

September 10, 2018

Administrator Verma
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, Southwest
Washington, DC 20201

RE: CMS-1693-P

Dear Administrator Verma:

The National Renal Administrators Association (NRAA) is a voluntary organization representing dialysis providers throughout the United States. Our membership primarily includes small and independent for-profit and not-for-profit providers serving patients in urban, rural, and suburban areas in both free-standing and hospital-based facilities. We strongly support efforts by the Centers for Medicare and Medicaid Services (CMS) to improve patient quality of care and health outcomes for Medicare beneficiaries with Chronic Kidney Disease (CKD) of all stages. We appreciate the ongoing recognition by CMS of the unique challenges posed to small and medium facilities providing high quality care to these vulnerable pediatric and adult patient populations.

The NRAA welcomes the opportunity to comment on “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; an Medicaid Promoting Interoperability Program” (CMS-1693-P). Our comments address:

1. Potentially expanding facility-based measurement in the Merit-based Incentive Payment System (MIPS) to clinicians practicing in dialysis facilities;
2. Proposed new MIPS quality measure for the nephrology measure set entitled “Medication Reconciliation Post Discharge”; and
3. Proposed new MIPS quality measure for the nephrology measure set entitled “Adult Kidney Disease: Catheter Use Greater Than or Equal to 90 Days”

Our comments reflect our continued desire to effectively partner with CMS to improve patient quality of care and health outcomes for Medicare adult and pediatric beneficiaries with CKD.

1. Potential Expansion of MIPS Facility-Based Measurement to Clinicians Practicing in Dialysis Facilities

Recommendation: NRAA opposes use of Medicare’s end-stage renal disease (ESRD) Quality Incentive Program (QIP) for purposes of facility-based measurement in MIPS because the QIP includes many measures assessing performance outside of the direct control of both the clinician and facility. Moreover, attributing facility performance to a specific clinician would be challenging in the dialysis facility setting where both the facility medical director and individual attending clinician have significant oversight over an individual patient’s care.

CMS solicits comment on whether the agency could extend the option of facility-based measurement to clinicians practicing in dialysis clinics in future years of the MIPS. Specifically, the agency asks the extent to which quality measures of dialysis clinics assessed in the QIP reflect clinician performance and whether it could be possible to attribute the performance of a specific dialysis facility in the QIP to an individual clinician to give that clinician the option of facility-based measurement in MIPS in future years.

NRAA opposes use of the ESRD QIP for purposes of facility-based measurement in MIPS. The QIP includes many quality measures that assess facility performance that are beyond the direct control of the facility *and* the direct control of clinicians practicing in the facility. For example, NRAA has significant concerns with use of the Standardized Transfusion Ratio (STrR) Measure in the QIP; in a meaningful number of cases, facilities are penalized in the QIP for patient transfusions even though many of those transfusions may be unrelated to dialysis but are recorded as such by hospitals and other third parties or are necessary because of a patient's comorbidities unrelated to ESRD such as sickle cell anemia. We also have significant concern with the National Healthcare Safety Network (NHSN) bloodstream infection (BSI) measures in the QIP, which currently cannot distinguish between BSIs related to dialysis and those unrelated to dialysis. Without such distinctions, facilities inappropriately are penalized in the QIP for non-dialysis related infections. For both of these measures, neither the facility nor the clinician practicing at the facility has control over facility performance. As such, NRAA firmly believes would be inappropriate to extend a dialysis clinic's performance on these measures and others in the QIP for purposes of future facility-based measurement in MIPS.

Moreover, attribution of a facility's performance in the QIP to a specific clinician practicing in the facility would be challenging. The medical director at a dialysis facility oversees the care of all patients in the facility and individual attending clinicians attend to specific patients seen at the facility. Both types of clinicians are critical to the care provided to ESRD patients at dialysis clinics. As such, it would be very challenging to attribute a facility's QIP performance to either of these clinicians directly. Given these attribution challenges, in addition to NRAA's concerns about the QIP outlined above, NRAA strongly believe it would be premature to extend MIPS facility-based measurement to clinicians practicing in dialysis clinics.

2. MIPS Quality Measure Entitled "Medication Reconciliation Post-Discharge"

Recommendation: NRAA supports adoption of the "Medication Reconciliation Post-Discharge" measure for the nephrology measure set for MIPS performance year 2019 and urges CMS require hospitals to provide all relevant patient information – including medication use – to clinicians and dialysis clinics post discharge.

CMS proposes to add the "Medication Reconciliation Post-Discharge" measure to the nephrology measure set for MIPS performance year 2019.

NRAA supports adoption of the "Medication Reconciliation Post-Discharge" measure for the nephrology measure set for MIPS performance year 2019. This measure will foster more coordinated care that should result in improved patient outcomes.

NRAA further urges CMS to require all relevant patient data to clinicians and dialysis clinics post discharge, including medication reconciliation information. Currently, in some instances, hospitals do not always provide dialysis clinics and practitioners taking care of ESRD patients with all hospital

discharge information. To improve quality of care and enable clinicians to succeed on the proposed new “Medication Reconciliation Post-Discharge” measure, we urge CMS to require hospitals to share all patient discharge data with dialysis facilities and practitioners seeing these patients in those facilities.

3. MIPS Quality Measure Entitled “Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days”

Recommendation: NRAA supports adoption of the “Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days” measure for the nephrology measure set for MIPS performance year 2019, but recommends the time period be extended from 90 days to 150 days.

CMS proposes to add a measure entitled “Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days” to the MIPS nephrology measure set for the 2019 MIPS performance period.

NRAA supports adoption of the “Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days” measure for the nephrology measure set for MIPS performance year 2019. Reducing rates of catheter use is the most important and meaningful way to improve ESRD patient health outcomes. Patients who use catheters have a 15-fold increased risk of catheter-related BSIs and an all-cause mortality rate ranging from 12 percent to 25 percent. Patients with fistula, by contrast, tend to have lower rates of hospitalization, better anemia management, and reduced rates of infection.¹

However, when adopting this measure, we urge CMS to extend the time period to 150 days from 90 days. Certain patients have difficulty scheduling surgery for fistula access, particularly in rural areas where there are not many vascular surgeons. A longer time period would give facilities and vascular access surgeons more time to schedule patients to receive fistulas.

V. Conclusion

In conclusion, NRAA again wishes to thank you for the opportunity to comment on CMS’s proposed rule CMS-1693-P. We look forward to continuing our valuable partnership with CMS to improve the quality and cost of care for the highly vulnerable pediatric and adult CKD patient population. If you have any questions concerning our comments, please do not hesitate to call Marc Chow at 215-564-3484.

Sincerely,



William Poirier

NRAA President

¹ Landry et al. “[Reducing Catheter-Related Infections in Hemodialysis Patients.](#)” *Clinical Journal of American Society of Nephrology*. 2014 July 7; 9(7); 1156 – 1159.