatment of diabetes in CKD patients be prioritized and pursued.

Question: How can we improve health literacy among the general population, and individuals at higher risk about the prevention of CKD?

Given societal concerns about the diversity of the health care provider workforce generally and the primary care physician population specifically, it is imperative to address this issue as without access to trusted individuals there will be no ability to penetrate the hearts and minds of the vulnerable. Also, CMS should consider the development of compelling social media campaigns that can have a lasting impact on populations at risk.

As noted in responses to earlier questions, substantial enhancement in the design, implementation, and use of the KDE benefit would be a worthy investment toward improving health literacy around CKD. It is self-evident that the KDE benefit is an existing structure created by CMS that has the explicit purpose of providing education to relevant populations about kidney disease; RPA strongly recommends that CMS take the simplest path forward and take every necessary measure to advance KDE. Specific steps in this effort could include increased reimbursement and elimination of patient copayments for the services, and exploration of processes for providing patients with transportation to KDE services.

Question: How can individuals facing complete kidney failure be informed and empowered to make choices about their care?

In addition to greater access to KDE, facilitated pathways to nephrology care that incorporate the use of health care navigators and which utilize standardized shared decision-making tools that are validated, freely available, and culturally appropriate would greatly advance the involvement and empowerment of persons with kidney conditions in their care.

Transition to Dialysis

Question: To improve long-term outcomes and quality of life, how can we support and promote transplantation prior to the need for dialysis (preemptive transplantation)?

First, improved and comprehensive KDE that is used more widely will advance preemptive transplantation. Second, CMS should consider exploring avenues for reimbursing for improved oral health. This is especially true for minority patient populations in that similar to how disproportionately patients of color are affected by kidney disease, these persons are also more likely to have periodontal disease and cavities which impact CKD and often confound transplant

care. Further, allocation of additional financial resources to reimburse for: (1) transportation to transplant counseling and other associated activities such as tests and evaluations; (2) caregivers to take time off work to support the patient; (3) peer mentors - especially Black and Hispanic ones - to talk to their communities about the benefits of transplant, would all likely contribute to increased use of preemptive transplantation.

Once the transplant process has started, an easier and faster process in transplant centers for accepting a referral and identifying potential living donor must be standardized and implemented. Currently, it takes a long time to get a patient evaluated and then subsequently to determine if they have a living donor. Additionally, use of incentives (either financial, as a quality measure, or both) for nephrologists who successfully guide a patient to preemptive transplant as established in the ESRD Treatment Choices (ETC) mandatory kidney payment model would compel referring nephrologists to actively monitor the progress of an individual referred for transplant. CMS should also evaluate the barriers to a smooth and swift transplant evaluation process as well as review the barriers to living donation, particularly for those patients who might be clinically eligible for a pre-emptive transplant but not yet on Medicare.

Question: For people beginning dialysis, how can CMS support a safe transition?

Supporting efforts towards an optimal beginning of a patient's dialysis journey would be a major step in supporting safe transitions. A key component of this is ensuring patients have access to surgical and interventional care for fistula or peritoneal dialysis (PD) catheter placement. There are three major barriers to progress in this area: 1) the large number of patients who do not have prior nephrology care (which may be addressed if the previously referenced elements such as education and engagement are improved); 2) the lack of surgeons/interventionalists specialized in dialysis access (while this is difficult to address, ensuring adequate payment/incentive for this work is certainly important); and 3) the limited access to operating rooms and interventional radiology suites (which can be improved by promoting development of limited focus ambulatory surgical centers—ASCs—or office-based labs—OBLs—providing dialysis access care outside the hospital).

These latter two barriers are critically important to address. Sufficient reimbursement for dialysis access in non-hospital settings is essential so that nephrology practices can operate these centers – particularly ASCs where full-service access care can be done. Both ASCs and OBLs need improved and stabilized reimbursement so providers will risk opening (not closing) these centers. Hospitals do not have capacity to provide dialysis access services and indeed the pandemic has shown that this care is disrupted much more by those unrelated issues in hospital settings. Further, because it will not be possible to have enough full-service ASC's and trained surgeons to be locally available for everyone, reimbursement should be provided for patient transportation and lodging to have access placed in regional centers where processes can be put in place to see a new patient consult and perform surgery in a single visit spanning 2 days.

Like other aspects referenced in our comments, RPA believes this would represent a prudent investment that in many if not most cases will turn out to be a financial savings longitudinally.

RPA would also recommend consideration of more flexibility around non-typical modalities such as incremental dialysis, respite care, self-care, and other hybrid dialysis modalities between in-center and home. Current regulations set forth in the ESRD Facilities Conditions for Coverage (CFCs) and elsewhere are rigid to the degree that innovative solutions are dismissed due to absence of reimbursement and concerns about non-compliance. Recognizing the Agency's fiduciary responsibility to the Medicare Trust Fund, CMS should encourage creative solutions that can improve the dialysis patient experience and potentially save money.

Question: Are there concerns regarding the location or quality of care of the transitional care units?

RPA has not identified specific concerns about the quality of care provided in transitional care units (TCUs), it is our understanding that they are subject to the regulatory oversight structure set forth in the ESRD facility CFCs so that quality of care would be monitored through those processes. Regarding location concerns, CMS should consider efforts to promote their use in underserved areas, and availability in rural areas of services unique to TCUs could be provided virtually via telehealth technology.

Question: How can these care transitions be equitably provided?

As noted above, ensuring TCU availability in areas where it might otherwise be easily accessed would represent progress in ensuring that the care transitions are equitably provided. CMS may want to consider facilitating these efforts by aggregating ICD-10 Z code data that provides information on social determinants of health to identify areas where availability of TCUs could be improved, in addition to exploring other ways that equity can be ensured in care transitions.

Home Dialysis

Question: What are patient barriers to dialysis modality choice? How can we overcome barriers to ensure patients understand their options and have the freedom to choose their treatment modality?

Once again, greater and more comprehensive use of KDE are a pathway to promote patient modality choice, and enhanced patient understanding and freedom of choice regarding dialysis modalities. RPA believes that making KDE available at CKD Stage 3B would with descriptions of modality options would foster not only the uptake of home therapies but also awareness of the potential for preemptive transplant and conservative care.

CMS could also promote home dialysis by working with Congress to advance the use of staff-assisted home dialysis. Often a patient's home circumstances are themselves a barrier to choosing home dialysis, and trained staff with expertise in home dialysis may be able to help alleviate concerns emanating from the home situation. As previously noted, greater regulatory flexibility pertaining to options such as respite care and self-care would also likely eliminate barriers to home dialysis.

Question: What are reasons for differing rates of home dialysis by race/ethnicity? How can we address any barriers in access to home dialysis to improve equity in access to home dialysis?

Inconsistent pre-dialysis care and education, sometimes challenging home situations, lack of incentive to engage, and lack of trust in health care broadly all contribute to the differing rates of home dialysis by race and ethnicity. Education and publicity within these communities outside of the health care setting about the benefits of home dialysis (targeted to that race/ethnicity group and presented whenever possible by professional staff of the specific underrepresented minority) would help open minds to home therapy. This is another situation where waiver of the patient co-payment for KDE would be of benefit, and where exploring innovative use of ICD-10 Z code data could improve equity in access to home dialysis.

Question: With regard to home dialysis, how can CMS ensure adequate safety standards such as appropriate infection control behaviors and techniques are enforced?

Application of existing structures from the CFCs such as establishing a requirement that a local nephrologist medical director must oversee all home therapy programs would enhance compliance with safety standards, essentially extending the CFC safeguards already in-center hemodialysis programs. Additionally, periodic demonstration of patient/caregiver competency in the use of the preferred home dialysis technology should be required.

Question: What can CMS do to increase availability and use of home support resources with regard to home dialysis as described in 42 CFR 494.100(a)((3)(iv)? Given the increase in home dialysis patients, is there a need to revise the current standards § 494.100, including but not limited to updating and revising training and care delivery requirements?

While RPA is wary of continually suggesting increased reimbursement for whatever service or modality is the topic of a specific CMS question, we will take this opportunity to point out that the home dialysis training payment of \$500 for CPT code 90989 has not changed since it was created over 25 years ago. We recognize that this is a legislatively determined payment amount that is not based on relative value units (RVUs) and as such CMS may be constrained in what steps it can take to increase that payment. However, if that reimbursement level had been adjusted for inflation over that time period, it would be substantially higher than it is currently,

and thus would be provide the crucial support for expanding resources needed by nephrology practices to refine and increase their home dialysis training activities.

Question: If more patients choose home dialysis, would there be systems and infrastructure in place to support this? Were more patients to choose home dialysis, what other supports, systems or infrastructure might be necessary?

This is an appropriate question to ask given the challenges in maintaining the health care workforce in the present environment both generally and in kidney care. The current systems and infrastructure would likely be capable of supporting care to an expanded home dialysis patient population, and if sufficient emphasis on and regulatory change affecting home dialysis were put in place, RPA believes the workforce would grow to meet the need. Payment for staff-assisted care, permanent reimbursement for home care via telehealth, home nursing payment for the ESRD patient (coverage for home health for all home dialysis patients) would all promote increased use of home dialysis.

Question: To what degree does telehealth and remote monitoring technology impact decisions of home dialysis use? Would allowing physicians to leverage evolving telehealth and remote monitoring technology for their patients increase the selection of and uptake of home dialysis as a modality? What are best practices in this area that would facilitate the delivery of safe and quality care?

It is RPA's sense that the decision and choice of modality is not influenced by the availability of telehealth except perhaps in very remote locations. That said, maintaining the ability to use telehealth is important for times and circumstances that preclude a patient-nephrologist face-to-face interaction. RPA believes that the "telehealth at patient home site" is definitely not equivalent to a face-to-face visit and continues to support the need for a quarterly face-to-face visit. Further, telehealth interactions should not replace the services provided by a local nephrologist as that will fragment care when patient becomes acutely ill. Telehealth using actual telehealth technology that can facilitate a physical exam and a medically trained telepresenter at the patient's location is needed in order to simulate, to the extent possible, the face-to-face visit.

Alternate Models of Care Questions w/Staff Assisted Home Dialysis

Question: Should there be two sets of guidelines for staff-assisted home dialysis in residential homes and staff-assisted home dialysis in alternative settings; and if so, how should they differ?

No, RPA does not believe there should be different sets of guidelines for staff-assisted dialysis in residential homes versus alternative settings. Adhering to one set of guidelines would help ensure that the services delivered from a patient care and safety perspective are of the highest

possible quality, consistent, and reliable. If staff is assisting in providing home dialysis that means by definition that the patient, family member or other caregiver is not trained to perform dialysis independently. Hence, the staff person should be continuously present and in alternative settings there should be a reasonable ratio of staff/patients so that a staff member would be able to oversee dialysis for multiple patients simultaneously.

Nephrology Joint Ventures

Question: Would it be helpful for CMS to collect information on joint venture arrangements as part of Medicare enrollment in order to support analysis of the impact of these arrangements on the quality of care furnished to Medicare beneficiaries?

RPA's general sense is that joint venture (JV) ownership improves quality of care – or at minimum is neutral to outcomes. We believe robust data collection and careful statistical analysis would demonstrate physician ownership to be a positive for quality outcomes. It is our understanding at least anecdotally that several participating entities in the ESRD Seamless Care Organizations (ESCO) demonstration found that their JV's had fewer missed treatments (and hospitalizations) than non-JV clinics. However, we are concerned that such data collection would be an exceptional administrative burden to both the JV participants (nephrologists and dialysis organizations) and to CMS, with limited actionable findings. At a time of resource constraints in the kidney care community (and we presume at CMS), we are concerned that information collection efforts would be challenging and of finite benefit.

Question: Should a dialysis facility or nephrologist be required to disclose information on joint venture arrangements to patients for improved transparency?

RPA fully supports transparency with regard to nephrologist participation in dialysis facility joint venture relationships, and disclosure of the fact that the facility is part of a joint venture as well as the names of all of the owners of a facility including nephrologists is perfectly reasonable and should be done openly. Improved transparency would be beneficial before enrollment in a facility for the purpose of full transparency and informed choice by the patient.

Question: Do joint ventures between nephrologists and dialysis facilities have an impact on resource use, patient care, and/or choice of modality? If so, please describe how joint venture arrangements affect resource use, patient care, or choice of modality.

Joint ventures align nephrologists' interests with providing value to patients and payers – improving quality at optimal cost. JV nephrologists are more likely to ensure expensive options in a dialysis treatment are implemented in an evidence-based manner. These nephrologists are also more likely to take an active role in advocating for patients in facility operational matters and establishing processes to ensure that comprehensive care (such as education regarding home modalities and outpatient vascular access care) is provided. We are not aware of data

suggesting JV affects dialysis modality choice although certainly quality measures and programs such as ETC drive modality choice more directly than does dialysis ownership, in our view. Finally, we are not aware of evidence-based data on JV impact on transplantation rates but again involving the nephrologist in dialysis ownership ensures that a physician advocating for the patient has a voice at the table to keep referral/waitlisting/transplantation as priorities.

Finally, we believe the nephrologist should be at the center of efforts to improve outcomes and lower health care costs, and we appreciate that CMS has acknowledged the benefit of having nephrologists share a financial stake in care of ESRD patients via its promulgation of various kidney payment demonstration projects. Data from the ESCO, Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC) projects will likely be transferable to dialysis facility JVs in that the principle is the same: giving the patient's nephrologist incentive to drive outcomes results in optimal and cost-effective kidney care. When the nephrologist has financial incentive to provide value (whether through accepting risk or quality outcome incentive payments), patient care improves. Despite significant program flaws, the ESCO's were a good initial attempt at involving nephrologists in outcome/risk management, and overall demonstrated improved quality at lower cost. CMMI's KCF and CKCC are advanced, next generation programs that again focus on the nephrologist in a key role with opportunity for financial benefit. This has led to a myriad of other players now in the market forming JVs and otherwise sharing risk and financial benefit with nephrologists to significantly lower health care costs and improve quality. The value a nephrologist brings to these models/entities is equal in importance to the value he/she brings to dialysis facilities. When the nephrologist has opportunity to influence governance and operations through a financial stake, patients benefit.

Summary

RPA commends CMS for issuing this RFI. Soliciting input on kidney care in the U.S. in a holistic, 'across-the-waterfront' manner represents important progress in the effort to improve CKD care, increase transplantation rates, delay the onset of dialysis where possible, and enhance the delivery of dialysis services when necessary. As always, we welcome the opportunity to work collaboratively with CMS in its efforts to improve the quality of care provided to the nation's kidney patients, and we stand ready as a resource to CMS in its future work in this area. Any questions or comments regarding this correspondence should be directed to RPA's Director of Public Policy, Rob Blaser, at 301-468-3515, or by email at rblaser@renalmd.org.

Sincerely,



Timothy A. Pflederer, MD FASN FASDIN
RPA President

