American Kidney Fund®
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October 5, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: CMS–1734–P: CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA–PD Plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy

Dear Administrator Verma:

The American Kidney Fund appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule referenced above.

The American Kidney Fund (AKF) fights kidney disease on all fronts as the nation's leading kidney nonprofit. AKF works on behalf of the 37 million Americans living with kidney disease, and the millions more at risk, with an unmatched scope of programs that support people wherever they are in their fight against kidney disease—from prevention through transplant. Through programs of prevention, early detection, financial support, disease management, clinical research, innovation and advocacy, no kidney organization impacts more lives than AKF. AKF is one of the nation's top-rated nonprofits, investing 97 cents of every donated dollar in programs, and holds the highest 4-Star rating from Charity Navigator and the Platinum Seal of Transparency from GuideStar.

AKF is also a member of Kidney Care Partners (KCP), an alliance of members of the kidney care community. In addition to our comments below, we support the comments that KCP has submitted.

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Telehealth and Other Services Involving Communications Technology

AKF supports CMS actions to increase access to telehealth during the public health emergency (PHE) for the COVID-19 pandemic, including using waiver authority to remove geographic and site of service originating site restrictions, adding a number of services to the Medicare telehealth service list on an interim basis, and allowing certain services to be furnished via audio-only communication. For chronic kidney disease (CKD) and end-stage renal disease (ESRD) patients, greater access to appropriate telehealth services during the PHE has been an essential option for them to receive necessary care while maintaining physical distance, because their chronic condition puts them at increased risk for severe illness from COVID-19.

The PHE has allowed patients, providers, and CMS to see how a combination of telehealth services and in-person care can meet patients' health needs and preferences. We support CMS efforts to extend certain telehealth flexibilities beyond the PHE, where appropriate, such as CMS' proposal to create a third temporary category of criteria for adding services to the list of Medicare telehealth services. As CMS notes, the proposed Category 3 would allow the agency to "include in this category the services that were added during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria." We also support the proposal that any service added under Category 3 would remain on the Medicare telehealth services list through the calendar year in which the PHE ends. We agree that creating a temporary Category 3 will enable clinicians and CMS more opportunity to gather information and conduct adequate reviews that are necessary for CMS to determine the appropriateness of adding a service permanently to the Medicare telehealth service list.

However, we recommend that CMS allow all telehealth services that were added to the Medicare telehealth service list on an interim basis for the duration of the PHE to remain on the list through the calendar year in which the PHE ends. This would include the telehealth services added on an interim basis for the PHE that CMS did not include in Category 3 in the proposed rule. We also recommend that CMS clarify that the waiver of geographic and site of service originating site restrictions would be extended for at least the same time period. We believe this would minimize the disruption to provider practices and beneficiary access that would occur if these telehealth services were abruptly halted as soon as the PHE has ended.

ESRD services (90952, 90953, 90959, 90962) were added to the Medicare telehealth service list for the duration of the PHE but are not being proposed for addition permanently or in Category 3, and CMS seeks comment on this. The appropriate standard of care for ESRD patients who receive in-center dialysis is to have at least one face-to-face visit a month with their nephrologist. Therefore, AKF supports maintaining the requirement that for in-center dialysis patients, at least one of their Monthly Capitation Payment (MCP) visits with a physician be in-person, and not allow all their monthly visits to be furnished via telehealth. We support and appreciate that CMS included ESRD services on the telehealth service list for the duration of the PHE, and in keeping with our recommendation above, we recommend that they remain on the list through the calendar year in which the PHE ends.

As CMS continues to examine the appropriateness of extending certain telehealth flexibilities outside the circumstances of the PHE, we also urge the agency to examine the impact of telehealth services on patients with chronic conditions such as kidney disease and the impact across different socioeconomic, racial and ethnic populations. This examination will be important to track any disparities that exist with respect to telehealth access and health outcomes.

End-Stage Renal Disease Monthly Capitation Payment Services

CMS proposes to update the ESRD MCP codes "to more accurately account for the associated office/outpatient E/M visits." We fully support this proposal and encourage CMS to finalize it. As noted in the proposed rule, in the past CMS has not updated the value of the MCP code set to reflect the updates to the valuation of the office/outpatient E/M visit code set, and therefore values of the ESRD MCP codes have become misaligned with the value of their constituent visits. Updating the codes to correct this misalignment will provide additional resources for providers to help their patients living with chronic kidney disease manage their condition and improve their quality of life.

Thank you for your consideration of AKF's comments and recommendations.

Sincerely,

LaVarne A. Burton
President and CEO