

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

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In accordance with the Physician-Focused Payment Model Technical Advisory Committee's (PTAC's) proposal review process, proposals for Physician-Focused Payment Models (PFPMs) that contain the information requested by PTAC's *Proposal Submission Instructions* will be assigned to a Preliminary Review Team (PRT). The PRT will draft a report containing findings regarding the proposal for discussion by the full PTAC. This PRT report is preparatory work for the full PTAC and is not binding on PTAC. This report is provided by the PRT to the full Committee for the proposal identified below.

A. Proposal Information

1. **Proposal Name:** Incident ESRD Clinical Episode Payment Model
2. **Submitting Organization or Individual:** Renal Physicians Association (RPA)
3. **Submitter's Abstract:**

"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. 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 Medicare 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. Evidence-based 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. 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.”

B. Summary of the PRT Review

The proposal was received on May 18, 2017. The PRT met between July 29, 2017 and October 25, 2017. A summary of the PRT’s findings are provided in the table below.

PRT Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary (at 42 CFR§414.1465)	PRT Rating	Unanimous or Majority Conclusion
1. Scope (High Priority)	Meets	Unanimous
2. Quality and Cost (High Priority)	Meets	Unanimous
3. Payment Methodology (High Priority)	Meets, except for transplant bonus component	Unanimous
4. Value over Volume	Meets	Unanimous
5. Flexibility	Meets	Unanimous
6. Ability to be Evaluated	Meets	Unanimous
7. Integration and Care Coordination	Does not meet	Unanimous
8. Patient Choice	Meets	Unanimous
9. Patient Safety	Meets	Unanimous
10. Health Information Technology	Meets	Unanimous

C. Information Reviewed by the PRT

1. Proposal Summary

The PRT reviewed the proposal submitted by the Renal Physicians Association as well as additional information provided by the submitter in written responses to questions from the PRT. The submitter also participated in a phone call with the PRT. The proposal, questions and answers, and call transcript are available on the PTAC [website](#).

The proposal is a clinical episode payment model for Medicare patients with end-stage renal disease who have just begun receiving dialysis for the first time (which is referred to as “incident dialysis”).¹ The proposal seeks to improve 1) upstream preparation for dialysis; 2) equality of access to modality types and shared decision making; 3) access to renal transplant; 4) healthy transition to dialysis; and 5) well-being during the first 6 months of dialysis. Although the cost of care for all dialysis patients is high, the proposal is focused on addressing the particularly high rates of hospitalizations and associated costs for patients that typically occur in the first six months of dialysis, partly due to suboptimal transitions to dialysis. Patients start dialysis by one of several methods, including peritoneal dialysis, hemodialysis with a fistula or graft, or hemodialysis with catheters. The modalities associated with lower rates of complications and higher patient satisfaction require patient education as well as surgical preparation and healing at least several weeks before dialysis begins. Dialysis can be performed in a center or in a home; training for home dialysis often takes several weeks. Most patients begin dialysis with a catheter rather than a fistula, and many patients begin dialysis during an inpatient hospitalization (“crashing into dialysis”). These two groups of patients have particularly high rates of morbidity, mortality, hospitalizations, and total Medicare costs.

The proposed APM has two major elements. The first element is shared savings payments to the nephrologist (or repayments to Medicare for losses) based on a) the total amount Medicare spends on all services to the nephrologist’s patients (including services unrelated to their kidney disease) during the six months following initiation of dialysis, compared to a regional benchmark, and b) performance on a set of quality metrics. The second major element of the proposal is one-time bonus payments for preemptive transplantation before dialysis (\$3,000) or transplantation after dialysis begins but during the clinical episode (\$1,500).

In addition to dialysis, treatment options for patients with advanced kidney disease and ESRD include kidney transplants or medical management of their condition without dialysis. The shared savings component of the proposed payment model would only apply to these patients if they initiated dialysis and then transitioned to medical management or had a transplant during the six months after dialysis began.

The population of patients eligible for this proposed model is limited to patients who are enrolled in Medicare when they begin dialysis or receive a transplant. For the shared savings component, the episode would begin the first day of the month during

¹ It is possible that Medicare beneficiaries who have had a kidney transplant that subsequently fails will then need to start dialysis (or restart dialysis). This dialysis initiation would occur at a much later point after first being diagnosed with end-stage renal disease than most ESRD patients. The PRT interpreted the proposal’s focus on “incident ESRD” to mean that it would be limited to those who are initially transitioning from chronic kidney disease to ESRD and who are receiving dialysis as their first form of renal replacement therapy, rather than those who initiate dialysis after a transplant.

which dialysis begins, as noted on the Medicare 2728 form (unless dialysis begins on or after the 16th of the month).

Nephrologists would continue to receive fee-for-service reimbursements during the clinical episode. During two annual reconciliation periods, the APM Entity (which could be the nephrology practice or another entity) could receive shared savings (in the upside-only MIPS APM option or the advanced APM option) or be required to repay losses (only in the two-sided advanced APM option) based on the comparison of the actual episode-adjusted patient cost to a risk-adjusted regional benchmark. For the purposes of the APM, the episode-adjusted patient cost is calculated by 1) summing total Medicare A and B costs for eligible patients, subject to truncation and some exclusions mirroring the Comprehensive ESRD Care Model (CEC) Model methodology; 2) dividing the total by the number of eligible patients; and 3) dividing by the average normalized Hierarchical Condition Category (HCC) score. The regional benchmark is based on the two most recent years of Parts A and B expenditures for incident ESRD cases in the APM participant's health care referral region, divided by the patients' normalized HCC scores.

The amount of money a participating APM Entity could receive as shared savings (or owe to Medicare as shared losses in the two-sided model) depends on whether the Entity achieved the required minimum amount of savings (or losses) and how it performed on the quality metrics. If participating providers achieve savings of at least 3% (1% in the two-sided approach) compared to the benchmark, providers would receive 75% of the total savings (the difference in APM per-patient costs compared to the benchmark, multiplied by the number of patients) multiplied by their quality score (expressed as a percentage of the 100 possible quality points). Providers must achieve a quality score of at least 30 (in which case the provider's share of total savings would be multiplied by 0.3) to receive quality-adjusted shared savings payments. For participants in the two-sided risk option, losses would need to be at least 4% compared to the benchmark before repayments are required. Participants would be responsible for 50–75% of the losses, depending on their quality scores.

2. Additional Information Reviewed by the PRT

a) Data Analyses

The PRT sought additional information regarding the characteristics, utilization, and expenditures of traditional Medicare beneficiaries with ESRD. The Office of the Assistant Secretary for Planning and Evaluation (ASPE), through its contractor, produced data tables that are available on the PTAC [website](#).

b) Literature Review and Environmental Scan

ASPE, through its contractor, conducted an abbreviated environmental scan that included a review of peer-reviewed literature as well as a search for relevant gray literature, such as research reports, white papers, conference proceedings, and government documents. The abbreviated environmental scan is available on the PTAC [website](#).

Documents comprising the environmental scan were primarily identified using Google and PubMed search engines. Key words guiding the environmental scan and literature review were directly identified from the letter of intent (LOI). The key word and combination of key words were utilized to identify documents and material regarding the submitting organization, the proposed model in the LOI, features of the proposed model in the LOI, or subject matter identified in the LOI.

Key terms used included “ESRD,” “payment reform,” “bundled payment,” “Medicare,” “outpatient dialysis,” “renal transplant,” “GAO,” “MedPAC,” “chronic kidney disease,” “CMS,” “USRDS,” “statistics,” “ESRD bundled payment,” “clinical evidence,” and “payment policy.”

These documents are not intended to be comprehensive and are limited to documents that meet predetermined research parameters, including a five-year look back period, a primary focus on U.S. based literature and documents, and relevancy to the LOI.

As part of this environmental scan, the PRT reviewed the Centers for Medicare and Medicaid Services’ (CMS’) Comprehensive ESRD Care (CEC) Model and the ESRD Quality Incentive Program (QIP).

c) Public Comments

The PRT reviewed six public comment letters on the proposal. The public comment letters are available on the PTAC [website](#).

d) Other Information

The PRT spoke with a nephrologist at the University of Pennsylvania to discuss how end-stage renal disease is treated and the opportunities for improved quality and savings. A transcript of the conversation is available on the PTAC [website](#). The PRT also obtained information from the CMS Office of the Actuary (OACT) and Center for Medicare and Medicaid Innovation (CMMI) regarding the proposal.

D. Evaluation of Proposal Against Criteria

Criterion 1. Scope (High Priority Criterion). Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

PRT Qualitative Rating: Meets Criterion

Strengths:

- The proposed model would expand access to APMs for nephrologists who have not been able to participate in the CMS CEC model. The minimum number of patients required for the CEC model precludes small nephrology practices from creating an ESRD Seamless Care Organization (ESCO). In addition, large dialysis organizations are not participating in the CEC model in all regions. CMMI estimated that 10% of nephrologists are part of an ESCO, which are disproportionately located in urban areas, the Northeast, and the South.
- The model would also expand the number of Medicare patients with incident dialysis who have the potential to benefit from better quality care supported by an APM.
- Although Medicare currently reimburses for fistula or graft placement in preparation for dialysis, the physician fee schedule neither includes payments to nephrologists to support proactive education and outreach to patients with chronic kidney disease nor payments for coordination with surgeons to encourage preparation for dialysis. The proposed model would enable and encourage nephrologists to provide these services.

Weaknesses:

- Small nephrology practices could be unfairly rewarded or penalized due to random variation in spending. The practice size requirements and minimum number of cases that are part of the CEC are intended to reduce the effects of random variation on shared savings and losses.

Summary of rating:

ESRD patients have high costs of care and there are many opportunities to improve care and reduce Medicare spending for their care. The only APM focused on ESRD patients is the CEC model, and only a small number of nephrologists are participating in that model. By extension, a relatively small share of Medicare patients with incident ESRD are benefiting from participation in an APM. CMMI does not plan to solicit new ESCOs, so nephrologists who are not in a position to join one of the 37 total existing ESCOs will not have the ability to participate in an APM. In the view of the PRT, this model could significantly expand the number of nephrologists who can participate in an APM with the potential to lower costs and improve the quality of care for ESRD patients.

Criterion 2. Quality and Cost (High Priority Criterion). Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

PRT Qualitative Rating: Meets Criterion

Strengths:

- Average annual spending for Medicare ESRD patients is approximately \$90,000, and a significant portion of that spending involves potentially preventable hospitalizations. All ESCOs in the CEC model achieved savings in the initial year of the program, so it seems likely that nephrologists participating in this model could also achieve savings.
- The model makes shared savings payments contingent on a number of important quality metrics which will help ensure that savings are generated through improved care for patients.

Weaknesses:

- Although there are opportunities to improve care and reduce costs after dialysis begins, the biggest impacts would occur if improved care started before dialysis was initiated. The PRT was concerned about how often a nephrologist who treats incident dialysis patients would have the ability to influence upstream care prior to dialysis. USRDS data show that 28% of ESRD patients did not have nephrology care prior to beginning dialysis, and 43% had less than 6 months of nephrology care prior to beginning dialysis.
- The PRT felt that a payment model that began with a clinical indicator (e.g., tests indicating late-stage CKD) might be more effective at improving outcomes than a payment model triggered by the initiation of dialysis, but the applicant expressed concern about the reliability of an episode trigger based on the stage of CKD.
- The minimum quality score for receiving shared savings is 30, which providers could achieve merely by reporting performance. The PRT is concerned that the way in which patients experience the changes in care delivery under the model is only given a small amount of weight, and it felt that the model would be strengthened by including a minimum patient satisfaction score as part of the quality score threshold.
- The PRT felt that the transplant bonus was unlikely to have a significant impact on improving quality via higher transplantation rates because there is a limited number of available organs for transplant.

Summary of Rating:

In the view of the PRT, this model could improve quality and reduce costs for Medicare patients with incident ESRD by providing incentives to improve the transition to dialysis and improve care management during a period associated with high hospitalization rates and health care costs. The PRT would prefer to see a greater emphasis on the patient experience in the quality measures and minimum quality score threshold. Rather than simply requiring reporting of patient experience, the PRT would prefer to see the model include a minimum score on a patient experience measure in order to receive shared savings payments. Even with these concerns, the PRT views the proposal as meeting this criterion because the opportunity for improvement is so great.

Criterion 3. Payment Methodology (High Priority Criterion). Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.

PRT Qualitative Rating: Meets if only the shared savings/risk component is included, does not meet if transplant bonuses must be included.

Strengths:

- The payment methodology is designed specifically to direct higher payments to nephrologists who achieve better results for patients in the first six months of dialysis, a time of particularly high costs and poor outcomes.

Weaknesses:

- An episode-based model that begins at dialysis could achieve higher quality and lower cost, but the PRT wondered whether an alternative that began with a clinical indicator more upstream in disease progression (e.g., tests indicating late-stage CKD) might be more effective at improving outcomes. Dialysis is the starting point for the episode, but much of the work necessary to achieve the maximum benefits during the six months following initiation of dialysis would need to occur prior to dialysis. Moreover, not all patients have the same nephrologist or use the same nephrology practice before and after dialysis begins. The data analysis found that only 62% of Medicare patients beginning dialysis had used the same nephrology practice at least 60 days before dialysis began.
- The payment methodology does not provide any upfront payment to providers to support enhanced education and care management activities.
- The shared savings payments are based on risk-adjusted spending and regional benchmarks that are designed to account for patient comorbidities, but small numbers

of eligible patients for some participating providers could hinder effective risk adjustment and cause payments for savings and losses to be based on random variation outside the providers' control rather than on the quality of care provided.

- The PRT is supportive of encouraging kidney transplants instead of dialysis, but the kidney transplant bonus that is part of this proposal is an area of major concern to the PRT for the following reasons:
 - It seems unlikely to significantly increase the number of transplants performed because of the limited supply of organs, and this could increase Medicare spending without improving outcomes.
 - The majority (80%) of patients added to the kidney transplant waiting list each year are under age 65 and potentially subject to Medicare secondary payer status. Providing bonuses for transplants for Medicare beneficiaries could shift transplants from patients otherwise paid for by other insurers to patients covered by Medicare, thereby increasing costs incurred by the Medicare trust funds.
 - The receipt of a transplant reflects factors that are largely beyond the nephrologist's control; an enhanced quality measure for transplant referral and education would seem to better reflect activities within the realm of the nephrologist's influence.
 - The bonus raises potential distributive issues. Physicians could potentially focus efforts to obtain transplants on those patients who are most likely to find a living donor; these patients tend to be younger and have more resources.
 - PRT members debated whether the size of the bonus would enhance or diminish patient choice. The large incentive could potentially put physicians at odds with patients who do not want a transplant, but at the same time it could encourage physicians to work harder to obtain transplants and expand the range of treatment options available to some patients.
- PRT members expressed concern about the definitions and weighting of the proposed quality measures, particularly that there is only a small amount of weight given to the patient experience.

Summary of Rating:

The PRT divided its evaluation of this criterion into two parts, the shared savings payment methodology and the transplant bonuses. Though there are some weaknesses in the shared savings payment methodology, the PRT believes that the proposed model does have the potential to achieve the goals of the PFPM and thus meets the criterion.

Regarding the transplant bonuses, the PRT agreed that increasing the rate of kidney transplants would improve quality for this population, but achieving increased transplant rates is largely out of the nephrologist's control and awarding bonuses could lead to unintended consequences. As a result, the PRT felt the transplant bonuses would not meet the criterion.

The PRT felt that the shared savings component of the proposal could be implemented without the transplant bonus. If the two components cannot be separated, the PRT felt that its concerns about the transplant bonuses were significant enough that the model would not meet this criterion.

Criterion 4. Value over Volume. Provide incentives to practitioners to deliver high-quality health care.

PRT Qualitative Rating: Meets Criterion

Strengths:

- This model provides incentives to reduce the total cost of care for incident dialysis patients, in part by reducing the rate of hospitalizations and other avoidable complications of treatment.

Weaknesses:

- By beginning the episode with a procedure, this model could create an incentive to start dialysis earlier in the disease process when patients are healthier and less likely to have complications. The submitters proposed that the GFR levels of dialysis patients be monitored to protect against this, but no methodology was proposed to determine when a problem existed nor were specific remedies proposed.

Summary of Rating:

Overall, the PRT felt that this model provides a reasonable balance of incentives designed to reduce health care utilization and provide value to patients and Medicare rather than incentivizing volume.

Criterion 5. Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care.

PRT Qualitative Rating: Meets Criterion

Strengths:

- The model provides greater flexibility than fee-for-service Medicare or the CEC Model in the types of activities physicians could undertake to deliver high-quality health care. The model does not require participating physicians to do specific activities to achieve improvements on the quality metrics, but the proposal does offer some suggested activities. Providers could use shared savings payments to support a range of activities to improve quality.

Weaknesses:

- While the model is flexible in the ways in which providers could achieve quality improvements, the PRT questions the extent to which a shared savings model will truly enable providers, particularly small nephrology practices, to deliver care differently. During the episode, provider reimbursement remains the same; only during the reconciliation periods can providers potentially recoup their investments and realize their performance on quality measures.
- In order for nephrologists to deliver unreimbursed services that would improve patient care, they would need to make upfront investments and hope that they could recoup these investments after reconciliation. This could discourage many practices, particularly small practices, from implementing desirable but relatively expensive services.

Summary of Rating:

The PRT believed the proposed model would meet this criterion because (a) it would provide more resources to nephrologists to deliver services that could benefit patients than is possible under the current payment system, and (b) it would give providers more flexibility regarding the types of activities they can undertake to achieve the performance metrics and improve quality than other APMs.

Criterion 6. Ability to be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

PRT Qualitative Rating: Meets Criterion

Strengths:

- The PRT believed it is feasible to assess changes in spending and quality associated with model implementation; the goals of the model, the quality measures, and potential impact on health care costs are clear and can be evaluated.

Weaknesses:

- For assessment of quality outcomes, there may be challenges in reporting some of the quality measures through the EHR, particularly the patient experience (PROMIS) if a nephrologist does not participate in the RPA-sponsored Kidney Quality Improvement Registry.

Summary of Rating:

The PRT views the model as meeting this criterion because it has evaluable goals with clear performance metrics.

Criterion 7. Integration and Care Coordination. Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

PRT Qualitative Rating: Does Not Meet Criterion

Strengths:

- Because savings would depend in part on improving the transition to dialysis for incident dialysis patients, the payment model would indirectly encourage nephrologists to establish better mechanisms for communication with primary care providers and other specialists in the community regarding patients with chronic kidney disease who are likely to need dialysis in the near future.
- In addition, because the dialysis patients with the highest avoidable costs are likely to be those with multiple comorbidities, the model would implicitly encourage nephrologists to improve care coordination with the patients' other physicians.

Weaknesses:

- The proposal does not provide clarity about how providers would achieve better coordination both prior to and during dialysis. There is no indication as to whether or how nephrologists would involve other physicians in the APM Entity or share savings and losses with other providers.

Summary of Rating:

This model implies that care coordination will happen both before and during the clinical episode, but it does not provide sufficient detail about how the providers will achieve this integration.

Criterion 8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

PRT Qualitative Rating: Meets Criterion

Strengths:

- By encouraging earlier education and preparation for the transition to dialysis, this proposal has the potential to expand the range of treatment options available to patients with incident ESRD.
- This proposal also could encourage providers to identify patients unlikely to benefit from dialysis and educate patients about the possibility of medical management for their disease; existing financial incentives encourage providers to recommend dialysis for these patients.

Weaknesses:

- As noted earlier, the model could create an incentive to start dialysis earlier in the disease process when patients are healthier and are less likely to have complications. However, because dialysis is not a desirable option for patients, it seems likely that the primary focus for nephrologists would be on reducing spending for patients who need dialysis rather than trying to encourage patients to start dialysis sooner.
- The bonus for transplants could have both positive and negative consequences for patient choice. The transplant bonus could lead to greater patient choice if one views the bonus as a pathway to overcome existing barriers (particularly the unreimbursed costs of transplant education, referral, and coordination) that may reduce the number of patients pursuing transplants. On the other hand, the size of the bonus is large enough that it could encourage physicians to ignore or try to override patient preferences.

Summary of Rating:

As with Criterion 3 (payment methodology), the PRT separated the model's implications for this criterion into the shared savings component and the transplant bonus component. The PRT believed the shared savings component would facilitate patient choice by incentivizing providers to educate patients about a wider range of dialysis modalities as well as encourage medical management for patients unlikely to benefit from dialysis. In contrast, the transplant bonuses could potentially conflict with patient choice. Overall, however, the PRT felt that concerns about the impact of the transplant bonuses were not significant enough to prevent the model from meeting this criterion.

Criterion 9. Patient Safety. Aim to maintain or improve standards of patient safety.

PRT Qualitative Rating: Meets Criterion

Strengths:

- This proposal has a clear focus on avoiding hospitalizations and other problematic outcomes for patients during the first six months of dialysis, which would improve patient safety.

Weaknesses: None noted

Summary of Rating:

The proposed model meets this criterion.

Criterion 10. Health Information Technology. Encourage use of health information technology to inform care.

PRT Qualitative Rating: Meets Criterion

Strengths:

- All providers would be required to use CEHRT.
- Nephrologists and other participating providers would be encouraged to coordinate care prior to and during dialysis with the aid of health information technology.
- The proposal notes that the RPA Qualified Clinical Data Registry (QCDR) would be available to model participants and would facilitate the collection of patient and disease data.

Weaknesses:

- This proposal does not provide specific information about how it encourages use of health information technology.

Summary of Rating:

While the proposal does not provide extensive detail about how it would encourage use of health information technology, the PRT felt that model participants would have an incentive to use HIT to inform care for their patients with incident ESRD.

E. PRT Comments

The transition to dialysis is associated with particularly high health care expenditures and adverse health outcomes for patients, and this model defines a viable payment methodology that would enable and encourage providers to better manage this transition. It also would complement rather than duplicate the existing CEC Model, which focuses on managing prevalent ESRD and leaves out many nephrologists from participation. A weakness of the model is that it rewards activities that ideally would begin prior to dialysis, such as education and vascular access preparation, but the episode starts only after dialysis begins. Although this would still give nephrologists an incentive to improve care before dialysis begins, it would be difficult for them to do so if they were not involved in the patient's care prior to dialysis. Another weakness is that it does not provide upfront funding to support care management activities and instead forces physician practices to incur the financial risk of providing desirable services without immediate reimbursement and with no assurance they will recoup these investments during the reconciliation period. The model relaxes practice size requirements that are part of the CEC model, but this makes the shared savings calculations potentially more vulnerable to random variation, particularly for small providers.

In its review, the PRT grappled with how to handle the transplant bonuses included as part of the proposed model. While the PRT supports approaches to encourage transplants for patients with late-stage CKD or ESRD and the associated improvements in quality and cost, it viewed paying bonuses as both a problematic and unnecessary component of the proposal. By providing bonuses for transplants prior to dialysis, an entirely different patient group that does not meet the definition of an incident dialysis patient with Medicare would be included. The PRT believes that factors such as organ availability, patient genetic compatibility, and geography play a much larger role in determining whether a patient receives an organ transplant than the nephrologist's actions. The PRT supports strengthening the quality measure for transplant referrals or other modifications to the proposal that incentivize transplants while connecting more directly with nephrologist's actions. The PRT would also support testing this model without the transplant bonuses.