KIDNEY CARE PARTNERS

June 27, 2016

Mr. Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services,
Attention: CMS-5517-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-5517-P: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule

Dear Acting Administrator Slavitt:

Kidney Care Partners (KCP) appreciates the opportunity to provide comments on the "Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule" (Proposed Rule). KCP is an alliance of members of the kidney care community that serves as a forum for patient advocates, dialysis care professionals, providers, and manufacturers to advance policies that support the provision of high quality care for individuals with both chronic kidney disease (CKD) and End-Stage Renal Disease (ESRD).

ESRD is an irreversible failure of kidney function that is fatal without a kidney transplant or dialysis treatments. There are more than 26 million adults living with CKD, which can lead to kidney failure if untreated. More than 636,000 Americans are living with kidney failure with about 430,000 of these individuals relying on dialysis. The number of individuals suffering from ESRD is expected to double over the next decade.

Proper management and treatment of ESRD is extremely time intensive, which usually involves dialysis three to four times a week with each session lasting three to four hours. Individuals with ESRD do not live with this disease in a vacuum, but typically have one or more serious co-morbidities, such as diabetes, high blood pressure, cardiovascular disease, and congestive heart failure.

KCP supports efforts to develop and implement other care models, such as the Comprehensive ESRD Care (CEC) model, that advance care coordination for ESRD patients. The high costs associated with ESRD patients' care and the complexity of their clinical and non-clinical needs warrant this additional focus. In our view, the considerable time that ESRD patients spend at dialysis facilities

creates a strong rationale for care models that support dialysis providers and clinicians with substantial kidney care expertise in assuming greater leadership and accountability roles in serving ESRD patients currently receiving care under FFS.

In this context, KCP and its member organizations seek to ensure that as CMS implements the MACRA requirements the Agency take into account the unique nature of this patient population. To this end, we have focused our comments on three key areas that we believe are critical to addressing the unique nature of dialysis patients and the existing nephrology-focused alternative payment models. Specifically, we ask that CMS:

(1) Provide additional flexibility with regard to the implementation timeline.

(2) Adopt a more graduated approach that set the CEHRT use thresholds for nephrology-focused APMs as follows: 25 percent in the first performance year; 50 percent in the second performance year; and 75 percent in the third performance year.

(3) Affirm in the final rule that the denominator for the CEC QP determination will only include beneficiaries who could be attributed to the ESCO[1] as defined by the CEC Model Participation Agreement.

I. KCP Supports Additional Flexibility in the Implementation Timeline.

KCP appreciates the need for CMS to meet the myriad of statutory requirements with regard to implementing APMs. We are concerned with the timeline set forth in the Proposed Rule. For example:

- Letters of intent for APMs, such as the Next Generation Accountable Care Organization (ACO) program, were due prior to the proposed rule's release.
- Applications for other APMs will be due prior to the rule's finalization.

This compressed timeline may result in organizations and providers who support APMs not being able to participate. Others may decide not to move forward because the rules and requirements will not be finalized before they are required to commit to the program. The compressed timeline will also make it difficult to make the necessary system upgrades to support the data submissions under the Quality Payment Program (QPP).

We recognize that throughout the Proposed Rule CMS seeks to provide flexibility for clinicians to incentivize their participation in APMs. We suggest that

[1] *See* 81 Fed. Reg. 28323 (May 9, 2016).

CMS also provide flexibility to address the compressed initial implementation timeline and ongoing annual QPP schedules.

II. KCP Generally Supports the Proposals Related to the Advanced APM Criteria Use of Certified EHR Technology (CEHRT), But Recommends that CMS Avoid a "One Size Fits All" Approach for the Implementation of CEHRTs for Nephrology-Focused Advanced Alternative Payment Models (APMs).

KCP appreciates the inclusion of CEHRT as part of the Advanced APM criteria. In the context the Medicare ESRD program, we continue to support efforts to improve information sharing among patients' providers and their dialysis facilities. We also support efforts to incentivize the use of electronic health records to improve patient outcomes and the quality of care they receive.

We agree with the proposal to use the same MIPS CEHRT definition for Advanced APMs and Other Payer Advanced APMs.[2] This consistency between MIPS and APMs is critically important for physicians who may be part of practices in which some individuals are participating in APMs and others may not be. These physicians may share common resources, especially EHRs. It would be not be appropriate to implement different definitions in light of these practical realities. The alignment of the Advanced APM CEHRT requirement and the MIPS requirement as it relates to Advancing Care Information is also important given that the Qualifying APM Participants (QP) designation is determined retrospectively. The consistent definition supports the goal of improving and encouraging physicians' use of certified EHR technology.

KCP also agrees with the proposal for scoring Advancing Care Information that uses a base score for participation and reporting and a performance score to measure performance at varying levels above the base score.[3] In addition, we suggest that CMS clarify in the final rule that clinicians meeting the base score are counted as the eligible clinicians using CEHRT within the Advance APM to further maintain consistency with CEHRT standards for clinicians.

In terms of establishing an increasing threshold of CEHRT use by eligible physicians as part of the Advanced APM criteria, we recommend that CMS refrain from adopting a "one size fits all approach." While we agree that it is important to incentivize those clinicians who are engaged in care transformation through the use of CEHRT, the goals and populations of APMs will vary and the criteria should be designed to address such variation. Thus, rather than adopt the CEHRT utilization thresholds of 50 percent in 2017 and 75 percent in 2018, we recommend a more graduated approach that set the thresholds for nephrology-focused APMs as

[2] 81 Fed. Reg. 28299 (May 9, 2016).
[3] *See* 81 Fed. Reg. 28220 and 28221 (May 9, 2016).

follows: 25 percent in the first performance year; 50 percent in the second performance year; and 75 percent in the third performance year.

We appreciate that the Proposed Rule acknowledges that a more measured pace of CEHRT adoption for certain specialty-focused Advanced APMs may be more appropriate.[4] This is particularly the case for the Comprehensive ESRD Care (CEC) Model. Under the current meaningful use program, a number of nephrologists have qualified for the hardship exceptions under practice at multiple locations category (lack of control over availability of CEHRT for more than 50 percent of patient encounters).[5] This fact has resulted in different CEHRT experiences among nephrologists. Adopting lower thresholds would continue to reward early adopters of APMs in the nephrology community and those already providing care through the ESCOs, but also provide the time these nephrologists need to adopt and improve their use of certified EHR technology. Thus, similar to the proposal to adopt an alternative CEHRT requirement for the Shared Savings Program based on the unique nature of that program, we recommend that CMS adopt alternative thresholds for nephrology-focused APMs.

III. KCP Seeks Clarification about the Calculation of the Qualifying APM Participant Denominator.

KCP is pleased that CMS recognizes that specialty-specific APMs need alternative methods for calculating beneficiaries in the Qualifying APM Participant (QP) denominator.[6] In the case of the CEC model, if the denominator were to include all Medicare beneficiaries encountered by the nephrologist, only those nephrologists who stopped seeing all other non-ESRD Medicare patients would qualify. This result, which would limit access to nephrologists, would seem counterintuitive to the Administration goal of expanding access generally. Therefore, we ask that CMS affirm in the final rule that the denominator for the CEC QP determination will only include beneficiaries who could be attributed to the ESCO[7] as defined by the CEC Model Participation Agreement.[8]

---

[4] *See* 81 Fed. Reg. 28300 (May 9, 2016)
[5] Provider Application for Hardship Exception, 2017 Medicare EHR Incentive Program Payment Adjustment, § 2.3 (2017).
[6] *See* 81 Fed. Reg. 28323 (May 9, 2016).
[7] *See* 81 Fed. Reg. 28323 (May 9, 2016).
[8] *See* Participation Agreement (LDO-CEC Model), 1.1.1 Identifying Eligible Beneficiaries, 2 (August 24, 2015).

IV. Conclusion

KCP appreciates the opportunity to provide comments on the Proposed Rule. Please do not hesitate to contact our counsel Kathy Lester at klester@lesterhealthlaw.com or (202) 534-1773 if you have questions about our recommendations.

Sincerely,

Frank Maddux, M.D.
Chairman
Kidney Care Partners