



March 27, 2017

Physician-Focused Payment Model Technical Advisory Committee  
C/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy  
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Letter of Intent—Renal Physicians Association’s Proposed APM for Improved Quality & Cost in Transition to End Stage Renal Disease Care

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. We are writing to indicate our intent to submit a Physician-Focused Payment Model for PTAC review on or about May 1, 2017, as briefly described below.

### **Payment Model Overview**

The first months for adult patients transitioning from Chronic Kidney Disease (CKD) to End Stage Renal Disease (ESRD) therapies are associated with increased mortality and complication rates, frequent hospitalizations, and notably higher payer costs. RPA proposes a condition-specific, episode-of-care payment model (Clinical Episode Payment—CEP) that would span the first six months of dialysis therapy for established Medicare beneficiaries. This model could easily be made adaptable to payer types other than Medicare, as well.

This CEP will meet the standards as defined in the Federal Register (June 30, 2016) for a nephrology specific AAPM. Specifically, this model: (1) incentivizes coordination of care for incident dialysis patients; (2) promotes renal transplantation (both pre-emptive and after the initiation of dialysis) (3) removes obstacles and disparities for patient choice in dialysis modality; (4) encourages upstream CKD patient education; (5) promotes quality of life, medical management and advanced care planning; and (6) improves overall quality at reduced cost. Additionally, this CEP requires little additional infrastructure creation that renders it feasible in urban, suburban and rural regions. For simplicity purposes specifically to attract participation by groups of all sizes, the model is built upon utilization of the current Physician Fee Schedule billing. The financial incentives or penalties would be determined in a reconciliation period following the episode of care and would constitute shared savings or shared losses when benchmarked against a risk-adjusted target cost. This CEP, with an upside/downside risk option, would allow participants to be afforded Advanced APM status. The upside only option of this APM model would be expected to allow credit to a participating physician under the MIPS Quality Payment Program.

### **Goals of the Model**

Anticipated achievements will include measurable improvements in clinical quality outcomes, as well as a reduction in payer spending accompanying the enhanced focus on care processes during this early period of dialysis therapies. Evidence-based outcomes quality metrics as well as processes that represent surrogates for improved outcomes (permanent dialysis vascular access, for example) will be utilized to assure quality. An emphasis on hospital admission and re-admission avoidance, care coordination, and home therapies, as well as expanded use of palliative care where appropriate will impact payer spending. Avoiding the need for dialysis altogether by incentivizing pre-emptive and early renal transplantation would result in the ultimate improved outcome. This particular feature represents a novel concept of this model, as currently there exists no financial incentive to encourage transplantation.

Purposefully, the design of this model by necessity involves a more dedicated focus on care of patients while in the latter stages of CKD to achieve its stated goals. Incentivizing care to more consistently deliver optimal transitions from CKD to ESRD is expected to result in improved outcomes and reduced costs compared to results in the current health care delivery system. Moreover, the CEP encourages discussions and actions such as advanced care planning, medical management, and palliative care to those who may benefit from that care more so than dialysis therapies.

### **Expected Participants**

Particularly during this timeframe of incident dialysis, nephrologists serve as the most influential physicians in the care of ESRD patients, often more so than primary care providers. Accordingly, to a large extent nephrologists' efforts also impact payer costs. Given that this model is built upon established infrastructures and billing mechanisms, it is anticipated that nephrologists and nephrology groups of all sizes, both in rural and urban areas, would be eligible participants and attracted to this CEP.

### **Implementation Strategy**

RPA, as the sponsoring organization for this model development, will remain available as a resource for consultative activities to participants, both members and non-members.

### **Timeline**

On or about May 1, 2017, RPA anticipates submission of the full APM model proposal. If recommended to CMS, implementation would be determined once the agency agrees as to the logistics of participant identification and risk-adjustment and benchmark cost assessments. Ideally, these activities can be completed by no later than mid-2018.

Sincerely,



Michael D. Shapiro, MD,  
RPA President