September 5, 2018

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8013

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

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 Medicare Fee Schedule Proposed Rule.

Our comments focus on the following areas:

- **Expanding Access to Home Dialysis Therapy Via Telehealth**
- **Proposed Implementation Date of Evaluation and Management Visit Policies**
- **CMS' Proposal for Use of Evaluation and Management Service Complexity Adjuster**
- **Impact of Evaluation and Management Visit Policies on Chronic Kidney Disease Care**
- **Interoperability in Medicare**

The following issues proposed as part of the Quality Payment Program will be addressed:

- **MIPS Quality Measures**
- **Improvement Activities**
- **Promoting Interoperability**
- **QCDRs**
- **Use of QIP Measures for AKI Patients**
- **Expanding QIP Facility-Based Measurement from ESRD settings to the QPP**

Fee Schedule Comments

Expanding Access to Home Dialysis Therapy Via Telehealth

RPA commends CMS for its straightforward interpretation of the provisions of the Balanced Budget Act of 2018 pertaining to home dialysis and telehealth. We believe that allowing the patient's home and the dialysis facility to serve as originating sites for home dialysis telehealth services, and to allow the use of telehealth technology in two months of a consecutive three-month period in the provision of the monthly face-to-face visit (after an initial three-month period), all without geographic restrictions, is a major step forward in the use of home dialysis modalities. This change will facilitate the care of patients facing transportation challenges, whether caused by long distances or transportation availability.

RPA does urge CMS to take a broad view with regard to the allowable interactive telehealth technology platforms to be used from the patient's home. Allowing patients to use their mobile tablet or hand-held devices to interact with their nephrologist during the monthly face-to-face interactions occurring via telehealth would eliminate possible unnecessary regulatory barriers to the promotion of home dialysis. If development of a waiver process is necessary to address confidentiality concerns as they relate to protected health information**, RPA urges the Agency to create such a waiver addressing interactive technology used in the patient's home in underlying sub-regulatory guidance.**

Proposed Implementation Date of Evaluation and Management Visit Policies

In the proposed rule, CMS specifically seeks comment on whether a delayed implementation date, such as January 1, 2020, would be appropriate for the Agency's proposals. RPA appreciates CMS' forethought in soliciting input on this issue, and for noting that such a change would be difficult to implement in a limited timeframe given the need to educate practitioners and their staff, transition clinical workflows, revise electronic health record (EHR) templates, and update institutional processes and policies, among other necessary preparations. Further, a delay would offer the opportunity to revise relevant CPT and associated documentation guideline related definitions integral to such a change, and to coordinate the revisions with non-governmental payers.

Accordingly, RPA strongly urges CMS to delay implementation until at least January 1, 2020 and would go even further by echoing comments from the American College of Physicians (ACP) to not establish in rulemaking a regulatory deadline for implementing such a change. Rather, we believe that CMS in coordination with the AMA CPT Editorial Panel should take the time to develop a process and structure that optimally achieves the regulatory relief goals in the area of documentation guidelines while accounting for the concerns of nephrologists and other physicians regarding the revision of the E&M payment levels.

> **RPA strongly urges CMS to delay implementation of the E&M visit policies until January 1, 2020 or later, and consider the possibility of not setting a date for implementation in rulemaking until revisions required in the process and structure necessary for smooth implementation have been completed**.

CMS' Proposal for Use of Evaluation and Management Service Complexity Adjuster

CMS includes in the proposed rule a proposal to account for those specialty physicians with disproportionately high percentages of E&M services within their overall Medicare billings and who predominantly treat high complexity chronic conditions such as chronic kidney disease (CKD). However, RPA is troubled by the unfortunate omission of nephrology from the list of specialties in which complexity is considered inherent to the E&M services provided to their patients.

When CMS published the proposed rule for the 2018 Quality Payment Program (QPP), it included a table based on Hierarchical Condition Category (HCC) ratings entitled *Table 36: Average HCC Risk Score and Dual Eligible Ratio by Specialty*. On that table, nephrology is the only specialty with a risk score exceeding 3.00 at 3.05. Five specialties have scores of 2.00 or more (infectious disease has the next highest score at 2.35), while all other specialties listed (66 total) have HCC risk scores of 1.95 or lower. RPA recognizes that the HCC risk score is not a perfect comparator for measuring complexity for the purposes of what CMS is outlining in the proposed rule with regard to the adjuster. However, given the numerically determined margin by which kidney disease patients are evidently more complex and at higher risk than those treated in aggregate by other specialty physicians, we would argue that any adjuster in any Medicare payment system that accounts for the complexity of patients must include nephrology. Further, since the publication of the proposed rule CMS has stated in public meetings that the G-codes associated with the complexity adjuster are in fact not specialty specific and can be billed when any of the specialty specific "topics" included in the codes are addressed during the visit. While CKD patients typically have multiple co-morbidities that may fall within the specialty-specific content areas listed in the rule, there is substantial ambiguity as to whether and how the adjuster may apply to services billed for their care.

> **RPA strongly urges CMS to make the complexity adjuster outlined in the proposed rule applicable to the services provided by nephrologists to CKD patients**.

Impact of Evaluation and Management Visit Policies on Chronic Kidney Disease Care

RPA greatly appreciates CMS' efforts to reduce the administrative burden associated with complying with E&M documentation guideline requirements. The proposed changes will substantively alleviate much of the unnecessary difficulty in providing these services and will allow nephrologists and other physicians to focus on the patients' medical needs and not seemingly arbitrary administrative requirements. Understanding that CMS views the proposals to ease documentation burden and to combine payment levels for outpatient E&M services into a single payment level as inherently linked, we concur with our colleagues in the cognitive specialty community that several of the proposed documentation requirement changes could be implemented in 2019 while not making changes to the E&M payment levels. These include the proposals to:

- Allow physicians the option to document visits based solely on the level of medical decision making or the face-to-face time of the visit as an alternative to the current guidelines.

- If physicians choose to continue using the current guidelines, limit required documentation of the patient's history to the interval history since the previous visit (for established patients).

- Eliminate the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient.

- Eliminate the prohibition on billing same-day visits by practitioners of the same group and specialty.

- Remove the need to justify providing a home visit instead of an office visit.

- Eliminate the requirement that teaching physicians have to enter a separate note in the medical record.

While the proposal to reduce the E&M documentation is more than welcome and indicative of foresight on the part of CMS in the facilitation of the delivery of care to Medicare beneficiaries, RPA is concerned that there are reasons both in general and specific to nephrology that would limit the benefit of the changes, owing to the numerous reasons that physicians document E&M services apart from CMS requirements. These include: (1) the presumed difficulty in aligning the proposed changes with the multitude of EHR systems with which a nephrology practice must interact, internal and external to the practice; (2) the likely wide variability among commercial payers in adjusting to the revised requirements; (3) documentation of issues such as medication reconciliation and those emanating from the Quality Payment Program (QPP); and (4) most importantly, to document the care provided in a high level E&M service to appropriately and sufficiently inform not only the next interaction that that physician or member of that practice has with the patient, but for those of all of the other specialists and other practitioners who will have contact with the patient in the provision of optimal care. Regardless of the CMS requirements for documentation, the high degree of complexity of typical late stage CKD patients will not change, and the documentation necessary to record medically necessary and appropriate care will not change either.

> **RPA urges CMS to recognize that despite the obvious benefits of the reduction in documentation requirements, for specialties treating complex patient populations like nephrology, the advantages will be finite.**

With regard to the proposal to designate a single payment amount for E&M levels 2 through 5, RPA is concerned that this will adversely affect the care provided to CKD patients, and will run counter to efforts to delay progression to end-stage renal disease (ESRD) and dialysis for patients whose disease state worsens. The same single flat fee for E&M levels 2 through 5 will invariably undervalue the physician work and expertise associated with caring for complex and vulnerable patient sub-populations like those with each stage of progressive CKD that will distract attention

from the incremental complexities of the treatment needs at each stage of CKD together. The potential downside is that if this care is adversely affected over time, it may lead to an otherwise avoidable increase in the number of patients who move from CKD to ESRD and dialysis without optimal coordination of care and medical management resulting in an appropriate transition to renal replacement therapy.

> **RPA believes that this is an additional rationale for not only proceeding cautiously with the E&M visit policy revisions but also delaying their implementation until more of the potential unintended consequences of such a change can be identified, studied and addressed.**

RPA also is concerned that the specialty-specific impact charts reflecting the effect of the proposed E&M changes on nephrology lack face-value validity. While Table 21 in the proposed rule indicates that nephrology is projected to experience a less than 3 % reduction in payments due to the E&M payment revisions, we have received numerous reports from nephrology practices nationwide indicating that the negative effect for their practices ranges from 10-15%, and this aligns with the nephrology-specific impact released by the AMA, which is estimated to be negative 13%. RPA appreciates the magnitude and complexity of CMS' task in seeking to implement the E&M payment revisions, but it is our belief that if the lack of clarity and transparency in the proposal make the specialty-specific impacts not reproducible, the proposal should be tabled until this is the case.

> **RPA urges CMS to delay implementation of the E&M payment revisions until the specialty-specific impacts of the changes can be published in a clear, transparent and reproducible manner.**

Interoperability in Medicare

As noted, RPA supports the general direction that CMS has taken in this proposed rule with regard to streamlining administrative burden, increasing efficiencies in the delivery of medical care, and to making health care delivery in Medicare more patient-centric (while accounting for the recommendations outlined above). These changes are long overdue and will facilitate the ability of physicians and other Medicare Part B providers to focus on the patient care for which they were trained.

However, RPA believes that CMS could greatly accelerate this process by mandating interoperability of health records in the Medicare program; and in the short-term, by using national patient identifiers (NPIs) and non-proprietary Health Information Exchanges (HIEs) to enhance delivery of care. Regarding interoperability, establishing a requirement for seamless data exchange across the multitude of care settings (hospital, physician's office, dialysis facility, clinical laboratory, pharmacy, etc.) regardless of proprietary considerations and in a common format that is understandable to all users of that data would represent a positive and transformative advancement that would be a 'game-changer' in health care delivery. Such a change would result in patients having a unified and continuously updated electronic health record rather than the current circumstance where patients have multiple electronic medical records comprised of differing elements of the patient's health care history that may share a

minimal number of common informational items and result in fragmented and often counterproductive medical treatment. For example, kidney disease patients typically have the highest number of comorbid conditions and the most significant polypharmacy burden, and receive their care in a greater number of settings (inpatient hospital, dialysis facility, physician's office, ambulatory surgical center) of any group of Medicare beneficiaries. The necessity of using multiple EHRs without interoperability exponentially increases the chances of medication errors or the ordering of duplicative tests, or tests that are contraindicated for the patient's condition.

In the short-term, CMS could promote greater interoperability through more assertive use of NPIs and non-proprietary HIEs. Much of the problem posed by the absence of mandated interoperability in Medicare is not the inability to export or import data, but it is to do so in a way that minimizes the amount of time that the clinician needs to spend on this activity. Thus, ensuring that patient and data matching is handled in an appropriate fashion is key to optimizing improvement in this area. The only practical way to do this is to create national HIEs such that instead of a constant stream of data coming into the EHR, there is the ability for the clinician to quickly and easily "pull" the data that is needed at the time it is needed with the minimal number of barriers possible.

> **RPA urges CMS to mandate interoperability of health records in the Medicare program; in the short-term, CMS should use national patient identifiers and non-proprietary HIEs to enhance the extraction of data necessary for optimal beneficiary care.**

2019 Quality Payment Program

RPA has long been involved in the quality measure development process, and in the intersection of quality measurement with CMS' Medicare incentive programs. We served as the lead kidney organization with the American Medical Association Physician Consortium for Performance Improvement (AMA PCPI) to develop CKD, ESRD, and palliative care measures. RPA also collaborated with the American Society of Pediatric Nephrology (ASPN) and the American Society of Diagnostic and Interventional Nephrology (ASDIN) to develop physician-level measures related to pediatric nephrology and interventional nephrology, respectively. RPA measures have been used in PQRS (now MIPS) and the RPA Kidney Quality Improvement Registry, the only specialty owned nephrology-specific CMS-approved Qualified Clinical Data Registry (QCDR). As an early adopting organization, we have a deep investment in how quality measures are developed and put into use by CMS.

While RPA appreciates CMS' efforts to streamline programs and reduce provider burden, we are concerned that the rate at which such changes are being proposed and implemented is counter to CMS' own goals. RPA believes the QPP program must be allowed to mature, as full years of data have not yet been collected and therefore changes are premature. Furthermore, continually changing the program has increased provider burden by requiring time to study changes and implement new workflows, rather than allowing providers the space to understand and comply with the existing components of the QPP.

MIPS Quality Measures

Removal of Measures—**RPA strongly advocates for the retention of the following two kidney disease measures as we believe their removal would threaten patient care**:

Adult Kidney Disease: Blood Pressure Management

As the measure steward of Adult Kidney Disease: Blood Pressure Management, RPA disputes CMS' categorization that this measure has not been updated nor is planned to be updated. Per discussion with PQMM staff in 2018, it was determined that this measure will be updated in 2019 for the 2020 program year. Additionally, RPA notes that CMS has proposed retaining measures that also use 140/90 mmHg as the blood pressure goal, including Measure 236: Controlling High Blood Pressure which also uses the target of 140/90 mmHg rather than 130/80 mmHg.

Pediatric Kidney Disease: Adequacy of Volume Management

RPA joins the ASPN in disputing that this measure is a standard of care. Recent research notes that dysregulation of intravascular fluid leads to chronic volume overload in children with ESRD and that has consequences, which include left ventricular hypertrophy and remodeling and impaired cardiac function. As a result, cardiovascular complications are the most common cause of mortality in the pediatric dialysis population. The clinical need to optimize intravascular volume in children with ESRD is clear; however, its assessment and management is the most challenging aspect of the pediatric dialysis prescription. Minimizing chronic fluid overload is a key priority; however, excessive ultrafiltration is toxic to the myocardium and can precipitate intradialytic symptoms. (Hayes, W. & Paglialonga, F. Pediatr Nephrol (2018). https://doi.org/10.1007/s00467-018-3916-4).

Addressing fluid intake and volume control requires alignment and coordination of patients and their parents, providers, dialysis facilities and payers. This measure asks the clinician to focus on patient fluid management goals allowing for both components critical to success in dialysis patients – minimizing fluid intake between dialysis treatments and ensuring that dialysis treatments are achieving the goal volumes for dialysis fluid removal. As such, this measure meets several national quality strategy domains – clinical care, care coordination, and patient and caregiver experience. Furthermore, removal of this measure would leave only one MIPS measure for pediatric nephrologists (Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL).

Changes to Quality Category Measure Scoring—We appreciate CMS' efforts to prioritize measures that matter and the reporting burden for physicians. However, RPA believes it is premature to support this tiered approach without additional detail as to how these tiers will be derived and what the specific content of the measures will be. **We urge CMS to release details of the tiering categorizations for public comment before proceeding in this area.**

Eliminating Measure Points for Guideline Changes—RPA believes CMS' proposal to give a score of 0 and reduce the Quality category denominator by 10 for reporting on measures where

there has been a guideline change is punitive to clinicians. As CMS knows, measure stewards and clinicians do not control when guidelines are released; therefore, practitioners should be able to continue to use the measures for the remainder of the program year.

Removal of Topped Out Measures—RPA believes that CMS should maintain the topped-out measure removal process finalized in the 2018 rule. In order to accelerate the process, CMS must provide publicly accessible data demonstrating the topped-out status is stable and must do so in a timely manner (e.g., not 2 years after the end of the reporting year).

Removal of Process Measures—While we are supportive of removing topped out measures, the methods of removing measures must remain transparent and subjected to a public comment period to allow providers ample opportunity to modify and retain certain successful measures rather than for them to be eliminated altogether. Additionally, it is critical to note that important quality of care aspects may only be capturable by a process measure. Furthermore, even outcome measures are not completely within a physician's control. A physician may follow guidelines and provide high quality care and yet the patient outcome may not reflect that effort. **RPA believes that process measures have value; process measures almost always support a positive outcome in patients and therefore we do not support a blanket removal of process measures.**

Small Practice Bonus—RPA appreciates that CMS will continue the small practice bonus but believes it should remain as a standalone bonus rather than under the Quality category in order to provide greater flexibility and reduce the burden on providers.

Combination of Collection Types—RPA supports CMS's proposal to allow the combination of collection types (such as EHR, registry and QCDR reporting) to be scored on the data submission with the greatest number of measure achievement points.

Improvement Activities

Removal of Bonus Score for Attesting via CEHRT—RPA believes CMS should retain the bonus score for attesting to completing one or more specified improvement activities using CEHRT. Doing so will reduce provider burden by allowing their activities to count for more than one MIPS category and further promote interoperability.

Promoting Interoperability

Changes to Reporting Requirements—RPA is concerned that the proposed rule removes the ability for eligible clinicians to choose their performance measures in Promoting Interoperability (PI). Instead, eligible clinicians will be required to report on all 6 measures in the category, which conflicts with CMS' goal of reducing provider burden. **RPA believes the current reporting and scoring methodology should be retained.**

Furthermore, RPA is concerned about the impact the new PI framework has on scoring. The proposed changes have not impacted the contribution PI brings to the total MIPS score (still 25 of the possible 100 points), but the proposed change would make it more difficult to capture

those 25 points. The proposed change is troubling because it has raised the total number of MIPS points one needs to accumulate to avoid a penalty, but the change to the PI framework makes it more difficult to capture PI "MIPS points".

Query of PDMP and Verify Opioid Treatment Agreement Measures—While RPA appreciates that these measures are optional for 2019, we are concerned with the proposal to make to them mandatory in 2020, as the variation in state law and availability of PDMPs may exclude providers in certain states from being able to report these measures. As more and more states pass legislation around opioid prescriptions and PDMPs evolve, RPA is also concerned that it will become more difficult to care for those patients who really do need opioids, as other pain treatments – such as nonsteroidal anti-inflammatory drugs (NSAIDs) have been associated with disease progression in kidney patients. RPA believes that providers must be able to be assess a patient's clinical needs and quality of life when determining medications. Additionally, we question how the information will be obtained – whether PDMPs be the data source and if so, how will it be reconciled with the physician submitted data. RPA also questions how interoperability will tested and how providers will be able to access their data to assess its accuracy, as it is unlikely that PDMPs will transmit data into the provider's electronic health records which are used to report the other PI measures.

Qualified Clinical Data Registries (QCDRs)

RPA is very concerned about the combined effect of the above quality category initiatives. We strongly believe that for many complex chronic diseases there is a critical need for specialty-specific process measures that indicate that the appropriate kinds of care being delivered, especially in light of the long timelines to achieve any specific outcome. For example, within nephrology, success is often measured by the delay of dialysis and a patient receiving a preemptive transplant. Neither of these outcomes are under the full control of the clinician but certainly ensuring the steps to achieve these outcomes are among the nephrologist's responsibilities. **We strongly encourage CMS to support specialty societies in developing appropriate combinations of process and outcome measures**. By offering this flexibility, the work of transforming practices to more population health-focused care can be benchmarks of their success under the QPP program.

Additionally, there must be adequate time for specialty societies to develop measures, include them in QCDRs and then work with EHR vendors to ensure that the appropriate data can be collected and shared. This process can take many years. Therefore, **we strongly encourage CMS to work with both specialty societies and vendors in facilitating the time and effort needed to successfully popularize/socialize specialty-specific measures.**

Benchmarking QCDR Measures—RPA believes there is a benefit to having measure benchmark standards and strongly agrees that the lack of benchmarks for custom measures has limited their adoption by providers. However, we believe that this proposal requires additional input before moving forward. Furthermore, RPA is concerned regarding the need for additional data elements to ensure that the data reach all the appropriate standards to be used for benchmarking are quite real and could be quite daunting. As noted in previous comments, QCDR stewards must work with electronic health records vendors to ensure that appropriate data elements for custom

measures are collected – a process which often takes up to 18 months. Requiring additional data elements is likely to extend that timeline. We urge CMS to consider lead time required by EHR developers to respond to finalized changes to be able to release updated software solutions that reflect finalized changes to their customers. Once a vendor learns of a new set of measures that are being added or removed based on the Final Rule, vendors require time to move through the development life cycle while also ensuring they meet certification requirements set forth by the Office of the National Coordinator (ONC). **RPA believes that in order to make such efforts feasible, CMS must implement a multi-year measure approval process to allow custom measures to be socialized and adopted by providers and programmed into electronic health records rather than requiring annual submission and re-approval**. By approving measures for longer than 12 months, providers will have the necessary software updates to collect and report custom measures as well as time to make any necessary changes to their workflow. It also reduces burden by allowing providers to report on the same measure for multiple years and track their improvements over time, which in turn, improves patient care.

Quality Improvement Expertise Requirement for QCDRs—RPA appreciates CMS' evaluation of whether an organization applying to be a QCDR has quality improvement expertise as well as clinical and technological expertise. **RPA urges CMS to provide clarification of how this will be evaluated to ensure integrity, meaning and relevance in the measures.**

Changing QCDR Self-Nomination Period from September 1-November 1 to July 1-September 1 RPA believes that if CMS should go forth with this change, then a 1-year grace period must be provided; that is, QCDR approval will need to expand beyond 12 months as to avoid a scenario where a QCDR is only approved for a few months before they must go through the self-nomination process again. **RPA believes that this change this should not be implemented until at least 2021.**

Licensing Agreements for Use of QCDR Measures—We are concerned about CMS' proposal to require no cost licensing agreement from QCDR measure stewards. While many QCDRs may do this voluntarily, requiring them to do so ignores the time and resources spent in developing the measures. **RPA believes that QCDRs should be allowed to decline to license measures or be able to charge a licensing fee.**

Removal of Topped Out Measures from QCDRs—**RPA disagrees with CMS' proposal to exclude QCDR measures from the topped-out measures timeline**. We believe the timeline should be consistent with the MIPS measure removal process to reduce provider burden and confusion.

Simplified Self-Nomination Process—**RPA supports the proposal for QCDRs which have previously self-nominated and are in good standing to be able attest in whole or in part that their previous application is accurate and still applies**. RPA again encourages CMS to extend this provision to QCDR custom measures by allowing a multi-year approval to allow measures to be socialized and adopted by providers and programmed into electronic health records rather than requiring an annual approval. Multi-year measure approval would allow providers to better adapt workflows to report on clinically relevant custom measures as these measures address

critical clinical gaps in care, support evidence-based medicine, and engage patients as well as clinicians in care delivery.

Use of QIP Measures for AKI Patients

As noted in previous comments, **RPA strongly objects to the inclusion of acute kidney injury patients (AKI) in the QIP**. By definition, AKI patients are seen in outpatient dialysis facilities for a limited time, usually less than three months. Frequently, the patients have been recently discharged from the hospital resulting in low hemoglobin, presence of albumin, and have multiple active medical conditions which may result in re-hospitalization. Unlike ESRD patients who have been educated about access and treatment options, AKI patients often "crash land" into dialysis with little to no time for the preparation needed to mentally and physically prepare to have a functional access in place. Furthermore, AKI patients may be in transition in terms of their goals of care; they may recover kidney function or decide to withdraw from dialysis. Since any dialysis unit is unlikely to have many AKI patients over the course of a year, the denominator in any individual dialysis unit will be extremely low, making meaningful evaluation of quality metrics in these patients difficult. The nature of the patients discharged from the hospital with AKI is so heterogeneous as to make outcome comparisons between outpatient units hard to interpret.

Expanding QIP Facility-Based Measurement from ESRD settings to the QPP

RPA believes quality measures should be applied as specified – QIP measures are specified at the facility level, not the individual provider level. To do so undermines the intent of the measures and creates a high likelihood of calculation and attribution errors. On attribution, we would note that while every dialysis facility has a designated medical director, the care provided to each individual patient in the facility is delivered by a specific physician or by his or her practice. Accurately attributing facility level performance to specific nephrology providers would be exceptionally difficult if not impossible.

Our specific concerns about this proposal are outlined below:

- RPA is unclear whether the proposal would apply only to outpatient facility medical directors and questions what would be done at facilities where there are multiple attending nephrologists caring for patients at a given unit.

- RPA emphasizes that outpatient dialysis facilities vary greatly from an in-patient hospital setting. Patients may be seen by attending nephrologists rather than medical directors and may move to a facility where the attributed physician does not practice.

- RPA believes that holding the physician responsible for individual outcomes within a facility would undermine measure reliability as performance standards, weighting and minimum date requirements have all been specified and calculated at the facility level.

- RPA does not believe the “first touch” approach would be applicable under these circumstances.

RPA supports a consolidation of all dialysis facility rating systems (DFC/5 Star/QIP) into a validated representation of quality of the facility but it should not assign that performance to the physician. If physicians are held accountable for facility measures, proven methods and policies previously held to be effective will likely be undermined in the interest of individual practice variability and lead to greater confusion and deterioration in the facility quality process. Holding the physician responsible for individual outcomes within a facility would be disruptive to measure reliability.

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.

Sincerely,

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