Centers for Medicare & Medicaid Services
COVID-19 Dialysis Call
June 10, 2020
5:30 p.m. ET

Alina Czekai: Good afternoon. Thank you for joining our June 10th COVID-19 call with Nephrologist, Dialysis Providers and Other Clinicians Caring for Patients Living with Kidney Disease. This is Alina Czekai leading stakeholder engagement on COVID-19 in the office of CMS Administrator, Seema Verma.

Today, we are joined by CMS leaders, as well as providers in this field who have offered to share best practices with you all. I'd first like to turn it over to Dr. Shalon Quinn, Acting Director at the Division of Kidney Health at the Center for Clinical Standards and Quality, for an update on the agency's latest guidance in response to COVID-19. Dr. Quinn, over to you.

Shalon Quinn: Thank you, Alina. Welcome everyone. Thank you all for joining us today. We want to say that we're really, really thankful for all of you for working so hard to combat the spread of COVID-19 in your communities. We really appreciate all of your efforts so far to keep our patients safe and continuing to compassionately care for those that rely on you.

So, we have a wonderful speaker today that we'll be talking about the impact of COVID-19 on kidney transplant. But before we get to that, I have a couple of CMS updates on the ESRD Quality Incentive Program or QIP, the user interface phase one release.

So, last week, CMS announced the first of two phases for end-stage renal disease QIP user interface modernization effort. The QIP – the ESRD QIP is a pay-for-performance program that provides financial incentive for renal facilities to deliver high quality patient care.

As for the first phase, CMS is streamlining the ESRD QIP user interface is with single system where users only need one set of credentials for access. Additionally, the first phase of the roll out includes a new user rule request process and user interface with enhanced navigation features.

So, the first phase will be implemented this month and will allow users to test the new features prior to the start of the ESRD QIP program year 2021 preview period in mid July 2020. The second phase of the modernization efforts will commence during the start of the program year 2021 preview period. And it'll consist of two lines communication and inquiry submission process.

So, with that, I am going to go ahead and introduce our speaker today. We will have Dr. Andrew Howard, who is the past president of the Forum of ESRD Networks. He will be talking to us about the impact of COVID-19 on kidney transplant. Dr. Howard?

Andrew Howard: Thank you very much, Shalon. Pleasure to be speaking with all of you today. I'm trying to keep my remarks brief, no more than five to 10 minutes maximum because I'd love to hear experiences from those around the country and certainly if we have some transplant nephrologist or transplant center personnel who were on the call.

The datas that I'll be sharing with you is all publicly accessible. It's from UNOS, who provides wonderful weekly updates showing the impact of COVID-19 on both rate of transplantation and the rate of the kidney waitlist. The data again that I'll be showing you refers to just kidney transplant as well I'll be discussing; I won't be including kidney pancreas. And I'll be limiting it to adult which UNOS defines as age 18 or older.

A few brief words about myself. I did retire from full time clinical practice last summer. I was with a midsize nephrology group in the Mid-Atlantic region. For those of you who know that area, we practiced in Fairfax County, Virginia to include Alexandria, Arlington County and Prince George's County, Maryland.

For midsize nephrology group, I'd always had a love of transplant. I left the military, the U.S. Army, in 1989 and I practiced with this group for 30 years and given that we were just 10 providers, a combination of advanced practice providers and nephrologist.

We actively provided care to over 300 kidney and kidney pancreas transplant patients. We also had the pleasure of working with one of the large hospital systems in the area to provide a nephrology support. My group continues to do so for a very robust and growing heart and lung transplant program.

Having said that, a couple lot of things you should know about me, my group remains part of the Maryland ESCO and I'm a consultant to my group to continue to help them with that as well as serving as one of the managers for that ESCO and needless to say we have applied with the release today about initial applications for one of the KCC voluntary models. Obviously, I don't have to tell you all how important transplant is not only to the voluntary models but to the ETC or mandatory models should we hear more in the future about that.

So, having giving you that background, I and my group have always been passionate about this. We had the pleasure to work with seven regional transplant programs in our area. What I'd like to share with you is the data on Transplant First. If you'd look a total number of adult kidney transplants, they were averaging from just over 400 to just over 500 kidney transplants in adults across the U.S. on a weekly basis.

UNOS does break the United States down into eight regions, Northeast, Mid-Atlantic, Southeast, Great Lakes, North Midwest, South Midwest, Northwest and Southwest, and there clearly are regional differences. I don't need to imply that they aren't due to the impact of COVID. But again, the numbers I'll be sharing with you now are reflecting the entire U.S.

So, after bottoming out the end of March to very beginning of April where the total number of weekly transplants had fallen to about 200 with an almost complete cessation of living donor, they've rebounded nicely and the latest numbers which we have ending June 6th from UNOS are we've come back up to 454 transplants done in that week.

If you do a little deeper dive and you look at living donor versus deceased donor, you'll see that the living donor transplants in that week had rebounded to a 107 at the lower limit of what weekly living donor transplants were. And

then if you look at deceased donor, they've continued to increase over the past three weeks after some ups and downs in the same bottoming out to 347.

Changing gears to waitlist, I don't have to tell you all how important this is and this is a more complicated process obviously, but waitlist is not only important to all of us who take care of these patients to get them transplanted but also, Shalon, began with the discussion of the QIP and I think as all of you know that's one of the new clinical measures for performance year 2020. That would be the PPPW or Percent Prevalent Patient Waitlist measure.

And clearly, that has been impacted. For those of you who are involved with one of your ESRD Networks, one of their quality improvement initiatives was also increasing waitlist. There had been contract modifications due to the data that I'm going to show you and other urgencies related to COVID for them.

But if you go back to the end of February, you'll notice there were just under a thousand weekly additions to the kidney transplant waitlist across the U.S. Holds for COVID related issues started to show up in mid-March and reached a peak of just over 2,000 patients being held off to National Kidney Transplant Waitlist in mid-April and I'm happy to report that at least holds due to COVID had fallen to just 23 for the most recent week.

There's been a slight uptick in additions to the weekly waitlist. And for the last weekend in June 6th, there were 501 patients added. If you go back to the peak, again, the first week in March, there were 923. I've mentioned regional differences and if you have to pick out one region, this will be a surprise.

And I'd love to hear from some of you who practice in this region. But the Northeast was, to some extent, more heavily impacted than other of the eight UNOS regions and are continuing to lag behind but we'll certainly pick up and that will I think really push the whole country back up.

Needless to say, the impact from COVID was quite extensive in the Northeast and the improvements had been just excellent there so I expect the improvements in both transplant rate and waitlist to follow.

Lastly, transplant waitlisting is a complex process. Obviously, the patient has to be referred, whether that's out of the nephrologist office as we all hope it will be or once the patient gets to the dialysis facility whether they're on in center or at home. There's been a process itself which obviously includes a variety of testing that has to occur before the patient can actually be placed on the waitlist.

Some transplant centers do this all themselves and have an excellent process. Other nephrology practices, as ours did, take ownership and do as much we can, but this implies that a number of different facilities and physicians' offices need to be utilized. Hence it's a complex process with many roadblocks and probably at least is in part an answer to why the weekly additions to the transplant waitlist have lagged behind actual transplants.

Shalon, I thought I'd stop there. I didn't want to go more than that. I'd love to hear from other folks who may be able to add something. Thank you for the opportunity, Shalon.

Shalon Quinn: Great. Thank you so much, Dr. Howard. So, we will operate and we'll go ahead and open up for lines for questions now. If you have questions for Dr. Howard or for CMS.

Operator: That is noted. Ladies and gentlemen ...

Jesse Roach: No. Go ahead. I'm sorry.

Operator: I'm sorry. Ladies and gentlemen, we are about to start the question and answer session. To ask your question, you will need to press star one on your telephone. To withdraw your question, press the pound key. Please stand by while we compile the Q&A roster.

Jesse Roach: Hi, Dr. Howard, this is Jesse Roach with CMS. I'll ask while waiting for other people. Have you – and you might not have this on your data, have you noticed or heard of an uptick on the number of living donor evaluations? Because I know that they've been significantly down and I think that's a good piece of getting transplant done as well. And I don't know if you have known

anything. I've heard anecdotally that they might be starting back up, but I don't know if you have any information on that.

Andrew Howard: That's actually a great question. I didn't specifically break that down but yes. I think there was in general – in fact there was a wonderful thread from the American Society of Transplant, which is still ongoing although it was very robust in during the latter half of March and April and looking at transplant programs all over the country and I think initially there was – and this is probably why that living donor rates fell dramatically, but there was initially a reluctance, if you will, to I think proceed with living donor transplant. I think the focus was put more on deceased donor.

If an organ came up and issues concerning COVID could be worked around, obviously, a little easier to test the deceased donor organ, but then getting a recipient tested but particularly patients who have been waiting on the deceased donor list for some length of time where the PRA was quite high and I think as we all know they might not get another offer for a kidney for quite some time.

I think initially, that's where the focus was. But I think now, many of the transplant centers have at least to get a foot in the door have been using very successfully as nephrology practices the option of Telehealth to have that initial visit. So, I do feel that it's opening up for both now.

Certainly, the rate of living donor transplant has to shut up and by the numbers I gave you just at the lower limit of what we were seeing prior to COVID. But that's actually a great question and different transplant centers have different approaches to that, but I think others could perhaps offer comments if they're involved directly with transplant on the call.

Operator: Once again, ladies and gentlemen, if you would like to ask a question that's star one on your telephone keypad.

We don't have a question on queue. Please continue.

Shalon Quinn: All right. I guess we'll get a little bit of time back today. I really want to thank Dr. Howard for his wonderful presentation today on transplant rates and I will go ahead and turn it back over to Alina to close this out.

Jesse Roach: Oh, actually ...

Shalon Quinn: Yes.

Jesse Roach: ... before you go, I do have one more announcement I can make.

Shalon Quinn: OK. Great. Go ahead.

Jesse Roach: So, for the – some people had asked with the DFC and this star ratings program. So, there's going to be a plan for a dry run starting in July for the rebaselining of the star ratings program. Due to the burden that we thought that might cause and during a public health emergency, we're going to postpone that for until next year. So, we won't be doing the dry-run for the resetting – I shouldn't say rebaselining, resetting of the star ratings.

We're going to plan to release star rating as normal through the October 2020 release. However, the code that will includes data from end of 2019 – from calendar year of 2019, so stuff that shouldn't be affected by the public health emergency.

For updates after that, we will be giving guidance as to what we're – what we're going to do with the – because that will start when include data that includes – data that includes – that is affected by COVID when we had exemptions on reporting, the exemptions similar to the QIP.

So, we'll likely – actually we'll send out information soon via blast e-mail to the normal channels highlighting what we're going to do after the October 2020 DFC Refresh. So, that's it. Thank you.

Shalon Quinn: Great. Thanks. Alina, do you want to close this up?

Alina Czekai: Sounds great. Thanks everyone for joining our call today. We hope that you'll join us next Tuesday for our CMS COVID-19 Office Hours at 5:00 p.m. Eastern for technical Q&A with our CMS subject matter experts. And in the

meantime, you can continue to direct any questions to our COVID mailbox which is covid-19@cms.hhs.gov.

Again, we appreciate all that you are doing for patients and their families around the country as we address COVID-19 as a nation. This concludes today's call. Have a great rest of your day.

Andrew Howard: Thank you.

Operator: Ladies and gentlemen, that concludes today's conference call. Thank you for participating. You may now disconnect.

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