Proposed Payment Rules Yield Positive Results for Nephrology

On July 29, the Centers for Medicare and Medicaid Services (CMS) released three major payment rules for 2020: the Medicare Physician Fee Schedule (MFS), the ESRD Prospective Payment System (PPS), and the Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center Payment Systems (HOPPS/ASC). The headlines from these rules is that there’s not much huge news (at least relative to the mid-summer developments related to the Advancing American Kidney Health Initiative—AAKHI), and that for the most part the news is neutral, good, or really good.

In the MFS Notice of Proposed Rulemaking (NPRM) CMS announced that it was going to implement recommendations from the AMÂ’s Relative Value Update Committee (RUC) on outpatient evaluation and management (E&M) codes, and thus it appears that CMS’ proposal from 2018 to collapse payment for these code families has been abandoned, much to the relief of organized medicine. The 2020 conversion factor (CF) is proposed to be $36.09, a $00.05 increase over the 2019 value of $36.04, and resulting mostly from this, nephrology as a specialty will experience a 1% reimbursement increase for 2020 if the rule is finalized as proposed. [And to be clear, this is strictly for fee-for-service reimbursed care and does not reflect potential changes set forth in the AAKHI proposals.]

In the ESRD PPS NPRM, CMS set the bundled payment base rate for 2020 at $240.27, a $5.00 increase over the 2019 value of $235.27. As set in statute, the payment for acute kidney injury (AKI) services will also be $240.27.

The HOPPS/ASC rule might have been the source of the most substantial and unexpected good news, as CMS did not apply the office based designation to the high volume dialysis access codes (CPT codes 36902 and 36905; both are balloon angioplasty services), so the site neutrality policy proposed for implementation in 2019 that reduced reimbursement for these services by 55 and 54% respectively was not even proposed this year. In short, CMS indicated in the rule that it might still be premature to make such a change based on the availability of data, and noted that there had been a shift in utilization to the ASC setting, making them (seemingly) reluctant to make a change here. This has been a subject of focused advocacy for RPA over the past year as one of RPA’s legislative agenda priorities in addition to independent efforts by RPA and coalition work on vascular access.

This summary provides more details on these and related issues raised in the 2020 payment rules affecting nephrology. Comments on all three rules are due on September 27 and will be available on the RPA website after that date.
Medicare Fee Schedule

Nephrology and General Physician Payment Issues

As is typically the case, the relative value units (RVUs) for 14 of the 17 inpatient and outpatient dialysis services were at least incrementally increased for 2020, and with the increase in the CF should result in a slight uptick in reimbursement for those services. On high volume dialysis codes, CPT code 90960 (adult 4-visit MCP) has a proposed 2020 payment increase of $2.93, for a payment of $291.96, and 90966 (adult home hemodialysis) is increased by $1.78 for a payment of $243.97. The three codes being reduced for 2020 are CPT codes 90935 (hemodialysis, single evaluation) reduced 0.5%, 90951 (ESRD monthly services, 4 visits, patients <2 years old) reduced 0.2%, and 90968 (ESRD daily dialysis, patients age 2-11), reduced 2.1%. CMS continues to designate the home dialysis codes as misvalued, but once again no directive language is in the rule to address the issue. RPA RUC representatives will continue to monitor CMS’ requests to the RUC for code revaluation in case the Agency includes the home dialysis service codes among the requests.

Other noteworthy changes affecting nephrology include CMS’ proposal to allow billing of the transitional care management codes (CPT codes 99495 and 99496) in conjunction with the adult outpatient dialysis codes (CPT codes 90960, 90961, 90962, 90966, and 90970); billing the TCM codes these services to this point has been prohibited. This decision is based on the Agency’s valid perception that the services are underutilized.

Additionally, CMS proposes to create new codes for Principal Care Management (PCM) services.

A gap we identified in coding and payment for care management services is care management for patients with only one chronic condition. The current CCM codes require patients to have two or more chronic conditions. These codes are primarily billed by practitioners who are managing a patient’s total care over a month, including primary care practitioners and some specialists such as cardiologists or nephrologists. We have heard from a number of stakeholders, especially those in specialties that use the office/outpatient E/M code set to report the majority of their services, that there can be significant resources involved in care management for a single high risk disease or complex chronic condition that is not well accounted for in existing coding. This issue has also been raised by the stakeholder community in proposal submissions to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Therefore, we are proposing separate coding and payment for Principal Care Management (PCM) services, which describe care management services for one serious chronic condition. A qualifying condition 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 goes on to say that they are not proposing any restrictions on which specialties could bill for their services using the PCM codes, so these will presumably be available for billing for care provided to CKD patients. The codes for the services would be HCPCS codes GPPP1 and GPPP2. GPPP1 would be reported when, during the calendar month, at least 30 minutes of physician or other qualified health care provider time is spent on comprehensive care management for a single high-risk disease or complex chronic condition. GPPP2 would be reported when, during the calendar month, at least 30 minutes of clinical staff time is spent on comprehensive management for a single high-risk disease or complex chronic condition. This is similar to the coding structure created for the chronic care management code family. The
proposed RVU levels for the codes are 1.28 for GPPP1 (this would work out to a non-geographically adjusted payment amount of $46.19; the RVUs for GPPP2 would be 0.61, about $22). These would be for non-face-to-face services and would require patient consent. RPA will continue to review the proposed PCM codes to determine their specific applicability to kidney disease care.

Regarding the CF (recalling that it is the multiplier expressed as a dollar figure through which Medicare annually increases or decreases overall reimbursement to Medicare Part B providers), the $0.05 increase continues the pattern in recent years of CMS providing modest CF increases. It is possible that the CF will change in the final rule as this has occurred in the past, but not in the last several years.

**Evaluation and Management Codes**

CMS states in the rule that it will accept the RUC recommendations for both coding structure and valuation, and as a result does not implement the proposed arrangement outlined in the 2019 fee schedule NPRM that collapsed payment amounts for the higher-level codes into a single level. This is a huge victory for cognitive care in general, although it appears that the specialty-specific impact of the change for nephrology is 2%. While this impact is unexpected, it should be considered in the context of the cuts expected out of last year’s proposed rule (approximately 13%) and is only a projection.

Additionally, positive news in the proposed rule pertains to reduction of E&M documentation burden. For 2021, CMS has indicated that: (1) the arbitrary “bullet-point” methodology of documenting E&M services will be discontinued (CMS refers to this as “clinically outdated”), and the level of billing will be determined by either medical decision-making or time; (2) history and physical documentation only needs to reflect what is medically appropriate; and (3) if the clinician bases the billing level on time, it will include “the total time personally spent by the reporting practitioner on the day of the visit (including face-to-face and non-face-to-face time)” so time prior to or after the face-to-face interaction with the patient can be included.

**Physician Supervision Requirements for Physician Assistants (PAs)**

CMS also states that it is proposing to modify physician supervision of PAs to give PAs greater flexibility to practice more broadly in accordance with state law and state scope of practice. In the absence of state law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would be evidenced by documentation in the medical record of the PA’s approach to working with physicians in furnishing their services. This would appear to align physician supervision of PAs with that associated with nurse practitioners (NPs) and clinical nurse specialists (CNSs).

**Review of Notes by Medical Students**

To reduce the burden of redocumentation, the Agency states that it is proposing broad modifications to the documentation policy so that physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives could review and verify (sign and date), rather than re-documenting, notes made in the medical record by other physicians, residents, nurses, students, or other members of the medical team.
**Quality Payment Program**

In the proposed rule CMS continues to make refinements to the Merit-based Incentive Payment System (MIPS), which is composed of 4 categories; Quality, Resource Use (Cost), Improvement Activities, and Promoting Interoperability. Proposed changes to the overall MIPS program and the alternate payment model (APM) program and specific components are highlighted below.

CMS proposes to improve the Quality Payment Program (QPP) by streamlining the program’s requirements with the goal of reducing clinician burden through use of a new, simpler way for clinicians to participate in a pay-for-performance program. This new framework, the MIPS Value Pathways (MVPs), beginning in the 2021 performance period, would move MIPS from its current state, which requires clinicians to report on many measures across multiple performance categories, such as Quality, Cost, Promoting Interoperability and Improvement Activities, to a system with a reduced reporting requirement. Under MVPs, clinicians would report on a smaller set of measures that are specialty-specific, outcome-based, and more closely aligned to APMs. In addition, MVPs would allow CMS to provide more data and feedback to clinicians. A summary of the proposed changes for 2020 as they may affect nephrologists is provided in the following paragraphs.

**MIPS**

CMS is proposing to increase the MIPS performance threshold - the minimum number of points required to avoid a negative payment adjustment - from 30 points in 2019 to 45 points in 2020 and 60 points in 2021. They are also proposing to increase the additional performance threshold for exceptional performance to 80 points in 2020 and to 85 points in 2021.

- As required by statute, the maximum negative payment adjustment is -9%.
- Positive payment adjustments can be up to 9% (not including additional positive adjustments for exceptional performance) but are multiplied by a scaling factor to achieve budget neutrality, which could result in an adjustment above or below 9%. (Given MIPS historical positive payment adjustment rates, RPA believes the incentive payment will be less than 9%.)

**Changes to the Quality Category**

CMS proposes to reduce the Quality performance category weight to 40 percent in 2020, 35 percent in 2021, and 30 percent in 2022. The Data Completeness Requirement will increase from a 60% sample of a clinician's or group's patients to 70% in 2020.

CMS proposes to completely eliminate nephrology-specific MIPS measures by removing the following from the program:

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

CMS’ rationale is that this measure does not align with the meaningful measure initiative and applies to a limited patient population. They state that limited adoption over multiple program years suggests this is not an important clinical topic for MIPS eligible clinicians.
MIPS 329 Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis:
CMS’ rationale is that this measure does not align with the meaningful measure initiative. They state that limited adoption over multiple program years suggests this is not an important clinical topic for MIPS eligible clinicians.

MIPS 330 Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days
CMS’ rationale is that this measure does not align with the meaningful measure initiative. They state that limited adoption over multiple program years suggests this is not an important clinical topic for MIPS eligible clinicians.

MIPS 403: Adult Kidney Disease: Referral to Hospice
CMS’ rationale is that this measure does not align with the meaningful measure initiative. They state that limited adoption over multiple program years suggests this is not an important clinical topic for MIPS eligible clinicians. They also believe this concept would be more inclusive and better represented if the denominator was expanded to include patients with multiple chronic conditions.

RPA will offer a strong rationale for the importance of keeping these measures in the MIPS program in our comment letter.

Improvement Activities

CMS proposes Groups or virtual groups would be able to attest to an improvement activity when at least 50% of the MIPS eligible clinicians (in the group or virtual group) participate in or perform the activity. At least 50% of a group’s NPIs must perform the same activity for the same continuous 90 days in the performance period to qualify.

Resource Use (Cost Category)

CMS proposes to increase the Cost performance category weight to 20 percent in 2020, 25 percent in 2021, and 30 percent in 2022. CMS proposes to add 10 newly developed episode-based measures to the cost performance category beginning with the 2020 performance, including Acute Kidney Injury Requiring New Inpatient Dialysis Measure.

Promoting Interoperability

CMS did not propose significant changes to the Promoting Interoperability performance category, but is seeking comments on the following:

- Potential opioid measures for inclusion in the Promoting Interoperability performance category.
- Development of potential measures that are based on existing NQF and CDC efforts that measure the clinical and process improvements specifically related to the opioid epidemic.
- A metric to improve efficiency of providers within EHRs.
- Issues related to the standards-based API criterion in the ONC 21st Century Cures Act proposed rule with the goal of establishing an alternative measure under the Provider to Patient Exchange that would require providers to give patients their complete data contained within an EHR.
• Integration of patient-generated health data (PGHD) into EHRs using CEHRT.
• Engaging in activities that promote the safety of the EHR.

Alternative Payment Models (APMs)

In the proposed rule, CMS sets forth a relatively minimal number of changes relating to quality measurement in APMs. These include (1) creation of a Quality performance credit, which would equal 50% of the MIPS Quality component score, for those MIPS-APM participants that cannot feasibly be scored on quality within their APM entity; these participants could report MIPS quality measures to add to their base 50% credit; and (2) use of average marginal risk rates for Advanced APMs across all possible levels of actual expenditures, instead of the current practice of using the lowest marginal risk rate.

ESRD Prospective Payment System

2020 PPS Payment Rates

The proposed rule for the 2020 ESRD Prospective Payment (PPS) System included a number of noteworthy developments, the first of which is that the ESRD base rate for 2020 has been set at $240.27, a $5.00 increase over the 2019 value of $235.27 (and by law, this payment amount applies to provision of acute kidney injury (AKI) services as well). The PPS payment amounts reflects a 1.7% market basket increase and use of productivity adjustments and a wage index budget neutrality factor of 1.004180. CMS projects that the updates for CY 2020 will increase the total payments to all ESRD facilities by 1.6 percent compared with CY 2019. For hospital based ESRD facilities, CMS projects an increase in total payments of 1.9 percent, while for freestanding facilities, the projected increase in total payments is 1.5 percent.

New Innovation Adjuster

The ESRD PPS NPRM states that CMS has proposed a “transitional add-on payment adjustment for new and innovative equipment and supplies (TPNIES) under the ESRD PPS, as part of our goal to spur innovation to encourage the uptake of the latest renal dialysis treatments by ESRD facilities.” The proposed policy would provide a payment adjustment for renal dialysis equipment and supplies (with the exception of capital-related assets—this likely means that dialysis machines are not included as a new innovation).

TPNIES are defined in the rule as equipment and supplies that are: new, meaning they are granted marketing authorization by FDA on or after January 1, 2020, and innovative, meaning they meet substantial clinical improvement (SCI) criteria similar to those used for the hospital inpatient prospective payment system’s new technology adjuster, as well as commercially available, and have a Healthcare Common Procedure Code System (HCPCS) application submitted in accordance with the official Level II HCPCS coding procedures. The payment for TPNIES would be based on 65 percent of the price established by the Medicare Administrative Contractors (MACs), using the information from the invoice and other relevant sources of information. CMS also states that it would pay the TPNIES for 2 calendar years, after which the equipment or supply would qualify as an outlier service and no change to the ESRD PPS base rate would be made. This can be interpreted as the Agency saying that there will be no new money for innovation after the transitional period ends, so as good as this news is it also is exceptionally time-limited, given the challenges associated with bringing new products to market.
In the ESRD Quality Improvement Program (QIP) rule that was released in conjunction with the ESRD PPS, there were two significant developments. First, CMS is updating the scoring methodology for the National Healthcare Safety Network (NHSN) Dialysis Event reporting measure so that new facilities and facilities that are recently eligible can receive a score on the measure. CMS notes that it does not believe that the current policy appropriately accounts for the effort made by these facilities to report these data for the months in which they are eligible to report; this change should address that concern.

Second, CMS is converting the Standardized Transfusion Ratio (STrR) clinical measure (NQF #2979) to a reporting measure while CMS examines concerns raised by stakeholders regarding the measure’s validity. The Agency states in its press release on the QIP proposed rule that they would like to ensure that the Program’s scoring methodology results in fair and reliable STrR measure scores because those scores are linked to dialysis facilities’ TPS and possible payment reductions. It goes on to say that it believes that this approach is the most appropriate way to continue fulfilling the statutory requirement to include a measure of anemia management in the Program while ensuring that dialysis facilities are not adversely affected during its continued examination of the measure.

**Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center Payment Systems**

The HOPPS/ASC rule includes two substantial victories affecting dialysis vascular access. Recall that vascular access care has migrated in many localities to the ASC setting, thus fair and appropriate reimbursement for care in that setting has taken on increased importance.

**Office-Based Designation for CPT Codes 36902 and 36905**

In a big win, the application of the office-based designation to the two highest volume codes (CPT codes 36902 and 36905) did not occur (this is also referred to site-neutral payment policy). This was somewhat unexpected, as interactions with responsible CMS staff seemed to indicate that the intent was to revisit use of the site-neutral payment policy. However, in the proposed rule, CMS did not implement the proposed policy, explaining:

> As we stated in the CY 2019 final rule with comment period (83 FR 59036), the office-based utilization for CPT codes 36902 and 36905 (dialysis vascular access procedures) was greater than 50 percent. However, we did not designate CPT codes 36902 and 36905 as office-based procedures for CY 2019. These codes became effective January 1, 2017 and CY 2017 was the first year we had claims volume and utilization data for CPT codes 36902 and 36905. We shared commenters’ concerns that the available data were not adequate to make a determination that these procedures should be office-based, and believed it was premature to assign office-based payment status to those procedures for CY 2019. For CY 2019, CPT codes 36902 and 36905 were assigned payment indicators of “G2” – Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative weight.

> In reviewing the CY 2018 volume and utilization data for CPT code 36902 we determined that the procedure was performed more than 50 percent of the time in physicians’ offices based on 2018 volume and utilization data. However, the office-based utilization for CPT code 36902 has fallen from 62 percent based on 2017 data to 52 percent based on 2018 data. In addition, there was a sizeable increase in claims for this
service in ASCs – from approximately 14,000 in 2017 to 38,000 in 2018. As previously stated in the CY 2019 OPPS/ASC final rule (83 FR 59036), when we believe that the available data for our review process are inadequate to make a determination that a procedure should be office-based, we either make no change to the procedure’s payment status or make the change on a temporary basis, and reevaluate our decision when more data become available for our next evaluation. In light of these changes in utilization and due to the high utilization of this procedure in all settings (over 125,000 claims in 2018), we believe it may be premature to assign office-based payment status to CPT code 36902 at this time.

Therefore, for CY 2020, we are not proposing to designate CPT code 36902 as an office-based procedure and continue to assign CPT code 36902 a payment indicator of “G2” – nonoffice-based surgical procedure paid based on OPPS relative weights.

The CY 2018 volume and utilization data for CPT code 36905 show the procedure was not performed more than 50 percent of the time in physicians’ offices. Therefore, we are not considering assigning an office-based designation for CPT code 36905 and the procedure will retain its payment indicator of “G2” – non office-based surgical procedure based on OPPS relative weights.

In summary, CMS did not feel comfortable with the volume of data it had gathered to apply site neutrality to the affected codes, and the data it did have had shifted in the direction of not making the change. In fact, while some of the low-volume services in the dialysis vascular access code family are projected for minor reductions for 2020, CPT code 36902 is slated for a 2.3% increase in reimbursement, and 36905 is set for a 2.6% increase. Given that this rulemaking could have projected massive cuts (recalling the 55 and 54% cuts proposed in 2018) this is great news.

Ambulatory Payment Classifications (APC) Structure for Endovascular Services

In addition to the positive news on the high-volume dialysis vascular access codes, additional good news was found in the review of the Ambulatory Payment Classifications (APC) structure for endovascular services. This is like a diagnosis related group (DRG) structure where services of similar work and resource use are classified together, with an identical payment level assigned to the classification. Thus, downward movement among the classifications can have significantly negative payment implications. The good news is that CMS has at this time proposed no changes to the APC classifications (or ‘bands’) and this status quo is good news for all of the services in the dialysis vascular access code family. RPA will continue to monitor developments in this area on behalf of RPA membership.