



September 10, 2018

Seema Verma, MPH  
Administrator  
Centers for Medicare and Medicaid Services  
Attention: CMS-1691-P  
P.O. Box 8016  
Baltimore, MD 21244-8013

RE: CMS-1691-P: Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Disease Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Payment Program, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) and Fee Schedule Amounts, and Technical Amendments to Correct Existing Regulations Related to the CBP for Certain DMEPOS

Dear Administrator Verma:

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 comments on the 2019 ESRD PPS/QIP Proposed Rule. Our comments will focus discuss the following issues:

- Solicitation of Information on Transplant and Modality Requirements
- Pediatric Case Mix Adjuster
- Use of Transplant Measures in the QIP

### **Solicitation for Information on Transplant and Modality Requirements**

In the proposed rule, CMS outlines the requirements included in the PPS that are intended to promote transplantation and home dialysis and seeks comment on methodological ways to facilitate the advancement of transplant and home modalities in the PPS. RPA is encouraged by CMS' focus on these areas, and would note that with regard to transplantation, we concur with the Agency that a predominant barrier to increasing the rate of transplantation in the U.S is the rising number of people waiting for healthy donor kidneys which far exceeds the number of available organs.

On the issue of home dialysis, RPA believes that a major reason for the sub-optimal utilization of home therapies is the insufficient commitment to implementation of the Medicare Kidney

Disease Education (KDE) benefit, which presumably is one of the primary policy levers through which CMS can advance the use of all modalities, particularly home dialysis. RPA believes that there are several barriers to the policy that limit its wider use, and while we recognize that the Agency's implementation is somewhat limited by statute, we urge CMS to be assertive in what it can address. These include: (1) the limitation of the benefit to Stage 4 chronic kidney disease (CKD) patients, excluding Stage 5 patients (while a strict interpretation of the underlying law does limit the benefit to Stage 4 patients, we believe that if CMS pursued expansion of the benefit, it would not be opposed by Congress); (2) the inadequate payment rate for providing the services (since the KDE benefit is paid through a G-code, CMS could administratively increase the payment level for these services); (3) the administrative burden of providing the KDE services in a compliant manner; and (4) the coinsurance payment that providers of the service are legally required to collect from patients (since if the KDE benefit were considered a preventative benefit in Medicare, collection of coinsurance amounts would not be required).

**RPA urges CMS to petition Congress to allow coverage of the KDE benefit for CKD Stage 5 patients, to administratively address the payment rate insufficiency and regulatory burden of providing the KDE services, and to seek to have the KDE benefit deemed a preventive service in Medicare so that collection of coinsurance payments from Medicare beneficiaries receiving the services would not be required.**

Our concern about conflicting messages emanates from CMS including this solicitation in the proposed rule, and the release of draft local coverage determinations (LCDs) by Medicare Administrative Contractors (MACs) nationwide that would place limits on the frequency of dialysis in a manner that we believe would have a disproportionately negative effect on home dialysis. RPA fully and completely supports both CMS and the MACs carrying out their fiduciary responsibilities as stewards of Medicare funding. However, the CMS Central office expressing concern about the lack of progress in the use of home dialysis therapies while Medicare contractors propose policies that will clearly have a chilling effect on the prescription of home therapies is at best contradictory.

**RPA would therefore urge CMS to develop coordinated policies in conjunction with the MACs that will promote rather than interfere with the prescription of home dialysis.**

### **Pediatric Case Mix Adjuster**

RPA supports comments submitted by our colleagues at the American Society of Pediatric Nephrology (ASPN) relevant to the pediatric case mix adjuster in the PPS and the potential undervaluation of pediatric ESRD supplies and services. Acknowledging that that CMS can only work with the data reported by facilities, we urge the Agency to account for the discrepancy between actual costs of pediatric dialysis care and the data reported to the agency that is outlined in a cost comparison provided by ASPN as part of their comments. RPA seconds the comments submitted by ASPN which note that:

*Without accurate and appropriate reimbursement, pediatric facilities with the expertise to care best for this unique and complicated patient population, as well as pediatric*

*ESRD patients and their families, face an uncertain future. We believe that inadequate reimbursement will lead inevitably to more limited access of pediatric dialysis patients to specialized facilities with personnel trained to care for their unique needs. The result will likely be worse health outcomes for children with ESRD, with the potential for higher costs of care when these children become adults.*

**RPA urges CMS to work with the American Society of Pediatric Nephrology to address shortcomings in the Medicare dialysis facility cost report process affecting pediatric dialysis facilities to ensure that an equitable and appropriate prospective payment is provided for the services provided in pediatric facilities.**

### **Use of Transplant Measures in the QIP**

RPA believes quality measures should be applied as specified, and that just as measures that are developed for use at the facility level should not be applied to physicians, measures that are more appropriate for nephrologists should be not applied to dialysis facilities. To do so undermines the intent of the measures and heightens the possibility of calculation and attribution errors.

Accordingly, RPA urges CMS to not use measures that more appropriately evaluate physician behavior, such as transplant referral measures, in the QIP. Implementing measures in the QIP for metrics that are not actionable by the facilities is unnecessarily burdensome and of questionable benefit. Instead, RPA urges CMS to work with Kidney Care Partners (KCP) and other stakeholder organizations in the dialysis provider community to develop transplant measures that are actionable by facilities and which would better support the Meaningful Measures Initiative priority area of increased focus on effective communication and coordination.

**RPA urges CMS to work with the dialysis provider community to develop measures in the area of transplantation for use in the QIP to evaluate activities that are actionable by the dialysis facility, and not for activities that are predominantly in the domain of nephrologists.**

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 CMS in its future work on the Medicare Fee Schedule and the Quality Payment Program. 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](mailto:rblaser@renalmd.org).

Sincerely,



Michael D. Shapiro, MD, MBA, FACP, CPE  
RPA President