AMA
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June 26, 2017

Jeffrey Bailet, MD
Committee Chairperson
Physician-Focused Payment Model
Technical Advisory Committee
Office of the Assistant Secretary for
Planning and Evaluation
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Bailet:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide our strong support for the Renal Physicians Association (RPA) Incident End-Stage Renal Disease (ESRD) Clinical Episode Payment (CEP) Model proposal currently being reviewed by the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

The ESRD CEP proposed model focuses on patients transitioning from chronic kidney disease (CKD) to ESRD, and includes treatments within the first six months of ESRD care. Costs in the first six months of ESRD care are disproportionately higher than costs in later stages of the condition, often due to suboptimal transitions to renal replacement therapy. The AMA has participated in several discussions with nephrologists and others who provide medical care to patients with CKD and ESRD, which have illuminated the numerous opportunities to improve the delivery of care for these patients and the barriers to making those improvements within the existing payment system. Given the potential for improved quality of care, quality of life, and reduced Medicare spending, the AMA agrees that treatment for the first six months of dialysis care for patients with ESRD is an ideal condition to be treated through a condition-based episode-of-care Alternative Payment Model (APM).

The RPA argues that the proposed model will increase physicians' focus on improving care during the latter stages of advanced CKD, before patients develop ESRD. In addition, the proposal states that once patients develop ESRD, factors such as starting incident hemodialysis without permanent vascular access can create costly complications and higher mortality rates. Also, greater access to home dialysis and palliative care options can improve the quality of life and outcomes for ESRD patients. Therefore, the AMA agrees the proposed ESRD CEP model will support nephrologists' efforts to improve care and reduce costs by emphasizing pre-dialysis treatment planning, increasing care coordination, reducing complications that can lead to hospital admissions, increasing access to kidney transplants and to home dialysis, and promoting advanced care planning.

Furthermore, the proposed model requires minimal infrastructure creation, allowing physicians in a variety of practice locations and sizes to participate. In addition, the model has two tracks, one which includes upside risk only, which would allow physicians to participate in an APM within the Merit-Based

Incentive Payment System (MIPS). The second track includes both upside and downside risk, and would be considered an Advanced APM. The AMA supports allowing physicians the flexibility to participate in either MIPS APMs or Advanced APMs, and not requiring that they move to a two-sided risk model.

The ESRD CEP model could allow ESRD patients receiving the first six months of dialysis treatment to experience fewer hospitalizations and complications, which would significantly reduce Medicare costs for these beneficiaries. The proposed model provides an important opportunity to improve patient care and achieve cost savings for patients transitioning from CKD to ESRD.

The AMA urges the PTAC to recommend the RPA Incident ESRD Clinical Episode Payment Model as a high priority for adoption and implementation. We thank the Committee for the opportunity to comment.

Sincerely,

James L. Madara, MD