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December 9, 2019

Amy Bassano

Acting Director, Center for Medicare and Medicaid Innovation

WB-06-05

7500 Security Boulevard

Baltimore, MD 21244-8013

Dear Ms. Bassano:

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.

We are writing to provide input on the Kidney Care First (KCF) provisions in the Request for Applications (RFA) disseminated by CMS on October 24. In late October RPA conducted a careful review of the RFA and developed a list of questions for nephrology practices to consider before deciding whether to participate in the KCF. We shared some of our concerns with your team on a call on November 5.

Broadly, RPA has significant concern that this model may exclude small and medium size practices; and that it may lead to financial loss for those practices who do qualify to participate. Our comments below reflect the issues we urged our membership to consider before deciding whether to participate in the KCF.

These suggestions are offered in the spirit of seeking to help the KCF model succeed. As you know, RPA has a deep and long-term interest in kidney disease payment models, most recently exemplified by our successful development of an ESRD Clinical Episode Payment Model that was the only payment model recommended for implementation (rather than testing) by the Physician-Focused Payment Model Technical Advisory Committee (PTAC). In developing our model, we sought to make it accessible to as many nephrology practices as possible (by for example not imposing minimum numbers of assigned patients), and to minimize regulatory requirements (like required numbers of interactions as included in the CKD component of the KCF model). Recognizing that CMS will need to have some guardrails in place for a payment model available across kidney care, RPA believes that proposals that limit nephrology practice participation and necessitate superfluous administrative infrastructure stifle the development of innovative, local solutions to kidney care delivery concerns.

Patient Composition: RPA is concerned that for many small and even medium-sized nephrology practices, their census of patients will not be sufficient to support the minimum requirement of 500 late stage CKD and 200 ESRD aligned Medicare beneficiaries necessary to participate in the model. It is our understanding that the average nephrology practice size is between 5-8 full-time equivalent (FTE) nephrologists, and we estimate that these minimum requirements will necessitate the participation of 15-20 FTE nephrologists in order to achieve the thresholds. Our stance accounts for the categories of patients excluded from the minimum number, and the impending policy change allowing ESRD patients to enter Medicare Advantage (and thus being excluded from participation) in 2021. Thus, we believe that participation in the model will be adversely affected by the CKD and ESRD patient minimums, and small and medium-sized practices (and most nephrology practices overall) will be excluded.

Overlap with ACOs: The RFA states that “Overlap with other ACO models, including the CEC Model, will be allowed during the Implementation Period (2020), but under the terms of the KCF Participation Agreement, KCF Option participants will be precluded from participating in these other ACO models during PY1 and future years of the Model.” RPA would offer that given the degree to which nephrology practices already participate in other ACOs, the mutual exclusivity between the KCF and other ACOs will significantly limit participation of nephrology practices in the KCF. Alternatively, RPA would urge CMMI to permit alignment with either KCF or CKCC to take precedence over alignment with an ACO. We believe that beneficiaries with renal disease should have the opportunity to receive care within a model focused on renal disease.

CKD Patient Encounters: RPA believes that the requirement for the practice to have at least two interactions with 500 CKD patients every six months will substantially compromise the ability of nephrology practices to satisfy the 500-patient minimum.

AMCP Payment: RPA strongly believes that CMMI is underestimating the impact of the de facto 25% reduction in payment for practices that typically see their ESRD patients four times monthly (the four visit MCP code, CPT code 90960, represents about 70% of all Medicare MCP claims), even given some of the other beneficial features of the payment model (such as the transplant bonus and the presumed designation as an advanced alternate payment model—AAPM). This is a substantial payment reduction for nephrologist’s care of these very complex patients who will require significant regular attention from the physician, care navigators and others to provide high quality care that prevents complications and hospitalizations.

The practical effect of the 25% reimbursement reduction is that participating practices will experience an upfront pay cut (or withhold) that can be earned back only if the practices are successful with regard to the performance-based adjustment, transplantation, and, several years into the future, being designated as an AAPM. Our conservative, back-of-the-envelope estimate based on the approximate \$46 dollar reduction in the MCP (using the 2019 relative value units—RVUs—and conversion factor), the rough minimum number of nephrologists necessary to participate (15), and the average number MCP patients per nephrologist (80), is that this reduction over twelve months would be in excess of \$660,000 for practices that typically achieve patient-nephrologist interactions four times monthly. It is important to bear in mind that most nephrology practices are for all intents and purposes small businesses, and many of those practices will not be able to operate their small businesses with compromised or negative cash flow.

AMCP Visits: RPA has multiple concerns with CMS' assertions relating to the relationship between the number of nephrologist-patient interactions in a month and beneficiary outcomes. While CMS does cite a single study in the RFA for these assertions, RPA does not think that this lone study accounts for patient experience, as we steadfastly believe that dialysis patients want to see their nephrologists multiple times in a month. Further, we believe that additional interactions allow the nephrologists to identify and address changes in the patient's condition that wouldn't be identified otherwise. And while RPA appreciates that CMS is seeking to reduce nephrologists' burden in eliminating visit requirements in the KCF, we don't think it would be workable in practice, as other payment systems will still require multiple visits, and nephrologists are unlikely to skip their interactions with KCF patients when they are in the facility to see other dialysis patients.

CKD QCP Payment: For late stage CKD patients, RPA simply is not convinced that the quarterly capitated payment (QCP) for that care (approximately \$240 quarterly/\$80 monthly) will account for the staff and other expenses associated with effectively and appropriately providing those services. In contrast to estimating the impact of the payment reduction for the AMCP (which is straight forward based on existing RVUs and knowledge of existing nephrology practice), it is difficult if not impossible to determine the potential financial upside of the CKD QCP. As a result, nephrology practices have to determine whether the readily quantifiable payment cuts of the AMCP are worth the less quantifiable positive payment impacts of the CKD QCP.

Additionally, we think CMS is not appropriately accounting for the burden or complexities associated with nephrology practices submitting claims for E&M services (for data collection and quality purposes) that will not be reimbursed. Many practices use RVUs as a measure of productivity for their nephrologists, and we are concerned that introduction of the concept of non-reimbursed RVUs will compel practices to maintain either a parallel bookkeeping system or some other administrative process to account for both reimbursed and non-reimbursed RVUs. Further, in many cases this will necessitate assigning and/or hiring clinically trained staff to administer whatever process the practice utilizes to correctly differentiate between reimbursable services captured by the CKD QCP and non-reimbursed E&M services. Acknowledging CMS' desire for the E&M information for data collection and quality purposes, RPA believes the Agency hasn't taken into account how submitting these claims will unnecessarily complicate practice workflows and efforts to determine productivity within a practice.

Quality Strategy: RPA strongly urges CMS to reconsider the measures proposed to be used as part of the Quality Gateway. Our understanding is that there are few if any nephrology practices with familiarity with patient activation scores, and we believe in the strongest possible terms that evaluating nephrologists on depression remission is illogical and unreasonable. Further, beyond the appropriateness of the measures, neither patient activation nor depression remission is typically part of a nephrology practice's workflow, and thus creating an expectation that a practice will have the capacity to absorb the administrative overhead necessary to capture atypical quality measures is unnecessary and unfair. There are other CKD physician performance measures for which data can be captured that will impact quality of care and patient outcomes. RPA would be happy to work with CMMI to determine an appropriate measurement set.

As always, RPA welcomes 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 CMMI in its future work on innovative care delivery models in kidney disease care. 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,

A handwritten signature in black ink, reading "Jeffrey A. Perlmutter" with a stylized flourish at the end.

Jeffrey A. Perlmutter, MD
President