



September 27, 2019

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Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-1715-P
P.O. Box 8016
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Re: CMS-1715-P; Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Proposed 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 Proposed Rule and Updates to the Quality Payment Program. RPA's comments will address the following issues:

- I. Proposed MIPS Changes**
 - o **Changes to the Quality Component of MIPS**
 - o **Cost Measure on AKI**
 - o **Changes to Improvement Activities (IA) Performance Category**
 - o **Changes to Promoting Interoperability (PI) Category**
- II. Changes to QCDRs**
- III. MIPS Value Pathways (MVPs)**
- IV. Adjustment of ESRD Outpatient Monthly Code Family Commensurate with E&M Revisions**
- V. Concurrent Billing of Transitional Care Management and Monthly Adult ESRD Services**
- VI. Evaluation and Management Services**
- VII. Principal Care Management Codes**

I. MIPS Changes

Changes to the Quality Component of MIPS

RPA has long been involved in the quality measure development process, and in the intersection of quality measurement with CMS' Medicare incentive programs. We served as the lead kidney organization with the American Medical Association Physician Consortium for

Performance Improvement (AMA PCPI) to develop CKD, ESRD, and palliative care measures. RPA also collaborated with the American Society of Pediatric Nephrology (ASPN) and the American Society of Diagnostic and Interventional Nephrology (ASDIN) to develop physician-level measures related to pediatric nephrology and interventional nephrology, respectively. RPA measures have been used in PQRS (now MIPS) and the RPA Kidney Quality Improvement Registry, the only specialty society owned nephrology-specific CMS-approved Qualified Clinical Data Registry (QCDR). As an early adopting organization, we have a deep investment in how quality measures are developed and put into use by CMS.

While RPA appreciates CMS' efforts to streamline programs and reduce provider burden, we are concerned that the rate at which such changes are being proposed and implemented is counter to CMS' own goals. RPA believes the QPP program must be allowed to mature, and dramatic changes as proposed with the elimination of specialty-specific measures and the development of the MVPS are premature. Furthermore, continually changing the program has increased provider burden, and potentially burnout, by requiring time away from patients to study changes and implement new workflows, rather than allowing providers the space to understand and comply with the existing components of the QPP.

Removal of nephrology-specific measures from MIPS

CMS has proposed removing the remaining nephrology-specific measures from the MIPS program. RPA believes that MIPS quality measures should be relevant to the daily care provided by providers and that the move to primary care-centric measures is detrimental to the care of the nation's kidney patients. 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.

MIPS 328 Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10 g/dL

RPA strongly opposes the removal of this measure from MIPS. This outcome measure is directly linked to the meaningful measure area of Management of Chronic Conditions. Anemia is a common comorbidity in children with kidney disease. While the population of pediatric kidney patients is small, pediatric anemia is associated with multiple adverse clinical consequences and its management is a core component of nephrology care. Increased morbidity and mortality, increased risk of cardiovascular disease and decreased quality of life have been associated with anemia of CKD in children. Simply put, children with limited energy due to anemia struggle to go to school, engage with friends, and have a "normal" childhood. In addition, if not managed appropriately, anemia can lead to increased morbidity and mortality. RPA joins the American Society for Pediatric Nephrology and other organizations in advocating that this measure be retained.

MIPS 329 Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis and MIPS 330 Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days

RPA strongly opposes the removal of these measures from the MIPS program. Measures 329 and 330, which are designed to be used as paired measures, are

important outcome measures which address key areas of appropriate patient education and preparation, patient safety, and high-quality care. The measures are directly linked to three meaningful measure areas: Healthcare Associated Infections, Admissions and Readmissions to Hospitals, and Management of Chronic Conditions. RPA also notes that the proposed removal seemingly contradicts CMS' desire to harmonize measures across programs. As CMS' own Fistula First, Catheter Last initiative demonstrates, reducing catheter use may be one of, if not the, most important part of managing a patient's kidney failure next to adequacy of dialysis. The use of catheters increases the risk of infection, morbidity, mortality, hospitalizations, and readmission. The ESRD QIP contains a similar measure to reduce the use of catheters in dialysis patients. Therefore, to coordinate the care among facilities and nephrologists, it is important to maintain these measures.

MIPS 403: Adult Kidney Disease: Referral to Hospice

RPA strongly opposes the removal of this measure from MIPS. Measure 403 is directly linked to the meaningful measure area of End of Life Care According to Preferences. RPA believes that the nephrology care team is a critical part of shared decision-making with kidney patients to determine the patient's wishes for advance care planning and hospice care. Kidney failure is unquestionably a life-limiting illness, with 5-year mortality for those receiving dialysis about twice that of adults with cancer, congestive heart failure, and stroke. According to "Grubbs V. ESRD and Hospice Care in the United States: Are Dialysis Patients Welcome?" published in the American Journal of Kidney Disease in 2018, only ~20% of Medicare beneficiaries with ESRD received hospice at the time of death. While hospice use is significantly higher among patients who withdraw from dialysis therapy versus those who do not (53.9% vs 9.5%), the limited life expectancy following dialysis therapy withdrawal, on average 7 to 10 days, does not allow enough time for hospice providers to build sufficient rapport with patients and their families to optimally address a dying patient's physical and emotional needs. RPA believes that by providing a means to measure these actions is critical to improving utilization. This measure should be retained to promote patient choice and autonomy at the end of life.

MIPS 110: Preventive Care & Screening: Influenza Immunization

RPA opposes the removal of this measure from MIPS. A recent study in the Journal of the American Society of Nephrology estimated the 1,100 dialysis patients die each year of influenza. Most of these deaths can be prevented by influenza immunization. This is a critical area for dialysis patients, and Measure 110 should be retained until a new measure is fully specified and tested. RPA notes that the newly proposed Adult Immunization Status measure stewarded by the National Committee for Quality Assurance that is intended to replace this measure: a) was not recommended by the MAP; b) its specifications have not yet been released to the public, which means we cannot determine who could actually report this measure and whether the clinician would only need to confirm vaccination status or actually provide the immunizations; and c) it has not been previously implemented.

Increasing data threshold for quality measures

RPA does not support increasing the data completeness threshold to 70%. We are in favor of maintaining the 60% threshold since data collection for nephrologists is a challenge given that they are often seeing patients in multiple venues of care with multiple non-interoperable electronic health record systems. The 60% threshold is a manageable, fair, and reasonable portion of patients to include in any given measurement year. Increasing the threshold increases reporting burden on clinicians with no clear benefit to patient care at a time of great volatility with the impending MIPS Value Pathway changes. This change would disproportionately impact small practices and would make practices less able to overcome temporary reporting glitches, often caused by the vendor, which could result in more practices seeking hardship requests.

Topped Out Measures

RPA is not convinced of the value of having a higher data completeness threshold for extremely topped out measures and believes that increasing the data completeness threshold for these measures will disproportionately and negatively affect small and rural practices in these specialties.

Proposed Cost Measure on AKI

RPA believes that patient level variability in acuity/intensity of care required can make this measure a non-meaningful assessment of physician care – i.e., the cost may have less to do with the physician than the patient as duration of AKI is a major driver of the cost. Furthermore, RPA has strong concerns regarding attribution of this measure: the episode is attributed to the nephrologist(s) who sees the patient in the hospital when dialysis begins. When examining claims data, the majority of these patients are cared for by a different nephrology practice when they leave the hospital. RPA believes it is not appropriate to hold the physician who provided care during the inpatient stay accountable for care that happens on an outpatient basis when the patient is typically under the care of a different nephrology practice. ***Therefore, RPA does not support the inclusion of this measure in MIPS.***

Changes to Improvement Activities Performance (IA) Category

RPA generally supports most of the proposed new IA removal factors. However, RPA is opposed to Factor 5: activity does not align with the Quality, Cost, or Promoting Interoperability performance categories. ***We recommend that CMS continue to allow the Improvement Activities category to allow space for innovation but not to implement Factor 5 for removal since this could increase the burden on providers by limiting IAs related to their scope of practice.***

Changes to Promoting Interoperability (PI) Category

Scoring

RPA is opposed to the all-or-nothing scoring methodology as it places a great burden on clinicians, particularly those in small practices. Promoting interoperability forces clinicians to shoulder responsibilities for EHR functions that should be borne by EHR vendors. ***RPA urges CMS to allow for more flexibility in scoring the MIPS PI category to ensure that clinicians can get credit for their actions, even if they are unable to complete each measure.***

Supporting Electronic Referral Loops by Receiving and Incorporating Health Information

While RPA appreciates the intent of this measure, we know that many clinicians have difficulty performing this measure, through no fault of their own. Therefore, ***RPA urges CMS to continue the exclusion for clinicians and practices that are unable to implement this measure. We also recommend that, in future years, CMS should include an additional exclusion for clinicians who do not receive a summary of care from referring providers.***

Public Health and Clinical Data Registry Reporting Objective

RPA asks CMS to clarify that registries created by EHR vendors do not count as clinical data registries for purposes of the Public Health and Clinical Data Exchange Objective.

RFI on Metric to Improve Efficiency of Providers within EHRs

RPA is concerned that scoring physicians on efficient use would be premature, and lead to holding physicians responsible for EHR vendor shortcomings. Instead, CMS should refer to the ONC Physician Burden Report section on usability, which highlights actions that vendors must take to improve efficiency.

RFI on Provider to Patient Exchange Objective:

- Immediate Access: This could be problematic across the healthcare system, and particularly for small practices that have limited resources. As such, ***RPA recommends that CMS not change the 4-business-day timeline.***
- Persistent Access and Standards-Based APIs: RPA opposes applying the 24-month deadline to provider implementation of these updates. Implementing EHRs in clinical practice takes more time than allowed under the ONC proposed rule. As such, ***CMS should apply a separate timeline for the full implementation of the updated ONC 2015 CEHRT functionalities.***
- RFI on Engaging in Activities that Promote the Safety of the EHR: ***RPA recommends that CMS to convene stakeholders to evaluate ways in which an appropriate alternative or bonus measure on EHR safety could be appropriate for clinicians.***

II. Changes to QCDRs

RPA created the RPA Kidney Quality Improvement Registry, a CMS-approved QCDR in 2014, and launched it nationally in 2015. The RPA Kidney Quality Improvement Registry QCDR is used by practicing nephrologists nationwide and is the only specialty-society owned QCDR in nephrology.

RPA is concerned that this rule proposes numerous new and onerous requirements on QCDRs, and a new approach for MIPS Value Pathways that will threaten the continued success and financial viability of registries. This is counter to the intent of MACRA, which calls for the Secretary to encourage the use of QCDRs. As non-profit membership organization, resources are very limited, and it would not be feasible for specialty society owned QCDRs to continue to comply with ever-increasing and burdensome requirements, including many of those proposed in this rule. These registries are often supported via membership dues or society finances, and without meaningful maximum MIPS bonuses (which have been approximately 1.8% for both 2017 and 2018), many QCDRs could not justify an increase in participation fees. It is clear that QCDRs enhance the success of MIPS by bringing focus to important specialty outcomes through their QCDR measures, identifying best practices with timely feedback, and by supporting participating clinicians and practices through the complex MIPS rules. This also leads to improved quality and outcomes for patients.

Requiring QCDR measures to identify a linkage between their QCDR measures to cost measures, improvement activities, or CMS developed MVPs.

RPA supports the notion of linking nephrology specific measures to improvement activities and would be interested in developing IAs to associate with QCDR measures. While cost measures would be more difficult to account for in the nephrology space, we would look for opportunities to make this linkage as well. Either way, have a flexible set of options in building these linkages which would be welcomed. However, as noted above, specialty specific measures must be retained in order for this to be feasible. Additionally, CMS must grant exceptions for specialties in which there are no relevant cost measures or IAs.

Requiring QCDR measures to be fully developed with completed testing results at the clinician level at the time of self-nomination.

RPA does not support the proposed change, as it removes flexibility from QCDRs and instead replaces it with what is essentially the NQF-endorsement process, adding substantial time and cost burdens to the development of new measures. QCDR custom measures are designed to be novel and innovative – to assess performance in areas that are important but previously unmeasured.

Current testing methods (per the CMS Blueprint and NQF standards) require extensive time and costs. According to an August 2019 survey of QCDR owners, measure testing ranged between \$20,000 to \$165,000. Furthermore, testing would likely take place at an academic medical center since it would be very difficult to incentivize a small practice with limited staff or time to implement the measures and provide adequate data for testing analyses. However, most of our MIPS eligible clinicians work in small private practices. Thus, methodologies employed by academic medical centers lack applicability to many practicing community nephrologists. ***The CMS recommendation to use NQF/Blueprint testing proposed requirements is unreasonable for smaller specialties in which measure testing cannot easily be operationalized.***

Requiring QCDR measures to have data collected prior to submission for CMS consideration.

While RPA agrees that there must be proof of concept for a new measure – rationale, evidence, feasibility, face validity, usability, etc., it would not be reasonable to have provider data already collected prior to approval.

Furthermore, RPA is concerned that collecting data for a 12-month period may not be feasible given that the MIPS submission cycle consumes the majority of a registry's resources during the months of January – March. QCDRs must comply with the requirement to be “up and running” on January 1, the self-nomination deadlines have been moved forward to September 1, and a registry's measure development and update processes are already established around these deadlines. Furthermore, clinicians have no motivation to report on a measure that does not “count” towards reporting when they are already focused on meeting the requirements of components required for MIPS. RPA asks CMS take into account these considerations.

Requiring QCDR measures to available for to MIPS eligible clinicians for reporting through QCDRs other than the QCDR measure owner for purposes of MIPS.

As noted in previous comments, RPA is concerned about CMS' push to require no cost licensing agreements from QCDR measure stewards. While many QCDRs may do this voluntarily, requiring them to do so ignores the time and resources spent in developing and maintaining the measures. RPA believes that QCDRs should be allowed to decline to license measures or charge a licensing fee. ***CMS must clarify that measure stewards have intellectual property rights over their measures and therefore may limit commercial uses of the measures, which are copyrighted.***

Requiring harmonization of QCDR measures.

RPA urges CMS to provide clear feedback to measure developers on why they believe measures are related and/or duplicative. Additionally, CMS should provide a clear explanation of what is meant by measure harmonization. CMS needs to formally outline 1) criteria for when measures overlap/related 2) indications for harmonization, and 3) process for harmonizing.

QCDR measures may be approved for 2 years.

RPA strongly supports a multi-year measure approval and applauds CMS for making this change, as it would allow providers to better adapt workflows to report on clinically relevant custom measures as these measures address critical clinical gaps in care, support evidence-based medicine, and engage patients as well as clinicians in care delivery. ***RPA recommends limiting the revocation of two-year status to instances when the QCDR is no longer in good standing.***

Requiring case minimums and reporting volumes for benchmarking after being in the program for 2 consecutive performance years.

RPA objects to the proposed timeline, as it fails to account for the time needed for electronic health record (EHR) vendors to complete data integration to support QCDR measures. As noted in previous comments, QCDR stewards must work with EHR vendors to ensure that appropriate data elements for custom measures are collected – a process which often takes up to 18 months. Requiring additional data elements is likely to extend that timeline. We urge CMS to consider lead time required by EHR developers to respond to finalized changes to be able to release updated software solutions that reflect finalized changes to their customers. Once a vendor learns of a new set of measures that are being added or removed from a QCDR, vendors require time to move through the development life cycle while also ensuring they meet certification requirements set forth by the Office of the National Coordinator (ONC). EHR vendor fiscal years and development schedules do not typically coincide with the QCDR

application and approval process, thus limiting the immediate implementation of these custom measure fields.

As a specialty-specific QCDR, we continue to work with EHR vendors, especially those specific to nephrology, to not only begin the process of supporting the registry itself, but add the necessary data fields to collect numerator and denominator information that would populate our custom measures. This process is not simple, fast, or inexpensive. Furthermore, the low point value assigned to non-benchmarked QCDR measures has created a cycle where measures with low MIPS point values are less likely to be reported and therefore less likely to be benchmarked.

As such, we strongly believe that the absence of measure use indicates neither a lack of need nor lack of interest, but rather a lack of technologic capability.

RPA further proposes that CMS decrease the disincentive to use custom measures by increasing the points awarded for their use. Because they are new and have fewer subscribers using them, custom measures generally don't immediately meet CMS' threshold for performance benchmarking; therefore, they receive less than one-third as many points as benchmarked measures, making them less appealing to providers.

QCDR Audit of PI and IA categories

RPA is concerned with the requirement for QCDRs to audit the PI and IA categories, as both are essentially attestations, as defined by CMS. While we can perform a randomized audit asking for documentation from the EHR on PI measure data to ensure accurate transposition and monitoring of errors, and we can ask for clinical documentation to ensure the IA was attested to correctly, any errors discovered will be errors on the part of the practice or physician, not the registry. Furthermore, we are concerned that EHR vendors will charge practices to run these reports when a third-party entity (such as a QCDR) requests them. The ONC Interoperability and Data Blocking Final Rules have yet to be published, so we do not have policies codified in rulemaking yet to point to when this situation would be considered data blocking. Overall though, QCDRs are limited in what they can do with regard to conducting a detailed audit on attestation categories. If CMS plans to require this, further guidance needs to be provided, especially for the required clinical documentation for the IA category. This guidance also should recognize the limitations that QCDRs face in validating this information, as described above.

Use of QCDR measures in MIPS Value Pathways (MVPs)

It is critical that CMS consult with specialty society experts to develop specific MVPs and to ensure appropriate measure selection and benchmarking methodologies. RPA is concerned about nephrologists' ability to successfully participate in any quality component of MVPs based on CMS' aggressive proposals to remove specialty-specific measures from MIPS and custom measures from QCDRs. Historically, CMS has not allowed QCDR measure developers to re-tool measures removed from the program into specialty or procedure-specific measures, even when meaningful gap-in-care data can be provided and even though CMS does not analyze or publicly report data on topped out measures stratified by practice size, type, or specialty.

RPA believes QCDR measures would be of value to MVPs. Nephrologists should have choices for quality reporting, especially when there are few relevant MIPS measures available and each year more are proposed for removal. The current portfolio of primary-

care focused MIPS measures effectively serves as a barrier for specialties in quality reporting and would not presumably change under MVPs.

III. Proposed MIPS Value Pathways (MVPs)

RPA appreciates the opportunity to provide feedback on the MIPS Value Pathways (MVP). First and foremost, CMS has stated the MVP guiding principles are reducing burden, providing comparative performance data to patients and caregivers, encouraging improvements in high priority areas, and reducing barriers to APM participation. However, RPA believes that this dramatic change to the MIPS program will actually increase burden on providers and staff, by requiring them to understand and implement yet another reporting methodology which will require provider and staff time, changes in workflow and possible upgrades to their electronic health records system. As a result, health professionals will become more disengaged, and time devoted to patient care will be further reduced.

RPA recommends that CMS separate this RFI from the proposed rule and engage in communication with stakeholders prior to proceeding.

RPA also provides the following specific comments on MVPs:

- CMS should first develop a pilot program before rolling out the program to the entire country.
- CMS must work with the kidney community to develop meaningful nephrology-specific quality measures that focus on the critical processes and outcomes of treating patients with kidney disease. For example, a nephrology MVP could focus on Stage 4 chronic kidney disease (CKD) through early end-stage renal disease (ESRD) that mimics the measures, structure, and goals of the RPA's proposed Incident Dialysis Model that was presented and accepted by the Physician Focused Technical Advisory Committee (PTAC).
- RPA opposes CMS' proposal to layer population health/administrative claims-based measures into MVPs, using current cost/administrative claims measures. Many of the existing administrative claims measures have not been tested at the physician level and are based on retrospective analysis of claims and do not provide granular enough information for physicians to make improvements in practice. CMS also prohibits specialty societies from developing and proposing administrative claims measures. Once appropriate cost measures are determined, CMS must make cost data easy to access, timely, and in a format understandable to typical small and medium sized medical practices.
- CMS' proposal elsewhere in the proposed rule to remove a large percentage of the existing quality measures and remove measures after only after two years in the program may cause stakeholders to determine it is not worth their time to develop MVPs if they will soon be removed without adequate opportunity to report on measures.
- CMS must extend the timeline to provide adequate time for both physicians and EHR vendors to adapt their workflows and systems to meet the new needs of the disease-specific pathways and activities implied by the combined quality measure and improvement activities.
- CMS must provide clarification and recognition that dialysis patients are to be excluded from PI measures for physicians since they do not control the EHR used for patient documentation in most dialysis facilities.
- CMS must exempt physicians and practices participating in any other payment model (ETC, KCF, CKCC) from participating in the MVP.

- CMS should adopt an opt-in policy, which allows physicians to opt-in to CMS' suggested MVP, or to choose an alternative MVP, or to continue to report measures through the traditional MIPS pathway, rather than assigning physicians to MVPs.
- CMS must commit to maintaining the program for an established period to facilitate dissemination and benchmarking of any new quality measures that will be developed.
- Rather than mandate that physicians or groups report certain MVPs, CMS should incentivize physicians to report MVPs. CMS must provide sufficient funding such that high performing practices achieve an adequate financial bonus to meaningfully impact their business operations and cover their costs.
- CMS should also incentivize specialty societies, who have devoted limited resources toward developing measures, QCDRs and alternative payment models, to propose MVPs. For example, CMS should provide specialty societies with more QPP and claims data to help them identify MVP opportunities and reduce the costs of developing MVPs for consideration by CMS.

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

In the context of revaluation of the outpatient evaluation and management (E&M) code families for 2021, CMS states in the proposed rule that it recognizes there are services other than the global surgical codes for which the values are closely tied to the values of the office/outpatient E/M visit codes, and includes ESRD monthly services (CPT codes 90951 through 90961) among the codes to which this circumstance applies. Accordingly, the Agency seeks comment on whether it would be necessary or beneficial to make systematic adjustments to other related PFS services to maintain relativity between these services and office/outpatient E/M visits.

As CMS knows, valuation of the monthly ESRD codes have long been based on E&M services. In the December 8, 1994 issue of the Federal Register setting forth the Medicare Fee Schedule for 1995, then-HCFA established a process for development of work values for the Monthly Capitated Payment (MCP) for ESRD services that utilized different office visit codes as "building blocks" for the MCP. HCFA noted that the mix of the "visit code building blocks most appropriately represents the typical mix of encounters with the ESRD patient who is dialyzed in an ESRD facility and accounts for the service intensity and complexity of decision-making and the pre-service and post-service work for a month's care of a typical dialysis patient." A panel of carrier medical directors (CMDs) that included a representative of the RUC determined that the appropriate building block mix was four counts of the work RVUs for CPT code 99212 and two counts of the work RVUs for CPT code 99214.

These values remained in place until the rulemaking cycle for the 2004 Medicare Fee Schedule, in which now-CMS established a stratified MCP payment system based on the number of face-to-face interactions between the MCP physician and the ESRD patient. This system established a mid-level adult MCP code (G-0318) based on the previous adult MCP code (CPT code 90921) and representing 2-3 physician-ESRD patient interactions, and provided additional RVUs for 4 physician-ESRD patient interactions (G-0317) and fewer RVUs for 1 physician-ESRD patient interaction (G-0319). This methodology was also applied to the pediatric series of monthly dialysis services, codes G-0308-G0310 for patients less than two years of age, codes G-0311-G0313 for patients between the ages of two and eleven, and codes G-0314-G0316 for patients ages twelve to nineteen.

When the Five-Year Review of E&M Codes increased the work RVUs for selected E&M codes in 2006, the E&M value increases were applied to all global surgical packages with E&M elements. However, these increases were not applied to the family of ESRD MCP codes. As a result, RPA petitioned CMS to apply these increases in the MCP building block codes to the current MCP as part of its comments on the 2007 Medicare Fee Schedule Proposed Rule. RPA's recommendation called for CMS to revise the ESRD MCP codes based on the previously determined building blocks and using the mid-level code (G-0318) since that code most closely approximated the previous adult MCP code (CPT code 90921), with the same methodology being applied to the pediatric series of monthly dialysis services. This recommendation was not accepted, and CMS referred RPA to the AMA Relative Value Update Committee (RUC) to determine the current valuation of the services associated with the ESRD MCP G-codes. The codes were valued by the RUC in early 2008 and the values emanating from that RUC meeting form the basis for the valuation of the monthly ESRD services in the fee schedule today.

RPA believes that adjustment of the family of monthly ESRD service codes based on the increase in underlying E&M services is long overdue. The original component building blocks codes for the MCP (CPT codes 99212 and 99214) have seen multiple increases in value since the MCP was first transitioned into the RBRVS, and the subsequent increase to global surgical packages based on E&M code revaluation since then was not applied to the MCP code family.

Such a change would also be reflective of the Administration's appropriately increased focus on Advancing American Kidney Health. The nation's chronic kidney disease (CKD) patient population continues to grow rapidly and providing nephrology practices with additional resources to provide care to dialysis patients (only by providing increases in value commensurate with value adjustments for their underlying building blocks) would be of tremendous benefit to outpatient kidney disease care. ***Therefore, RPA recommends that CMS adjust the ESRD monthly service codes to reflect previous increases in underlying E&M services.***

V. Concurrent Billing of Transitional Care Management and Monthly Adult ESRD Services

In the proposed rule, CMS discusses utilization of the transitional care management (TCM) codes, noting that while it has grown since the first year the services were part of the fee schedule, utilization of TCM services is low when compared to the number of Medicare beneficiaries with eligible discharges. Additionally, the rule notes that according to analyses performed for CMS, beneficiaries who received TCM services demonstrated reduced readmission rates, lower mortality, and decreased health care costs. In that context, the Agency proposes to allow a series of services that were not previously allowed to be billed concurrently with the TCM codes, including the adult outpatient monthly ESRD codes (CPT codes 90961-62, 90966, and 90970).

RPA fully supports this proposed change. CMS notes in the rule that these codes, when medically necessary, may complement TCM services rather than substantially overlap or duplicate services, and we concur. Further, such a change is not only in complete alignment with the Agency's efforts on Advancing American Kidney Health but is also the right thing to do with regard to improving overall health outcomes of dialysis patients.

RPA urges CMS to proceed with the proposed change to remove the billing restrictions on the transitional care management codes to allow concurrent billing with adult monthly ESRD services.

Additionally, ***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.

VI. Evaluation and Management Services

CMS outlines in the proposed rule its plans for revising the structure, valuation, and documentation requirements for E&M services for CY 2021, and RPA supports the path that CMS proposes to follow in all three areas. Regarding the E&M coding structure and valuation, CMS describes in the rule the AMA CPT Editorial Panel and RUC processes that resulted in the coding structure (eliminating CPT code 99201 for new patient level 1 office/outpatient visits but retaining all other services) and the relative value units (RVUs) assigned to each of the codes in the E&M service code families. As an advisory member of both the CPT and RUC, RPA participated in both efforts and we completely support the revised E&M coding structure that emanated from the CPT process and the values assigned to the E&M codes for CY 2021 by the RUC. As such, we agree with CMS' statement in the proposed rule that "the RUC recommendations reflect a rigorous robust survey approach, including surveying over 50 specialty societies, demonstrate that office/ outpatient E/M visits are generally more complex, for most clinicians." RPA appreciates CMS' recognition of the thorough and exacting work performed by both the CPT and RUC, as demonstrated by the adoption of a majority of recommendations from both bodies.

Further, we are appreciative of CMS' ongoing commitment to reducing the administrative burdens placed on physicians by E&M documentation requirements. These include the proposals to eliminate the "bullet-point" methodology of documenting E&M services, and to streamline history and physical documentation to only require information that is medically appropriate and relevant. These revisions are long overdue and truly meaningful to physicians in practice providing E&M services, and RPA commends the Agency for making real progress in this area.

RPA urges CMS to finalize the CPT codes, CPT guidelines, and RUC recommendations for 2021 implemented by the CPT Editorial Panel and submitted by the RUC, and we urge the Agency to proceed with proposed changes to reduce E&M documentation requirements.

VII. Principal Care Management Codes

In an effort to address care management for patients with only one chronic condition, CMS proposes to create separate coding and payment for Principal Care Management (PCM) services. CMS states in the rule that qualifying conditions for these services "would typically be expected to last between three months and a year, or until the death of the patient, may have

led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.”

CMS notes in the rule that the PCM codes would not be billable by the same practitioner for the same patient concurrent with certain other care management services and includes the monthly capitated ESRD codes among these excluded services, with which we agree. That said, the PCM codes could prove to be useful in the care of CKD patients not yet on dialysis, and thus believe the proposed PCM codes would provide another avenue toward optimizing care for those patients. More broadly, RPA is encouraged by CMS’ continued efforts to utilize non face-to-face services to advance the care provided to not only patients with kidney disease but all chronic illness patient populations.

RPA urges CMS to finalize the PCM codes as proposed.

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