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September 9, 2024

Chiquita Brooks-LaSure, MPP

Administrator

Centers for Medicare & Medicaid Services

ATTN: CMS-1807-P

7500 Security Boulevard

Baltimore, MD 21244

RE: Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to ensure optimal care under the highest standards of medical practice for patients with kidney disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with kidney disease.

We are writing to provide comments on the 2025 Medicare Fee Schedule proposed rule. Our comments will address the following issues:

- **Medicare Physician Payment Reform and Inclusion of High-Tech Supplies and Equipment Costs in the Fee Schedule**
- **Expanding Access to Dental Services for Individuals with ESRD**
- **Advanced Primary Care Management (APCM) Services**
- **Inclusion of Compounded Immunosuppressive Drugs in the Part B-ID Benefit**
- **Home as Allowed Place of Service for AKI Dialysis**
- **Refinements to QPP for 2025**

Medicare Physician Payment Reform and Inclusion of High-Tech Supply and Equipment Costs in the Fee Schedule

RPA along with every other physician organization in the U.S. believes that Medicare physician reimbursement is at an existential inflection point at which patient access to care and sustainability of the program overall are being threatened to the point of becoming a crisis. Additionally, ongoing Medicare payment cuts fuel the erosion of the physician workforce nationally in an era where the Medicare beneficiary population is experiencing mushrooming growth. This problem is particularly acute in nephrology, an undersubscribed specialty primarily treating patients with chronic kidney disease, a patient sub-population that is now estimated by the Centers for Disease Control (CDC) to be in excess of 35 million adults.

As the Agency knows, concerns about Medicare Part B reimbursement are not limited to physician groups. The Medicare Trustees and the Medicare Payment Advisory Commission (MedPAC) have issued warnings about beneficiaries losing access to high-quality care due to insufficient Medicare physician payment, and of course there are numerous legislative proposals in Congress to address the looming Medicare reimbursement calamity. CMS stewards of the Medicare program are to be congratulated for innovative proposals in recent years in the areas of behavioral health, chronic care management, advanced primary care, health equity, and cancer prevention. RPA would urge CMS to apply this level of creative policy development to the actual mechanics of the fee schedule and conversion factor themselves, and seek to identify all policy levers that could be used to administratively provide relief from the annual Medicare fee schedule payment cuts.

One example of an area where RPA believes CMS could take administrative action to meaningfully impact the payment formula used to develop the conversion factor is to remove high-cost supplies and equipment as a practice expense input in the formula (with high-cost supplies and equipment being defined as those priced at \$500 or more). From our perspective this is analogous to when the cost of drugs was included in the Sustainable Growth Rate (SGR) formula over a decade ago. Physicians have no control over the costs of these supplies and equipment (just as they had no control over the cost of drugs in the old SGR formula), and yet the presence of high-cost supplies and equipment inputs within the payment formula artificially inflates the expenses assigned to fee schedule services that account for the high-cost supplies and equipment. In fairness to the Agency, the migration of these services to the physician office setting and the tremendous technological advances that result in higher expenses may have been difficult to anticipate as the Medicare payment methodology was being developed and refined over the past few decades. Regardless, the inclusion of high-cost supplies and equipment as an input to the conversion factor formula inflates the aggregate physician practice expenses in the fee schedule and thereby exacerbates issues related to budget neutrality. RPA believes that CMS could make this change administratively, thus we urge the Agency to remove high-cost supplies and equipment from the conversion factor formula.

Expanding Access to Dental Services for Individuals with ESRD

In the rule, CMS proposes to amend existing regulation to “include a dental or oral



examination performed as part of a comprehensive workup in either the inpatient or outpatient setting prior to Medicare-covered dialysis services when used in the treatment of ESRD; and medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with Medicare covered dialysis services when used in the treatment of ESRD.”

RPA supports this proposal in the strongest possible terms. We believe that access to periodic dental care will be greatly beneficial to Medicare ESRD beneficiaries (dialysis-dependent patients and those with or seeking a kidney transplant), and that this is a common-sense, forward thinking, and fiduciarily responsible proposal. RPA concurs with the Agency’s assertion that “the evidence base indicates that evaluation for and treatment of oral infection leads to improved outcomes and reduced risk of mortality for individuals with ESRD receiving covered dialysis services.” Regular dental care can identify and reduce the occurrence of infections and cardiovascular complications that adversely affect dialysis care, transplant success, and overall good kidney patient health, also a prerequisite for transplantation. Further, given that ESRD beneficiaries make up only 1% of the entire Medicare patient population, providing that coverage to Medicare ESRD beneficiaries would not profoundly burden the system financially.

Advanced Primary Care Management (APCM) services

CMS proposes to create a family of G-codes to bill for Advanced Primary Care Management (APCM) services. These codes could be furnished per calendar month, following the initial qualifying visit for new patients and obtaining patient consent. APCM services would include elements of existing care management codes, including chronic care management (CCM), transitional care management (TCM), and principal care management (PCM), as well as communication technology-based services (CTBS), including virtual check-in services. CMS proposes that APCM services could not be billed by the same practitioner or another practitioner within the same practice for the same patient concurrent with CCM, PCM, TCM, and other services. The rule also uses as an example of the type of patient who would receive APCM services as an individual with “heart failure and chronic kidney disease.”

RPA supports and appreciates CMS’ ongoing efforts to account for and provide payment pathways for services provided to patients with multiple chronic conditions. While many nephrology practices have embraced the existing families of care management codes and thus would have to determine whether the workflows and protocols associated with the APCM codes would be a better fit for their practices than the CCM, TCM, or PCM services, the fact that they are available to be part of the nephrologist’s armamentarium is a positive development, and RPA commends CMS for this proposed policy.

Inclusion of Compounded Immunosuppressive Drugs in the Part B-ID Benefit

CMS includes in the proposed rule a discussion of their intent to propose policies aimed to reduce barriers faced by beneficiaries receiving immunosuppressive drugs under the Medicare Part B-ID benefit, including policy barriers related to compounded immunosuppressive drugs. Pediatric dialysis patients are particularly affected by these policy complexities, so the CMS proposal to include orally and enterally administered compounded formulations for immunosuppressive drugs covered under the Part B-ID benefit represents a positive step forward. As such, RPA fully supports this proposal.

Home Setting as Allowed Place of Service for AKI Dialysis

In the proposed rule for the 2025 ESRD Prospective Payment System, CMS outlined its plan to provide Medicare payment for the treatment of patients with acute kidney injury (AKI) in the home setting; previously these services were not covered in the home as a place of service. Regarding physician reimbursement, it is provided through the use of codes more commonly used for inpatient dialysis, CPT codes 90935-90947. These codes can only be used in the outpatient setting for AKI care; dialysis for ESRD patients is billed using the Monthly Capitated Payment (MCP) family of services codes (90951-90970). To facilitate the ability of nephrologists to be reimbursed for AKI services provided in the home, RPA recommends that CMS add the home place of service code (POS code 12) to the list of approved sites of service for billing CPT codes 90935 and 90945 (this would not be applicable to the other codes in the family). Such a change would minimize any policy ambiguity concerning use of CPT code 90935 and 90945 for billing AKI services to home dialysis patients.

Refinements to QPP for 2025

Transplant Measures—General Commentary

As noted in past comments, RPA recognizes the critical importance of improving kidney transplantation rates, and that inequities exist among regions and patient populations. However, RPA does not support the measures as written, as they imply that the nephrologist can control both the management of the active wait list, and the movement to and from active status by the transplant team. In reality, transplant facilities have their own metrics and decision algorithms, which are not public, transparent, or harmonized. The nephrologist does not control the transplant team's decision to place a patient on the active wait list and usually is not involved in and often not aware of the decision to reclassify their waitlist status. Additionally, RPA is concerned that the measures do not reflect patient-centered care as they do not account for patient choice. There is no exclusion from the denominators for patients who chose not to consider transplantation. Instead, the measures inappropriately assume all patients should be referred and waitlisted, regardless of the patients' wishes or their medical status.

Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW)

This measure was previously two separate measures: Percentage of Prevalent Patients Waitlisted (PPPW), which did receive National Quality Forum (NQF) endorsement in Spring 2022, and the Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW), which was not endorsed by the NQF Renal Standing Committee during the Spring 2022 measure cycle. The



Renal Standing Committee stated that while nephrologists have a role in referring patients for transplantation, they have nothing to do with the selection of patients for the waitlist. In short, this measure does not reflect the quality of care provided by nephrologists but rather the transplant teams' assessment of the conglomerate of patient factors considered in each patient's evaluation. Concerns with the testing data, which showed extreme variation in the transplant center practice, are real and foster disparities among potential transplant candidates. These measures make it even harder for smaller transplant programs (which offer more opportunity to more patients (in for example rural and otherwise disadvantaged areas) to risk listing more complicated patients. The NQF Consensus Standards Approval Committee (CSAC) upheld the decisions of the Renal Standing Committee during their review, and voted not to reconsider this measure during the appeals process. RPA is particularly concerned that these two measures have been combined with no evidence of review or testing as a composite measure. There is no indication that feasibility and validity have been assessed as a composite, and therefore it is inappropriate to include in the QPP.

First Year Standardized Waitlist Ratio (FYSWR)

This measure was also not endorsed by the NQF Renal Standing Committee during the Spring 2022 measure cycle, citing concerns regarding exclusions and attribution. In particular, the Renal Standing Committee raised concerns about how the measure developer identified the physician caring for the patient. The NQF CSAC upheld the decisions of the Renal Standing Committee during their review, and voted not to reconsider this measure during the appeals process. Therefore, RPA does not believe this measure is appropriate for inclusion in the QPP.

Mandatory Specialist Alternative Payment Model Based on MIPS Value Pathways

The RPA opposes creating a new pay-for-performance program for specialists based on MIPS Value Pathways (MVPs) and mandating that they participate in that program, as CMS has outlined in its Building Upon the MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care Request for Information (RFI). CMS' existing mandatory pay-for-performance program (MIPS) has created large administrative burdens for physician practices without improving clinical outcomes for patients or reducing Medicare spending. There is no evidence that the approach CMS is considering would have better results. Instead, RPA joins the AMA and others in urging CMS to collaborate with specialists to develop and implement condition-specific payment models that provide the resources physicians need to deliver the most effective services to their patients, including underserved patients and those with complex needs.

Beyond these measures and proposed changes to MVPs, RPA commends CMS for maintaining the MIPS performance threshold at 75 points.

As always, RPA welcomes the opportunity to work collaboratively with CMS in its efforts to improve the quality of care provided to the nation's kidney patients, and we stand ready as a resource to CMS in its future work on the Medicare Fee Schedule. Any questions or comments regarding this correspondence should be directed to RPA's Director of Public Policy, Rob Blaser, at 301-468-3515, or by email at rblaser@renalmd.org.

regarding this correspondence should be directed to RPA's Director of Public Policy, Rob Blaser, at 301-468-3515, or by email at rblaser@renalmd.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Keith Bellovich".

Keith Bellovich, DO
RPA President

CC: Adonia Calhoun Groom, RPA Executive Director