KIDNEY CARE PARTNERS

August 26, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1751-P: Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements

Dear Administrator Brooks-LaSure,

On behalf of the more than 30 organizations working together to advance kidney care through Kidney Care Partners (KCP), I want to thank you for the opportunity to provide comments on the "CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements" (Proposed Rule).

KCP is an alliance of more than 30 members of the kidney care community, including patient advocates, health care professionals, providers, and manufacturers organized to advance policies that support the provision of high-quality care for individuals with chronic kidney disease (CKD), including those living with End-Stage Renal Disease (ESRD).

KCP wants to thank CMS for working with KCP members during the pandemic. As the Centers for Disease Control and Prevention (CDC) has recognized, patients with Chronic Kidney Disease (CKD), especially those with Stage 5 kidney failure, are at a heighten risk of contracting COVID-19. Thus, finding ways to promote care in the home through expanding telehealth services and access to laboratory testing in the home are important steps to reduce the risk of infection. In addition, allowing facilities to have the flexibility to implement programs to help patients who require in-center hemodialysis, even after diagnosed with COVID-19, has helped to ensure that all patients receive the care they need during these difficult times. Most importantly, we appreciate the Biden-Harris

Administration's decision to allocate vaccines directly to dialysis facilities to allow them to leverage their thrice weekly contact with patients and encourage them to be vaccinated.

In addition, we strongly support the Administration's efforts to address inequities in health care. As we described in detail in our July letter to the Office of Management and Budget (OMB) request for information "Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government," patients with kidney disease are disproportionately from communities of color and experience inequities in the delivery of health care.

However, the modifications to the ESRD programs alone are not enough. The systemic barriers to accessing basic health care likely play a substantial role in these individuals developing kidney disease and progressing to kidney failure. The leading causes of CKD and ERSD are hypertension, diabetes, and obesity. Black and Hispanic individuals are diagnosed with these diseases more than other Americans.[1] We know from several years of research that people of color have greater difficulties accessing preventive care and chronic disease management services.[2] It is very likely that the challenges these individuals faced when trying to access basic health care services resulted in chronic diseases, such as diabetes, obesity, and heart disease, not being fully managed, which led to the development of kidney disease. We specially encourage CMS to remove existing regulatory barriers that make it difficult to identify, educate, and treat patients with earlier stages of CKD. KCP renews its commitment to work with CMS and other federal agencies to find ways to address these challenges that exist prior to an individual's kidneys failing.

Improving quality outcomes remains a top priority for KCP as well. KCP since 2005 has led the kidney community in its efforts to shift to a patient-centered, quality-based approach to providing kidney care in America. Through the Kidney Care Quality Alliance (KCQA), our members have developed measures, navigated them through the National Quality Forum's (NQF) endorsement and maintenance processes, and advocated for their inclusion in the Medicare ESRD QIP and other quality programs.

KCP appreciates the ongoing collaborative partnership with CMS to promote transparency, accountability, and high-quality patient-centered care for the people living with kidney disease whom we serve. We look forward to working with you on this year's rulemaking.

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[1] Richard V. Reeves & Faith Smith. "Up Front: Black and Hispanic Americans at Higher Risk of Hypertension, Diabetes, and Obesity: Time to Fix Our Broken Food System." *Brookings.* https://www.brookings.edu/blog/up-front/2020/08/07/black-and-hispanic-americans-at-higher-risk-of-hypertension-diabetes-obesity-time-to-fix-our-broken-food-system/ Aug. 7, 2020). accessed June 28, 2021.

[2] Kenneth E. Thorpe, Kathy Ko Chin, Yarira Cruz, *et al.* "The United States Can Reduce Socioeconomic Disparities by Focusing on Chronic Diseases." *Health Affairs* (Aug. 17, 2017) https://www.healthaffairs.org/do/10.1377/hblog20170817.061561/full/. accessed June 20, 2021.

I. Updates to the Physician Fee Schedule Rates

KCP supports the proposal to make the RVUs for CPT code 90954 proportionate to those for the rest of the code family. This code is the ESRD related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents. When the other nephrology codes were adjusted last for 2021 to address long-standing problems with the valuation of the nephrology codes, this code was inexplicably not adjusted. We are pleased that the work RVUs for that code were increased from 15.98 to 20.86 and ask that CMS finalize the proposed modification.

II. Modification to the Medical Nutrition Therapy Benefit

KCP also supports the proposed changes to the medical nutrition therapy benefit. As MedPAC has recognized nutrition for dialysis patients remains an area that can be improved. By removing the requirement that the medical nutrition therapy referral be made by the "treating physician," CMS will expand the reach of this important benefit. We also support aligning the glomerular filtration rate (GFR) to reflect current medical practice with regard to the current standards for CKD stages III through V, which is GFR 15 – 59 mL/min/1.73m2. KCP asks that CMS finalize both of these proposed changes.

III. Telehealth

As KCP has referenced in previous letters, we agree that telehealth flexibilities enacted during the pandemic have benefited patients receiving kidney care. We support CMS's efforts to extend those flexibilities that are appropriate to make permanent once the public health emergency ends. Patients who receive dialysis do need to have at least one in-person visit each quarter with their nephrologist. We appreciate that CMS sought comments on this policy in the CY 2021 rulemaking cycle, and we urge CMS to work with the Congress to make these telehealth provisions permanent.

IV. Quality Measures

KCP remains concerned that CMS has eliminated measures for physicians (nephrologists in particular) that closely align with those used in the ESRD Quality Incentive Program (QIP) in favor of primary care measures that are not aligned. We ask that CMS reconsider this decision that was finalized for the CY rulemaking and reinstate the nephrology measures to promote better care coordination and alignment among the providers caring for patients receiving dialysis. Specifically we ask that CMS to reinstate each of the four nephrology measures for the following reasons:

- **MIPS 328 Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin (Hgb) Level < 10 g/dL.** Anemia management is a critical component of managing the care for patients with kidney failure. Consistent

with the comments KCP submitted on the ESRD QIP on August 30, 2019, we support using a Hgb < 10 g/dL measure for dialysis facilities and, thus, call on CMS to use a similar measure for nephrologists. While there may be a smaller number of pediatric patients, managing their anemia is a critical quality of life factor. Simply put, children with limited energy due to anemia struggle to go to school, engage with friends, and have a "normal" childhood. In addition, if not managed appropriately, anemia can lead to increased morbidity and mortality and an increased risk of cardiovascular disease. This measure should be maintained.

- **MIPS 329 Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis.** As CMS' own Fistula First, Catheter Last initiative demonstrates, reducing catheter use may be one of, if not the, most important part of managing a patients' kidney failure next to adequacy of dialysis. The use of catheters increases the risk of infection, morbidity, mortality, hospitalizations, and readmission. The ESRD QIP contains a similar measure to reduce the use of catheters in dialysis patients. Therefore, to coordinate the care among facilities and nephrologists, it is important to maintain this measure.

- **MIPS 330 Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days.** This measure, which is designed to be paired with MIPS 329 should also be retained. For the same reasons noted above, including the need to coordinate care among facilities and nephrologists, we ask that CMS retain this measure.

- **MIPS 403: Adult Kidney Disease: Referral to Hospice.** KCP's patient advocacy members consistently identify end-of-life choices as a critical component of kidney care. Many patients who receive dialysis remain on it for the rest of their lives, yet only about 20 percent of Medicare beneficiaries with kidney failure receive hospice care prior to their death. A nephrologist – the provider with whom a dialysis patients is the closest – is best positioned to work with the patient and through shared decision-making determine whether hospice is an appropriate option. This measure should be retrained to promote patient choice and autonomy at the end of life.

The Medicare program should focus on improving the Medicare ESRD benefit in ways that promotes care coordination, shared decision-making, and quality of life for patients. Removing the four nephrology measures from MIPS was inconsistent with these goals. Therefore, KCP recommends that CMS reinstate these measures in the MIPS.

V. Conclusion

KCP appreciates the opportunity to provide comments on the Proposed Rule. Thank you again for considering our recommendations. Please do not hesitate to contact KCP's counsel, Kathy Lester, if you have any questions or would like to discuss these recommendations. She can be reached at klester@lesterhealthlaw.com or 202-534-1773.

Sincerely,

John Butler
Chairman

Appendix: KCP Members

Akebia Therapeutics
American Kidney Fund
American Nephrology Nurses' Association
American Renal Associates, Inc.
American Society of Pediatric Nephrology
Amgen
Ardelyx
AstraZeneca
Atlantic Dialysis
Baxter
BBraun
Cara Therapeutics
Centers for Dialysis Care
Cormedix
DaVita
DialyzeDirect
Dialysis Patient Citizens
Dialysis Vascular Access Coalition
Fresenius Medical Care North America
Fresenius Medical Care Renal Therapies Group
Greenfield Health Systems
Kidney Care Council
Nephrology Nursing Certification Commission
Otsuka
Renal Physicians Association
Renal Healthcare Association
Renal Support Network
Rockwell Medical
Rogosin Institute
Satellite Healthcare
U.S. Renal Care
Vertex
Vifor Pharma