KIDNEY CARE PARTNERS

August 25, 2015

Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1631-P: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016

Dear Acting Administrator Slavitt:

On behalf of Kidney Care Partners (KCP), I am writing to thank you for the opportunity to provide comments on "Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016" (Proposed Rule). We strongly support the proposed modifications to align payment policies related to the hospitalization of in-center and home dialysis patients. As described below, KCP supports the expansion of telehealth codes for ESRD services and suggests that the Agency also expand the definition of originating sites to maximize the effectiveness of these codes. We also offer recommendations as to how to improve the use of the Chronic Care Management Service and Care codes. Finally, we support the addition of the Advance Care Planning Services codes.

KCP is an alliance of members of the kidney care community that includes patient advocates, dialysis care professionals, providers, and manufacturers organized to advance policies that improve the quality of care for individuals with both CKD and irreversible kidney failure, known as ESRD.[1]

I. KCP Supports Adding the Four Proposed ESRD-Related Codes to the List of Telehealth Services.

KCP applauds the Centers for Medicare and Medicaid Services (CMS) for proposing to add four ESRD-related codes to the list of telehealth services. CPT codes 90963, 90964, 90965, and 90966 each expand the opportunity for home dialysis patients to receive physician-monitoring services through telehealth. We also appreciate and support the clarification that "[a]n interactive telecommunications system may be used for providing additional visits required under the 2 to 3 visit Monthly Capitation Payment (MCP) code and the 4 or more visit MCP code."

[1] A list of KCP members is provided in Appendix A.

Having access to physicians through telehealth services is critically important for patients living in rural areas. As you are aware, the shortage of nephrologists remains a serious problem. This shortage means that some nephrologists drive several hours to see their patients. For example, patients in northern Idaho rely upon nephrologists from Washington State for their appointments. These nephrologists must budget long drives into their day to ensure they can meet with their patients. This means that they have less time to see patients overall.

Telehealth services offer these patients the opportunity to engage with their nephrologists more frequently and allow nephrologists to focus more of their time on caring for patients and less time on traveling to see them. Patients in rural areas may also find selecting home dialysis modalities more attractive if they can rely upon telehealth services to access their nephrologists. Telehealth services provide beneficiaries with the flexibility to interact with providers in a manner tailored to their needs.

To maximize the effectiveness of adding these codes, KCP recommends that CMS also allow dialysis facilities and patient homes to be originating sites for telehealth services. An originating site is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs. While some patients in rural areas may have access to rural hospitals or other types of physicians' offices, many may not. It may be that a dialysis facility is the closest option for patients, as well as physicians who are also caring for in-center patients. It is unclear why independent dialysis facilities have been excluded from the list of originating sites, while hospital-based facilities are included. We know of no reason why a dialysis facility cannot provide the same type of services as hospital-based or critical access hospital-based renal dialysis centers, which are on the list.

For other patients, especially those relying upon home dialysis, their home may be the best option for receiving telehealth services. It is also unclear why a patient who has the technical capability cannot agree to have his/her home serve as an originating site. Given the importance of providing telehealth options to patients with kidney disease and kidney failure, we encourage CMS to provide additional flexibility by recognizing dialysis facilities and patients' homes as originating sites.

II. KCP Supports the Implementation of the CCM Codes, but the Documentation Burden Makes Their Use Difficult.

Patient care management is critically important to improving patient outcomes and reducing overall Medicare spending. This fact is especially true when caring for patients with chronic conditions, such as kidney disease. We support the Agency's implementation of CCM service codes for chronically ill patients.

To ensure their utilization, KCP recommends that CMS review the documentation requirements to eliminate those aspects that are extremely burdensome. For example, physicians are expected to document the total number of minutes spent with a patient each month. This amount includes not only the physician, but also other professionals within the practice. Having to aggregate and document the time spent requires a substantial amount of work that reduces the time physicians can spend with patients. For nephrologists, especially, the overly burdensome documentation requirements result in the codes not being used. Therefore, we urge CMS to revise the documentation requirements so that the burden of documentation does not outweigh the benefit of these services.

In addition, we have heard concerns from patients that the attestation requirement is confusing and burdensome. Because the patient is often the common link among various physicians, this requirement places the patient in the awkward position of telling physicians whether they are or are not eligible to use the code. This approach is unduly burdensome on patients. Additionally, CMS should consider ways to address the added financial burden on patients that results from the copayment amounts associated with its use. These copayments may create disincentives for patients to agree to the attestation as well.

III. KCP Supports the Addition of Advance Care Planning Codes.

Advance care planning is an important part of the continuum of care that nephrologists provide to their patients.[2] Studies have shown that facilitating advance care planning "increase[s] the likelihood of wishes being respected and patients receiving treatment in their best interest."[3] Thus, KCP supports adding the new codes for advance care planning recognizing the importance of these discussions between patients and their physicians. We also commend CMS for including ESRD monthly capitated payment patients in this policy.

IV. KCP Supports the Modifications to the PQRS Measures, but Encourages CMS To Include A Graft Measure along with the Catheter Measure.

KCP supports measuring dialysis services within the PQRS. We support the addition of the referral to hospice care measure for adult patients who withdraw from hemodialysis peritoneal dialysis and who are referred to hospice care. While we are agnostic as to how the adult catheter measure is categorized, we encourage

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[2] *See generally,* "Facilitating Advance Care Planning for Patients with End-Stage Renal Disease: The Patient Perspective," 1 *Clin. J. Am. Soc. Nephrol.* 1023–28 (2006).

[3] W. Silvester, D. Mawren, K. Detering, and K. Wallis, "The Impact of Advance Care Planning for Renal Patients," 3 *BMJ Support Palliat. Care* 246-47 (2013).

CMS to retain the Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula measure, which is similar to the vascular access measure included in the ESRD Quality Incentive Program (QIP). Both PQRS and the QIP should also include a graft measure to ensure that there is no disincentive to use grafts when that type of vascular access is the most appropriate for the patient. Finally, despite the fact that there may be no gap in the dialysis adequacy metrics, they measure the core functions of dialysis. We believe that these measures should be retained in the PQRS, as it is in the ESRD QIP.

V. KCP Supports the Proposal to Provide an Exception to the Self-Referral Prohibition for Remunerating Physicians who Assist with the Employment of Nonphysician Practitioners, but Recommend that It also Apply to Dialysis Organizations.

KCP supports the proposed exception for certain hospitals and clinics that wish to provide remuneration to a physician to assist him/her with employing a nonphysician practitioner. CMS proposes this modification to address the shortage of primary care physicians. We encourage CMS to narrowly expand this exception to include dialysis facilities. Many communities face a shortage of nephrologists and concerns remain about whether there will be a sufficient number of nephrologists to care for the increasing number of Americans living with kidney disease and kidney failure.[4] To ensure access to care for these patients, we encourage CMS to expand this exception to allow dialysis organizations, as well as hospitals, Federal Qualified Health Clinics, and Rural Health Clinics to provide such remuneration.

VI. Conclusion.

We appreciate having the opportunity to provide comments on the Proposed Rule. Please do not hesitate to contact Kathy Lester at klester@lesterhealthlaw.com or at (202) 534-1773 to answer any questions or arrange a meeting to discuss our comments further.

Sincerely,

Edward R. Jones, M.D.
Chairman
Kidney Care Partners

[4] E. Salsberg, L Masselink, & X Wu. *The US Nephrology Workforce: Developments and Trends* 8 & 18 (2014).

Appendix A: KCP Members

AbbVie
Akebia Therapeutics, Inc.
American Kidney Fund
American Nephrology Nurses' Association
American Renal Associates, Inc.
American Society of Nephrology
American Society of Pediatric Nephrology
Amgen
Baxter Healthcare Corporation
Board of Nephrology Examiners and Technology
Centers for Dialysis Care
DaVita Healthcare Partners, Inc.
Dialysis Patient Citizens
Dialysis Clinic, Inc.
Fresenius Medical Care North America
Fresenius RTG
Greenfield Health Systems
Hospira
Keryx Biopharmaceuticals, Inc.
Kidney Care Council
National Kidney Foundation
National Renal Administrators Association
Nephrology Nursing Certification Commission
Northwest Kidney Centers
NxStage Medical
Renal Physicians Association
Renal Ventures Management, LLC
Rogosin Institute
Sanofi
Satellite Healthcare
U.S. Renal Care