



December 31, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-1715-F
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-1715-F; Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Final Rule

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 2020 Medicare Fee Schedule Final Rule and Updates to the Quality Payment Program. RPA's comments address the following issues:

- **Removal of Nephrology-Specific Measures from MIPS**
- **Adjustment of ESRD Outpatient Monthly Code Family Commensurate with E&M Revisions**
- **Concurrent Billing of Transitional Care Management and Monthly Adult ESRD Services**
- **Evaluation and Management Services**
- **Principal Care Management Codes**

Removal of Nephrology-Specific Measures from MIPS

RPA's comments on the proposed rule urged CMS to not implement its proposal to eliminate the nephrology-specific measure set from the MIPS program, and thus we are disappointed in the Agency's decision to proceed with this proposal and concerned for how it will affect kidney patient care. As noted in our proposed rule comments, we believe that constant change in the MIPS program runs counter to CMS' own goals, and that the QPP program must be allowed to mature. Further, continually changing the program increases provider burden, and potentially burnout, by necessitating time away from patients to review changes and implement new workflows, rather than allowing providers the space to understand and comply with the existing components of the QPP.

CMS leadership in recent months has made numerous public statements indicating their desire to work with specialties and subspecialties on appropriate measures for the conditions they manage and the persons with kidney disease they treat, and we were encouraged by these statements. However, in the final rule CMS made a decision against RPA's explicit recommendations. To advance the quality of care for patients with kidney disease, it is critical that nephrologists are measured by specific, relevant, and clinically meaningful measures. Further, elsewhere in this comment RPA commends CMS multiple times for how the policymaking in this proposed rule complements the kidney disease payment models proposed by the agency in recent months as part of the Advancing American Kidney Health initiative. Quality measures that are relevant and meaningful to nephrologists are critically important to the success of these proposals. CMS' decision to eliminate the nephrology-specific measures harms that potential success, and RPA therefore urges CMS to reconsider this determination at the earliest possible juncture.

Adjustment of ESRD Outpatient Monthly Code Family Commensurate with E&M Revisions

RPA appreciates CMS' decision to solicit comment on whether it would be necessary or beneficial to make systematic adjustments to services in the fee schedule closely tied to evaluation and management (E&M) services in order to maintain relativity between these services and office/outpatient E/M visits. We have long believed relativity was being lost for the ESRD monthly capitated payment (MCP) code family since the values of its E&M component codes have been increased several times over the past decade or so while the MCP code values have remained unchanged; it is worth noting that this loss of relativity applies to the inpatient/acute dialysis code family (CPT codes 90935-90947) as well. Given the Administration's appropriately increased emphasis on kidney care as evidenced by the Advancing American Kidney Health initiative, we urge CMS to adjust the ESRD monthly service codes to reflect previous increases in underlying E&M services.

Concurrent Billing of Transitional Care Management and Monthly Adult ESRD Services

RPA strongly supports CMS' decision to finalize its proposal to allow a series of services that were not previously allowed to be billed concurrently with the transitional care management (TCM) codes, including the adult outpatient monthly ESRD codes (CPT codes 90961-62, 90966, and 90970). We agree with the Agency that these codes, when medically necessary, may complement TCM services rather than substantially overlap or duplicate services, believe that this change is reflective of a commitment to continually improved patient care for Medicare beneficiaries, and as such commend the Agency for this decision.

Further, RPA urges CMS to make the TCM codes billable in place of service (POS) 65 (the ESRD Treatment Facility designation) when provided to ESRD patients. Our understanding of the experience in the ESRD Seamless Care Organizations (ESCOs) is that TCM services provided in the dialysis facility contributed to improved patient outcomes through reduced hospitalizations.

Evaluation and Management Services

As noted in RPA's comments on the proposed rule, we support CMS' decisions with regard to revising the structure, valuation, and documentation requirements for E&M services for CY 2021. From the development of the CPT codes, the valuation process at the AMA's Relative

Value Update Committee (RUC), to the Agency's efforts to reduce the administrative burdens faced by nephrologists and other physicians in documenting E&M services, RPA is encouraged by the direction taken by CMS over the past year, and we appreciate the decision to finalize the changes in E&M work as proposed.

Principal Care Management Codes

RPA believes that CMS' proposal to create separate coding and payment for Principal Care Management (PCM) services is another positive step forward in the effort to provide integrated health care to Medicare beneficiaries. RPA is encouraged by CMS' continued efforts to utilize non face-to-face services to advance the care provided to chronic disease patient populations including persons with kidney disease, as we believe that the PCM codes will be useful in the care of CKD patients not yet on dialysis. On a policy basis, this is one more instance where a provision in the fee schedule supports the proposals outlined in the Advancing American Kidney Health initiative, and we commend the Agency for its rulemaking in this regard.

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 and Quality Payment Program. 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,

A handwritten signature in black ink, appearing to read "Jeffrey A. Perlmutter" with a stylized flourish at the end.

Jeffrey A. Perlmutter, MD
President