April 11, 2018

Physician-Focused Payment Model Technical Advisory Committee
C/O Angela Tejada, Office of the Assistant Secretary for Planning and Evaluation (ASPE)
200 Independence Avenue, S.W.
Washington, D.C. 20201
PTAC@hhs.gov

Public Comment--APM for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities

Dear Committee Members:

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 proposed alternate payment model for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities.

As evidenced by RPA's own proposal to PTAC for an APM, the Incident ESRD Clinical Episode Payment Model, we are fully supportive of the reorientation of the Medicare program toward value-based care, and we also believe that ESRD care offers a unique opportunity to simultaneously improve care and provide cost savings to the Medicare program. Despite our favorable disposition on innovative payment models in general and their potential for enhancing ESRD care, we have the following concerns about the proposed model referenced above:

- The extent to which it is a physician-focused payment model;
- Issues regarding the quality of care are insufficiently addressed; and
- Palliative care and medical management issues of the vulnerable patient population that would be the subject of the model are not sufficiently addressed.

Extent of Physician Focus in Proposed Payment Model

RPA believes that the extent to which the proposed model is actually physician-focused is limited. Our interpretation is that the bonus payments to nephrologists, specialty physicians, or other Part B providers in the model seem to be a secondary aspect of the payment model, and that the primary emphases of the model are: (1) the two extra dialysis treatments per week that the model proposes, which would be reimbursed as part of the End-Stage Renal Disease (ESRD)

Prospective Payment System (PPS); and (2) the "application of the developing technology" (as noted in the second paragraph of the proposal's Background and Model Overview).

As noted in RPA's recently updated position paper on *Increasing Dialysis Options for Patients with End-Stage Renal Disease*, we support the use of more frequent dialysis (MFD) in treating patients for whom the thrice-weekly dialysis regimen is not sufficient, particularly for those who need it on a chronic basis for conditions that may be acute and/or life threatening and when medically appropriate. RPA also supports the investigation, development, and use of innovative dialysis modalities for those patients who might benefit from more intensive hemodialysis. However, we do not believe that a payment model should have as its fundamental basis the use of more frequent dialysis, or be modality specific, and our perception of the APM for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities is that both circumstances occur with this proposed APM.

Quality of Care Concerns

RPA is concerned that the proposed model does not sufficiently address quality of care or quality measurement issues. The proposal states that *"Quality Outcomes will be based on Medicare claim data and cost centers that permit tracking hospitalizations, re-hospitalizations, ER visits, observation hospital events, post[initial 100 day] hospital discharge outcomes, and complications of transportation (e.g. falls, fractures)"* and goes on to list Patient Reported Outcome Measures (PROMs) such as the In-Center Hemodialysis Survey Consumer Assessment of Healthcare Providers and Systems (ICH-CAHPS) and Kidney Disease Quality of Life 36 (KDOL-36) data as information that will be tracked in the development of the model. However, measure specification details such as benchmarks, goals, performance metrics, and weighting and/or point distribution are not addressed in any detail in the model. As the organization with the only nephrology-specific Qualified Clinical Data Registry (QCDR), RPA has substantial expertise in this area, and based on that depth of experience we would argue that a much more robust discussion of quality measurement would be appropriate and necessary in an APM proposal of this nature. In addition, since this is intended to be a physician focused alternate payment model, the quality metrics should be physician performance measures and the areas listed in the proposal are not physician performance measures.

Palliative and Medical Management Issues

Like our concerns with quality measurement, RPA believes that the model inadequately addresses palliative care and medical management issues, particularly in this exceptionally vulnerable ESRD patient sub-population. In the Potential Hazards section of the proposal, the submitters note that *"The model addresses the latter hazard* [end-of-life or palliative care issues] *by expanding the training of the social workers to include psychosocial issues, thereby permitting a significantly expanded role in supporting the patients, families, and caregivers with respect to palliative care issues, and ultimately assisting the nephrologists to oversee this area."* While RPA fully recognizes the critically important role of social workers in the ESRD care continuum, we do not believe that expanded training for social workers that enables them to play an enhanced supporting role in ESRD care delivery is sufficient to the task of ensuring that delivery of palliative care and medical management services to the frail and elderly geriatric

ESRD patients that are the focus of this proposed model are addressed with the necessary specificity. While dialysis is a life sustaining therapy, it can also be a difficult and challenging journey that is not necessarily appropriate for or desired by all patients, and decisions on whether or not to embark on this journey should be fully informed and carefully considered; this is especially true for geriatric ESRD patients. RPA believes that the model should more directly address the hazard of dialyzing patients for whom it may not be the best care option. Shared decision making and patient-centered care must be implemented in order for this patient population to make informed choices about their care.

As always, RPA welcomes the opportunity to work collaboratively with PTAC in its efforts to develop innovative payment models to improve the quality of care provided to the nation's kidney patients, and we stand ready as a resource to PTAC in its future work in this area. 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

FRESENIUS MEDICAL CARE

April 11, 2018

Physician-Focused Payment Model Technical Advisory Committee
U.S. DHHS Secretary for Planning and Evaluation Office of Health Policy
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Dear Committee Members:

Fresenius Medical Care North America (FMCNA) appreciates the opportunity to provide comments on Dialyze Direct's proposed APM for Improved Quality and Cost in Providing Home Hemodialysis to Geriatric Patients Residing in Skilled Nursing Facilities.

FMCNA is the nation's largest integrated provider of products and services for individuals living with kidney failure. Our Fresenius Health Partners group seeks to improve both the value and quality of care for patients with kidney disease by testing innovative approaches to payment and patient care coordination. We are currently the largest participant in the Comprehensive ESRD Care (CEC) alternate payment model, which created $75 million in new savings in the first performance year and provides one of the only opportunities for Nephrologists to participate in an advanced alternative payment model. FMCNA is deeply committed to pursuing a more holistic, coordinated approach to better treatment for patients with kidney disease.

FMCNA strongly believes that many patients with end-stage kidney disease (ESRD), including those who reside in a long-term care environment, can benefit from dialyzing at home. We applaud Dialyze Direct's proposal for bringing attention to the growing population of patients with end-stage kidney disease (ESRD) who reside in a skilled nursing facility. As technology improves and patients are living longer, we expect to see more beneficiaries with ESRD residing in long term care facilities. As noted in the proposal, these patients are often older and have multiple comorbid conditions, which make transport to and from free standing dialysis facilities difficult and disruptive to care. Patients may miss medication administration, meals, treatment regimens, and planned activities, which otherwise contribute positively to their health, mental status, and quality of life.

Home dialysis—peritoneal dialysis (PD) and home hemodialysis (HHD)—is an important treatment option that offers patients significant quality of life advantages, including clinically meaningful improvements in physical and mental health. Currently, about 11.6 percent of U.S. dialysis patients receive treatment at home.[1] According to its October 2015 report, "Medicare Payment Refinements Could Promote Increased Use of Home Dialysis," the Government Accountability Office estimates that

[1]United States Renal Data System (USRDS), 2016 Annual Data Report: Epidemiology of Kidney Disease in the United States.

up to 25% of dialysis patients could realistically dialyze at home.[2] FMCNA urges the committee to strongly consider this and any future physician-focused payment models that may help increase access to home therapies.

FMCNA believes that that breakthroughs can and will occur through the creation and testing of innovative models that promote home dialysis. We commend Dialyze Direct for advancing this proposal in an effort to incentivize home dialysis and thank the PTAC for their consideration.

For any questions you may have, please contact Dr. Franklin W. Maddux, Chief Medical Officer and Executive VP, Clinical and Scientific Affairs, at Frank.Maddux@fmc-na.com or (781) 699-2424.

Sincerely,

FW Maddux MD

Franklin Maddux, MD, FACP
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[2] (2015). *Medicare Payment Refinements Could Promote Increased Use of Home Dialysis* (GAO-16-125). Washington DC: Government Accountability Office