KIDNEY CARE PARTNERS

September 11, 2023

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

Re: CMS-1784-P: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Dear Administrator Brooks-LaSure,

On behalf of Kidney Care Partners (KCP), I want to thank you for providing us with the opportunity to provide comments on the "CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program" (Proposed Rule). KCP supports the proposal to adopt a complexity adjuster for Evaluation/Management (E/M) services and the proposals to support caregiver training. We are concerned that the proposals related to in-office procedures will create barriers to access for individuals with kidney failure who require in-office dialysis access-related procedures. While we support efforts to increase access to transplant, especially for individuals with kidney disease, we opposed the two transplant measures as specified. Finally, our members are concerned that the new denial and revocation authority is too broad given the goal of the policy and could disrupt patient care.

Kidney Care Partners is a non-profit, non-partisan coalition of nearly 30 organizations comprising patients, physicians, nurses, dialysis professionals, researchers, therapeutic innovators, transplant coordinators, and manufacturers dedicated to working together to improve the quality of care for individuals living with kidney disease.

I. KCP supports adopting a complexity adjuster for E/M services.

KCP supports the proposal to adopt a separate add-on payment for HCPCS code G2211 beginning January 1, 2024.[1] We understand that the code is designed to capture costs associated with E/M visits for primary care and longitudinal care of complex patients. We believe that visits involving evaluate or management of individuals with kidney disease would come within the scope of this complexity add-on adjustment. Addressing the complex needs of

[1] 88 *Fed. Reg.* at 52354.

individuals with Chronic Kidney Disease (CKD) is critically important to helping them manage their disease and comorbidities to delay the onset of kidney failure. Providing physicians, especially nephrologists, with additional resources recognizing the increased costs associated with providing pre-dialysis services will help address our nation's kidney care crisis. KCP urges CMS to finalize the complexity add-on and support its use for individuals with CKD.

II. KCP supports paying for caregiver training services.

CMS proposes to reimburse physicians, non-physician practitioners, and therapists when they provide training services to caregivers to support individuals with certain diseases or illnesses.[2] KCP supports providing such payments to incentivize training of caregivers and urges CMS to specify in the final rule that caregivers supporting individuals with Stage IV or Stage V kidney disease be included in the policy. Care-partners play an essential role in supporting individuals with kidney failure, especially those who select a home dialysis modality. It is a complex responsibility that requires significant training. We are pleased that CMS has recognized the value of training services for these individuals by establishing a payment for such training. We agree that this policy could have an important impact on reducing the current health inequities identified among dialysis patients, particularly as it relates to having the support for home dialysis modalities.

III. KCP remains concerned about the health equity inequalities the continued implementation of the in-office procedure reductions will have on patient access to dialysis access procedures for both home and in-center dialysis.

While we continue to acknowledge the budget neutrality constraints under which adjusting one set of physician codes has an impact on the values of the other codes in the fee schedule, we remain deeply concerned that the significant cuts resulting from the policy have a negative impact on individuals who need in-office dialysis access procedures to receive either home or in-center dialysis. We again encourage CMS to take into account the impact that reducing the value of codes for vascular and PD access placement has on these patients by mitigating the cut to address the health inequities these patients already face.

IV. KCP urges CMS to develop more appropriate transplant measures and not adopted those set forth in the Proposed Rule.

KCP strongly supports the adoption of meaningful transplant measures in both the physician and dialysis facility value-based purchasing programs. However, the two measures set forth in the Proposed Rule should not be adopted. We urge CMS to review the work of the Kidney Care Quality Alliance (KCQA) and the measures specifications for its measure set that

[2] *Id.* at 52322.

once tested could address the need for transplant measures while also ensuring that such measures are meaningful and actionable.

As we have noted in our comments on the ESRD Quality Incentive Program (QIP), KCP does not believe it would be appropriate to adopt the Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW) measure. Once two measures, this measure (and its predecessors) were not endorsed by a consensus-based organization. When they were considered for endorsement, the Renal Standing Committee of the National Quality Forum (NQF) raised concerns that even though nephrologists have a role in referring patients for transplant, it is the transplant center alone that controls the selection of patients for and from the waitlist. As a result, the measure does not accurately reflect the quality of care provided by nephrologists. There have also been concerns about the testing data, which showed extreme variation in transplant center practices. These results also demonstrate that the measure does not reflect nephrologist care, but rather that of transplant centers. Finally, it is not yet clear that the measure meets either feasibility or validity criteria. As such, it will mislead patients and should not be adopted.

Similarly, KCP does not believe the First Year Standardized Waitlist Ratio (FYSWR) should be adopted. The NQF Renal Standing Committee also refused to endorse the measure, raising concerns about exclusions and attribution. If a measure cannot accurately identify the physician being assessed, then the measure will fail to provide patients and care-partners with the information they need to make informed decisions. Such a flaw also means that accuracy of assessing physicians for payment will be undermined. For these reason, we also ask that this measure not be adopted.

V. KCP questions the benefit of the proposed denial and revocation policy.

CMS has proposed to broaden the application of the denial and revocation authority that currently applies only to felonies to include misdemeanor crimes as well.[3] We believe the list of such crimes is so broad that it could create access to care issues, especially given the significant workforce crisis facing the dialysis providers. We ask that CMS limit the list of misdemeanor crimes that would fall under this policy to those specific crimes that raise concerns under the Medicare program. This will not only reduce the potential negative impact on patients seeking care, but also make sure that the information CMS receives does not overburden staff by making them sift through many unimportant reports potentially missing those that are important and of legitimate concern. We also ask that CMS retain the current 60-day notice for a reversal of revocation instead of shortening it to 30 days. Finally, we ask that CMS revise the proposal to hold claims when a provider is in the stay of enrollment status period and to retroactively correct the payment after any errors are resolved that may have led

[3] *Id.* at 52516.

the to stay in the first place. CMS should also provide an expedited process pathway and clarification as to when the 60 day stay period begins and ends.

VI. Conclusion

Thank you again for the opportunity to provide comments on the Proposed Rule. Please do not hesitate to reach out to our counsel in Washington, Kathy Lester, if you have any questions. She can be reached at klester@lesterhealthlaw.com or 202-534-1773.

Sincerely,

John Butler
Chairman

Appendix A: KCP Members

Akebia Therapeutics
American Kidney Fund
American Nephrology Nurses' Association
American Society of Nephrology
American Society of Pediatric Nephrology
Ardelyx
AstraZeneca
Atlantic Dialysis
Baxter
Cara Therapeutics
Centers for Dialysis Care
Cormedix
CSL Vifor
DaVita
Dialysis Care Center
Dialysis Patient Citizens
Fresenius Medical Care
Greenfield Health Systems
Kidney Care Council
NATCO
Nephrology Nursing Certification Commission
Renal Healthcare Association
Renal Physicians Association
Renal Support Network
Rogosin Institute
Satellite Healthcare
U.S. Renal Care
Unicycive