



September 13, 2021

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-1751-P
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements.

Dear Administrator Brooks-LaSure:

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. Part of RPA's mission is to promote excellence in the delivery of high-quality kidney care within an environment that supports patient access to care and safety.

RPA is writing to offer our input on the 2022 Medicare Fee Schedule Proposed Rule and Updates to the Quality Payment Program. RPA's comments address the following issues:

- **Revaluation of Pediatric ESRD Monthly Capitation Payment CPT Code 90954**
- **Proposed 2022 Conversion Factor and Budget Neutrality**
- **Revisions to Policy on Split/Shared Visits, and Definition of Substantive Portion**
- **Impact of Proposal to Update Clinical Labor Data**
- **Refinements to the QPP for 2022**

Revaluation of Pediatric ESRD Monthly Capitation Payment CPT Code 90954

In the proposed rule, CMS notes that a rank order anomaly was created in the 2021 fee schedule when the ESRD monthly outpatient dialysis code family was revalued based on increases in underlying evaluation and management (E&M) codes, but which excluded from the

reevaluation CPT code 90954 (monthly dialysis services for patients ages 2-11), due to its previous valuation based on a crosswalk code. The Agency outlines its plans to restore relativity to the code family for 2022 by utilizing a different code for the crosswalk that more appropriately represents the time and effort of the service provided over one month for these patients than the existing crosswalk code, thus eliminating the rank order anomaly. **RPA fully supports CMS' proposal to revalue CPT code 90954 and commends the Agency for making this change.**

Proposed 2022 Conversion Factor and Budget Neutrality

RPA shares the concerns of many societies in organized medicine regarding the significant reduction in 2022 Medicare reimbursement due to the cut in the conversion factor (CF) for CY 2022 as a result of budget neutrality and scheduled reimplementation of various forms of sequestration. We acknowledge that these reductions have their origins in legislative mandates and thus the Agency's ability to unilaterally make changes to address the shortfalls is limited.

However, there is great urgency in the need to address the issue, as the drastic reduction in reimbursement due to the CF cut and sequestration changes will have a profoundly adverse impact on the care provided to many Medicare beneficiaries, and the specialists and non-E&M physician disciplines rendering those services. Accordingly, **RPA urges CMS to identify and take all administrative steps possible to alleviate the proposed reduction in the 2022 CF**

Revisions to Policy on Split/Shared Visits, and Definition of Substantive Portion

CMS makes numerous revisions to its policies governing the provision of split or shared visits (an E/M visit that is performed by both a physician and a NPP who are in the same group) in the fee schedule, and RPA is supportive of most of these provisions. For example, we believe the proposals to allow billing shared visits for new and initial visits and critical care services, to limit shared visit billing to services performed in institutional settings, and to allow practitioners to bill for a prolonged E&M visit for a shared visit are appropriate and should be finalized.

However, RPA is deeply troubled by the proposal to define the "substantive portion" of a shared visit as more than half of the total time spent by the physician and the advanced practice provider performing the visit. CMS goes on to state that medical decision making (MDM) is not easily attributable to a single physician or advanced practice provider and that time is a more precise factor than MDM to use as a basis for deciding which practitioner performs the substantive portion of the visit. Basing the definition solely on time serves to diminish both the importance of MDM and the physician's experience, fund of knowledge and judgement that inform the leadership role in needed in making decisions about patient care, much of which requires review and synthesis of multiple sources of information. [Separately, CMS' use of the phrase "pokes their head into the room" in a discussion of medical decision

making in the context of defining the substantive portion of a visit infers that all thinking and decision making must be done in front of the patient; this is not only inaccurate and inappropriate but also is demeaning to physicians and should not have been included in formal rulemaking language.]

In short, RPA strongly believes in the primacy of MDM over time as the most important element of patient care and that there is no valid justification for assigning insufficient importance to MDM in defining the substantive portion of a shared visit. This is especially true in the care of Medicare beneficiaries with kidney disease. Though the nephrologist's direct time with a patient may be less than 50% of the total time spent in the care of the patient, nephrologists are often performing the decision-making activities most critical to that patient's care – for instance helping a patient finalize a decision to pursue a home (rather than in-center) dialysis modality. Further, in the context of the current movement towards value-based care delivery systems that are being developed and refined to account for finite physician workforce resources, the proposed definition of substantive portion significantly disadvantages physicians and specialties providing a disproportionate amount of care in inpatient settings.

Finally, it is worth noting that for 2022 inpatient documentation will still be required for activities of care such as review of systems (ROS) and past family and/or social history (PFSH). This will in many situations tend to lessen the percentage of time that a physician would be involved in the substantive portion of a split/shared visit. So, while RPA is strongly opposed to ever implementing the proposed definition of substantive portion, doing so prior to 2023 is particularly illogical. **RPA strongly urges CMS to withdraw its proposed definition of substantive portion of a split/shared visit and explore an alternate path that sufficiently accounts for the importance of medical decision making in such a definition.**

Impact of Proposal to Update Clinical Labor Pricing Data

In the 2022 fee schedule rule CMS includes a proposal to update clinical labor pricing. The Agency's impetus to proceed in this area is understandable given that this has not occurred since 2002 and that the pricing for other related inputs such as those for supplies and equipment have recently been updated.

However, the profoundly damaging impact of these changes at both an individual service code level and on broad sectors such as non-facility settings of care cannot be ignored or understated. For example, the dialysis circuit code family of services (CPT codes 36901-36909) will experience reductions in value of between 9 and 19%; when the proposed reduction in the 2022 conversion factor is accounted for, these reductions range from 13 to 22%. These codes represent services that play a critically important role in maintaining and repairing a dialysis patient's vascular access, services that should be available in as many settings of care as

possible. However, if these changes were to be finalized as proposed, closure of many physicians' office-based labs in which these services are provided seems certain. Additionally, threatening the viability of vascular access care for dialysis patients at a time when improved kidney health is an area of emphasis for CMS (as evidenced by the mandatory and voluntary kidney payment models in various stages of implementation) seems counterintuitive at best if not harmful to Medicare beneficiaries with kidney disease at worst.

Further, RPA joins other groups in their concerns that CMS seeking to update 20 years' worth of policy inaction regarding clinical labor pricing in a single rulemaking cycle appears to invite substantial financial burdens that because of budget neutrality will fall disproportionately to certain sub-populations of patients, services, and specialties. The Agency does solicit input on whether this proposal should be implemented over a four-year transition period, and that would be less immediately detrimental to the impacted parties. However, RPA alternatively proposes that CMS retract the clinical labor pricing proposal and instead develop a revised proposal that reflects community input and provides the Agency with the opportunity to foster consensus on the best process for moving forward with updating clinical labor pricing in a way that is less harmful to Medicare beneficiaries and providers. **RPA urges CMS to retract its proposal for updating clinical labor pricing inputs for the 2022 fee schedule rulemaking cycle, and to instead develop a revised proposal based on community input that does not disproportionately impact the non-facility site of service and which ensures patient access to care.**

Refinements to the QPP for 2022

Under the umbrella of refinements to the physician Quality Payment Program (QPP) for 2022, RPA offers comments in the areas of the Quality category and the Promoting Interoperability Performance category.

Quality Category

- CMS proposes to update the quality measure scoring to remove end-to-end electronic reporting and high priority measure bonus points as well as the 3-point floor for scoring measures. While some exceptions are provided for small practices, RPA believes that these proposals will still negatively impact small nephrology practices, and that implementation of these changes should be deferred pending further review.
- RPA appreciates CMS' recognition of the challenges faced by providers in 2020 and supports the proposal to use performance period benchmarks from calendar year 2019, for scoring quality measures in the 2022 performance period, rather than 2020 benchmarks due to the public health emergency (PHE).

- As noted in previous comments, RPA does not support the new measure added to nephrology measure set - Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate. Specifically, our previous comments noted that the measure exclusions should be expanded to include patients for whom dialysis is part of palliative care, not only those who are receiving hospice care. The exclusions should also include patients who have had multiple previous unsuccessful attempts to establish permanent vascular access (either through placement of an arteriovenous fistula or arteriovenous graft), among other concerns. Given that the measure is unchanged, RPA's concerns remain.
- The QPP section proposes to increase the data completeness requirement in the Quality category to 80% beginning with the 2023 performance period. RPA believes that given the challenges facing Medicare providers during the PHE, an increase in the data completeness requirement to 80% would be unduly burdensome and should not be implemented for the 2023 performance period.

Promoting Interoperability Performance Category

- CMS proposes to add a requirement in the Provide Patients Electronic Access to Their Health Information measure that patients have access to their health information indefinitely, for encounters on or after January 1, 2016. While RPA supports transparency and availability of patient health information, going back six years will be far too burdensome for many nephrology practices, as some practices may have been affiliated with multiple vendors for their electronic platforms in that time period. **RPA recommends that this change either not be retroactive, or to utilize a start date much closer to the present than January 1, 2016.**

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.

Sincerely,



Timothy A. Pflederer, MD FASN FASDIN
RPA President