

RPA News

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The Advocate
for Excellence in
Nephrology Practice

Voluntary Kidney Models Present Opportunities/Challenges for Nephrology

On October 24, CMMI released the long-awaited Request for Applications (RFA) for what is now being called the Kidney Care Choices (KCC) model, which is comprised of Kidney Care First (KCF—the nephrologist/nephrology practice only model) and the Kidney Care Entities (KCE—the risk-bearing models that require the participation of a transplant provider in addition to the nephrology component).

The RFA presents a series of general provisions that apply to both the KCF and KCE models, followed by more detailed discussions of both models. However, many of the topics or provisions outlined in the separate KCF and KCE descriptions are identical, including the CKD Quarterly Capitation Payment (CKD QCP), the Adjusted Monthly Capitation Payment for Dialysis (AMCP) for End-Stage Renal Disease (ESRD) patients (which is set at the 2-3 visit level of the current MCP), and a list of benefit enhancements on issues such as application of the kidney disease education benefit, telehealth for home patients, home health, and hospice. Both the KCF and KCE sections include an application template for potential participants.

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Nephrology Breaks Even in 2020 Medicare Fee Schedule; Nephrology-Specific Quality Measures Eliminated from QPP

CMS issued the final rule for the 2020 Medicare Physician Fee Schedule on November 1 with minimal changes from what the Agency proposed in July. CMS finalized its proposals to allow for billing of transitional care management (TCM) codes for monthly dialysis patients and to update the structure and valuation of evaluation and management (E&M) services. In addition, payment for all dialysis codes is incrementally increased. However, on issues pertaining to MIPS, CMS eliminated nephrology-specific measures and implemented a cost measure for Acute Kidney Injury Requiring New Inpatient Dialysis; RPA opposed these provisions in its comments on the proposed rule.

The provisions in the final rule that affect nephrology are explained below. RPA’s comments on the final rule were submitted to CMS in late December and are posted on the RPA website.

Nephrology-Specific Payment Issues

On nephrology payment issues, the specialty is slated for a 0% impact for 2020. All dialysis codes, inpatient and outpatient, adult, pediatric and daily, experience increases of between 0.1% and 1.0% (except for CPT code 90970, the adult daily dialysis code, which was increased 4.5%). For CPT code 90960, the adult in-center, four-visit code, the increase is 0.8%, which with the increase in the conversion factor (discussed below) works out to a \$2.21 increase (unadjusted for geography), while CPT code 90935 (hemodialysis, single evaluation) is increased by 0.4%, working out to a \$0.32 bump. Regarding the dialysis circuit codes for interventional dialysis services, the two high volume codes, CPT codes 36902

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From Capitol Hill

2019 Was the Year of the Unlikely, at Nat’s Park and Elsewhere in DC

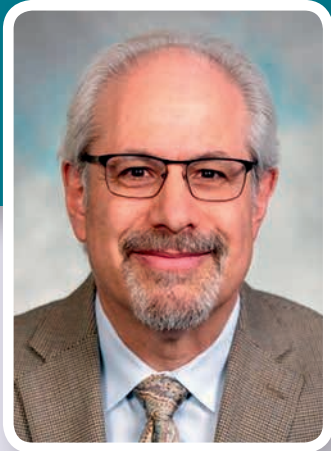
By Robert Blaser, RPA Director of Public Policy

Loyal readers of the *RPA News* know that this RPA staffer loves a good sports analogy, and happily my favorite baseball team has provided fodder for this month’s Capitol Hill column. As anyone with an appropriate level of awareness and good judgment knows, the Washington Nationals won the World Series in October, Washington’s first baseball championship since the Homestead Grays won the championship of the Negro League in 1948, and the city’s first World Series championship since the old Washington Senators won the series in 1924, a span of 95 years.

Beyond the glory of this championship for DC is the remarkable story of how unlikely it was. On May 23, the Nationals were 19-31; with their title run, the Nats joined the 1914 Boston “Miracle” Braves as the only team to come from 12 or more games below .500 at any point in the season to win a championship. But that’s not all. Washington played five elimination games, fell behind in all five, and came back to win all five. Three of the five elimination games were winner-take-all games in which the team was losing in the late innings (defined as the 7th inning or later by baseball analytical types) by two or more runs. Thus, in these three games entering the seventh inning the National’s win probability (for you non-seamheads out there, yes, this is something stats freaks track) was never higher than 14%, yet the team came back to win all three (and FYI this statistic is sourced all over the Internet; google it if you don’t believe me). All of this cumulatively lends itself to the claim that the Nats’ ultimate victory is the most improbable in World Series history, if not in the history of all North American team

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President's Message



Jeffrey Perlmutter, MD
RPA President

When I reviewed my prior presidential messages, I realized that this one represents another installment in the saga of the new payment models for the care of kidney patients. In the May column, I described a stakeholders meeting with broad representation from the kidney community that RPA had convened in February in anticipation of those payment models. By the time the September issue of *RPA News* was published, the excitement of the Presidential Executive Order outlining the Advancing American Kidney Health Initiative subsided (since the announcement was made in July); the renal community had digested the proposed rule for the ETC model and submitted comments from diverse perspectives. Those comments were sent to CMS by mid-September, and at press time we await the release of the final rule.

The initial proposed start for the ETC was January 1, but one must question whether even the backup start date in April 2020 will be possible. We expected the RFA to participate in the voluntary payment models to be out by the end of the summer, but as of my September message the RFA had not yet been released. It was announced October 22, with a January 22 due date for applications. RPA generated a summary of the RFA within a day that was sent to membership, and provided to you important questions to consider before submitting an application to participate, with the answers to those questions being dependent on the circumstances such as geography and patient census for each practice (e.g., mine is too small). Because the voluntary kidney care payment models include a reduction in the ESRD monthly capitated payment for practices that typically have four interactions with the patient monthly, and introduce a new quarterly capitated payment for the care of people with CKD stages IV and V, nephrology practices will have to do a careful analysis of the financial consequences of those changes to assess the viability of participating in the models. The questions to consider are included in the article on page 1.

At the ASN Annual Meeting in Washington, DC, last November, I was honored to co-moderate the session that RPA cosponsors which was titled “Nephrology Payment 2020.” The Christopher R. Blagg Lecture in Kidney Diseases and Public Policy was given by Amy Bassano, acting director of CMMI. Ms. Bassano spoke on the future of value-based care in nephrology and focused on the voluntary payment models. It was standing room only at the session, demonstrating the intense interest the new payment models have generated.

These payment models were among the issues the RPA Board of Directors considered when we met in October for our triennial strategic planning session. Participants also included diverse segments of the RPA membership that are not represented on the Board in an effort to obtain many different perspectives. We believe that the course that we set for the RPA at the sessions will allow the organization

to represent our members into the future. During the time between those meetings and this publication, we will be finalizing those strategic plans, and will present to our members a new vision and a new mission statement for the organization as well as key goals and strategies for the next 2-3 years. I look forward to sharing more details about our strategic direction during the Presidential Address at the RPA Annual Meeting.

I strongly recommend that you attend the annual meeting which will be held in Baltimore, MD, March 19-22. The program for this meeting is particularly timely. Topics will be addressed that are essential for the continued success of nephrology practices in the midst of a potential sea change in our practice environment. Reading RPA’s analyses about changes in government regulations and the new payment models come to life with expert speakers during this meeting, and attendees have the unique opportunity to not only engage in a dialogue with experts, but also with their peers and colleagues grappling with the same challenges.

As I mentioned in my November message, the PREZ and the PREZMOBILE visited two nephrology practices in North Carolina. Although these practices are in the same state, they face very different challenges in Asheville and Charlotte. I learned a great deal by engaging in conversations with both groups. It was clear to me that our members have much to tell RPA leadership, but the PREZ and the PREZMOBILE cannot reach everyone. The Annual Meeting provides the opportunity for you to come to us and avail yourselves of the numerous resources you will find there. We are listening. I hope to see you in Baltimore. ■



Drs. Ron Hyde, Harry Giles, Sallie Israelit, and Sarah Swartz setting goals at RPA strategic planning session.

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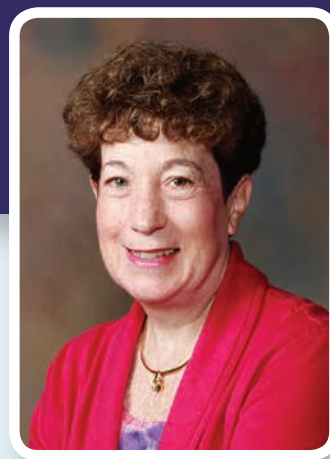


When you see this symbol in your *RPA News*, visit the RPA website at www.renalmd.org to learn more.



Scan barcode with your phone to visit our website!

Editor's Expressions



Dale Singer, MHA
RPA Executive Director

To state the obvious, on January 1 we not only began a new year, but we also entered a new decade. This month we pause to reset and start fresh with a clean slate, whether it's establishing new routines and visiting the gym more frequently, eating a healthier diet, or improving our work/life balance. Whatever our goals may be for 2020, the new year provides us with the opportunity to reflect on the past, identify what is important to us moving forward, and make plans to hit our targets.

Organizationally, RPA is future-focused. RPA's Board of Directors, several association volunteers and staff participated in a strategic planning retreat in October. In addition to revisiting our vision and mission, we identified four key goals for the association to focus on for the next two to three years. The Board will be further developing the strategies to achieve these goals as well as key performance indicators to measure our success toward achieving them during the upcoming Board meeting later this month. Join us at the RPA Annual Meeting in March in Baltimore, where RPA President Dr. Jeff Perlmutter will share key elements from the plan during his opening address.

The RPA leadership and staff will work together as a team to implement the strategic plan. As most of the readers of *RPA News* know, RPA employs eight full-time staff. We like to say that we're lean and mean! The American Society of Association Executives, my professional association, defines small staff associations as those entities with ten or fewer staff. There are numerous challenges small staff associations like RPA face. As you might imagine, we are dependent on each other. If one of us is out for an extended period of time, others must pick up and run with their duties to ensure that we

don't skip a beat. Each of us has tasks in our "other duties as assigned" list that are not typically items for which others with similar job titles in larger associations would be responsible. At the RPA office, each staff person answers phones, makes copies, and compiles meeting materials. We don't have the luxury of saying, "that's not my job."

I have tried to create a culture of teamwork where no one feels put upon for helping out another staff person because each of us is here to support our members and the association as a whole. Over the past nearly 25 years I have served as RPA's executive director, I have worked to build staff expertise in RPA's core competencies and business areas: advocacy, practice management, quality improvement, meetings, marketing, and member services. A team is defined as a number of persons associated together in work or activity who join forces or efforts. When a team is united and comes together for a common purpose, great things happen that benefit all members of the team. When the focus on the team is greater than the attention on one individual, the chances of successful outcomes increase dramatically because the whole is greater than the sum of its parts. This is exemplified in sports when we look at those teams that win world championships. (Congrats to my hometown Washington Nationals on their unexpected but well-deserved World Series win!)

When one member of the RPA team suffers an illness or loss, the rest of the team feels his or her pain and offers support in a time of need. Conversely, when a member of the team celebrates a wedding or graduation the rest of the team experiences joy. Since the majority of RPA staff members have worked for the association for more than ten years, we have become a family. As a family, we have been there for each other during difficult diagnoses and health scares, deaths in our families, a wedding, and several high school and college graduations. Our experiences outside of the workplace affect our performance on the job; therefore, we need to understand and empathize with our colleagues and lift each other up so we can be the best that we can be and contribute to the RPA staff team most effectively.

Sometimes we get caught up in the daily grind and meeting deadlines and we forget to take time to check in on our fellow staff members. Many of you reading this column employ staff to manage and run your practices. Don't underestimate the importance of understanding what makes each staff person special and take the time to learn something about what they do when they aren't at work. Building a culture of trust and fellowship will pay huge dividends for each individual as well as the entire team and organization.

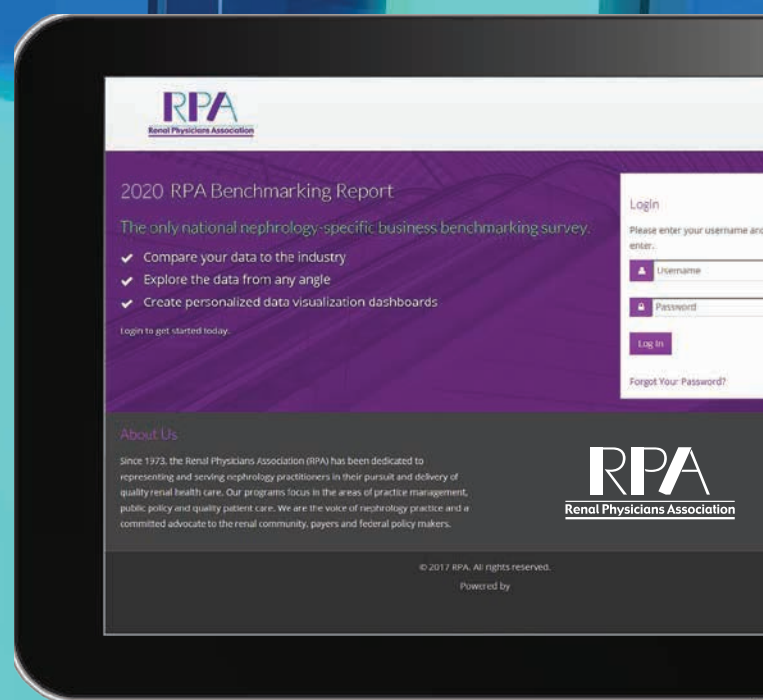
As we begin a new year, I hope that RPA can help each of you achieve professional success. ■



The RPA staff team: Katrina Murray, Dale Singer, Mary Orgler, Shalice Smedley, Robert Blaser, Desiree Bryant, Rose Butts, and Amy Beckrich.

Save Your 2019 Data for the upcoming 2020 RPA Nephrology Practice Business Benchmarking Survey.

Watch your inbox for an invitation to
participate in the survey in April 2020.
We appreciate and value your participation.



Voluntary Kidney Models

from page 1

A summary of the key points outlined in the general provisions and both models is provided below. RPA disseminated a series of guidance questions to membership in early November to assist nephrology practices in determining whether participating in any of the voluntary models would be appropriate for their situation. RPA’s guidance questions are included at the end of this article. RPA also shared its concerns regarding the RFA with Acting CMMI Director Amy Bassano in mid-December. The comment letter as well as RPA’s complete analysis of the RFA are posted at www.renalmd.org.

General Provisions

Timeline

- Application responses due January 22, 2020
- Application decisions made and participants informed—Winter 2020
- Agreements to be signed— Spring 2020
- Implementation Period—2020
- Final Decisions on 2021 participation—Winter 2020
- Performance year 1—2021; Performance year 2—2022, etc.

Monitoring and Oversight

CMMI will work with the Center for Program Integrity and the Office of Financial Management to monitor and assess the performance of individuals and entities participating in the Models.

The Centers for Medicare and Medicaid Services (CMS) monitoring activities may include:

- Auditing of samples of medical charts.
- Monitoring of beneficiary complaints and surveys.
- Analysis of claims and quality data.
- Vetting of model participants and their providers/suppliers and affiliated individuals and entities on the basis of program integrity issues.
- Review of warranted versus unwarranted inpatient services.
- Monitoring of external sources for sanctions, lawsuits, and investigations.
- Monitoring for appropriate use of Medicare Benefit Enhancements.

Interoperability Requirements

As expected, interoperability capabilities among participants will be required, and CMS notes in the RFA that there is an “Interoperability and Patient Access Notice of Proposed Rulemaking (NPRM) that sets forth CMS’ proposed goals in promoting interoperability for all providers, suppliers, and CMS-funded payers and health plans across multiple programs and models.”

In addition to what gets finalized from the Interoperability NPRM, KCC model participants will be required to (1) make full electronic health data available to all patients within 24 hours of an encounter; (2) support electronic, interoperable data exchange with other providers/suppliers and health systems, use 2015 Certified Electronic Health Record Technology (CEHRT); and (3) connect to regional and/or national/vendor-mediated health information exchange (HIE) to send and receive electronic alerts for patient transitions of care from hospitals or other providers, for all patients.

Waivers

CMS includes a table in the RFA with the payment rule waivers they will be allowing; these are the ‘benefit enhancements’ referred to earlier on KDE, telehealth and home dialysis, home health, etc. However, CMS also notes that the Secretary will consider issuing fraud and abuse waivers at a later juncture, but they are not being issued in the RFA. That is not surprising in that the Office of Inspector General (OIG) and the Department of Justice are much more circumspect in allowing fraud and abuse waivers, and waiting for those would have further delayed the release of this RFA.

Kidney Care First Option

The KCF option can be used by nephrologists and nephrology practices solely, and, as noted, has many features that are identical to the KCE

model that also requires participation of a transplant provider and involves varying levels of risk. Key points from each section of the RFA are provided below.

Applicant Eligibility

Nephrologists in KCF practices must meet **all** of the following requirements for the duration of their participation in the Model:

- Must be enrolled in Medicare;
- Must self-identify as nephrologists for the purposes of this Model. CMS will verify this information against PECOS, or through other means, including claims data.

Practices must meet **all** of the following requirements in order to be eligible to participate in the KCF Option and for the duration of their participation:

- A practice is defined as all individual National Provider Identifiers (NPIs) billing under a single TIN at a practice site’s physical address. To be eligible to participate in the KCF Option, the practice will need to demonstrate that at least 50% of the practice’s total revenue from the previous 6 months comes from nephrology services;
- At least 80% of all nephrologists that have reassigned their rights to receive Medicare payment to the practice must participate in the Model;
- The practice must receive at least 50% of its Medicare payments for services furnished to beneficiaries with CKD, ESRD, or a functioning transplant;
- The practice must provide certain services to a minimum of 500 late stage CKD and 200 ESRD aligned Medicare beneficiaries over the course of the previous 6 months. There is no requirement that the KCF practice furnish services to a minimum number of transplant beneficiaries;
- The practice must use the 2015 Edition CEHRT, support data exchange with other providers and health systems via Application Programming Interface (API), and connect to their regional HIE;
- The practice must demonstrate the ability to assume financial risk and make any required repayments to the Medicare program; and
- The practice and its locations must be entirely within a single KCF market area. A KCF market area is a geographic area which contains no more than four Medicare Core Based Statistical Areas (CBSAs), and any rural counties not included in Medicare CBSAs within the same state or states as the included CBSAs. The CBSAs included in the KCF market area need not be contiguous but must be connected by rural counties and/or have no more than one CBSA in between CBSAs included in the KCF market area. Alternatively, a KCF practice may be located in rural counties only, in which case all included rural counties must be located in the same state. Nephrology practices in the state of Maryland will be able to apply to participate in a KCE.

Individual nephrologists cannot participate in the KCE model, but nephrology practices can apply to be in both the KCF and KCE models, and if both applications are approved, choose the model in which to participate. Further detail is provided in the RFA on the interactions between KCFs and other shared savings programs.

Beneficiary Eligibility and Alignment

CMS criteria for a beneficiary to be eligible for inclusion in the model are as follows:

- Be enrolled in Medicare Parts A and B.
- Not be enrolled in a Medicare Advantage plan, cost plan, or other non-Medicare Advantage Medicare managed care plan.
- Reside in the United States.
- Receive the plurality of their Monthly Capitation Payments (MCPs) billed in the KCF practice’s market area, defined in section III.B of this RFA (ESRD beneficiaries only).
- Receive the plurality of their CKD care in the KCF practice’s market area (CKD beneficiaries only).
- Be 18 years of age or older.
- Be alive.

- Not have acute kidney injury (AKI).
- Not have already been aligned to a Medicare Accountable Care Organization (ACO) or another participant in a Medicare program/demonstration/model involving shared savings as of the date of alignment for the KCF Option (please refer to Section 14, Overlap, for additional information).
- Not have Medicare as a secondary payer.

One participation requirement that seems likely to exclude some potential participants is that during each performance year, KCF practices must have a minimum of 500 aligned Medicare beneficiaries with late stage CKD and 200 aligned Medicare ESRD beneficiaries. Also, CMS will prospectively align beneficiaries to KCF practices based on claims data and nephrology services. A lengthy description of how alignment and de-alignment of patients to a practice is provided, but long story short, it is based on evaluation and management (E&M) and/or nephrology services provides to a beneficiary, and how that might fluctuate. Transplant patients will remain aligned to their KCF practice for three years from the month of transplant in order for the KCF practice to be eligible to receive kidney transplant bonus payments.

Finances and Payment

The RFA outlines the previously promulgated payment types of a CKD quarterly capitated payment (QCP), an adjusted MCP (AMCP), and the kidney transplant bonus (KTB). The CKD QCP is designed to give a predictable upfront payment for CKD services; but in lieu of the typical E&M services that would be provided to these patients. As such, the following code families are included in the QCP and thus not separately billable:

- Office/Outpatient Visit E/M 99201-99205, 99211-99215
- Prolonged E/M 99354-99355
- Transitional Care Management Services 99495-99496
- Advance Care Planning 99497-99498
- Welcome to Medicare and Annual Wellness Visits G0402, G0438, G0439
- Chronic Care Management Services 99490

CMS states in the rule that:

KCF practices will still be required to submit claims with the relevant codes for data collection and quality purposes, but the CKD QCP will be the only payment to the KCF practice for the included services furnished to aligned beneficiaries with CKD stage 4/5.

This means that KCF practices will be expected to submit claims for these E&M code families but will not be paid for them.

With regard to the payment, CMS states that the CKD QCP will be the same as the AMCP, which is to be set at the current 2-3 visit level of the MCP, so this quarterly payment figure would be approximately \$242.

As for the AMCP, the \$242 payment would occur regardless of the number of visits the nephrologist has with the patient in a month, unlike the current fee-for-service MCP. The rationalization that CMS provides for this decision is that: (1) studies show there is no relationship between the number of MCP patient visit and outcomes; (2) the current structure creates an incentive to pursue 4 visits every month, while the revised structure will reduce provider burden and allow nephrologists to focus on care quality rather than the number of visits; and (3) the current payment structure of the MCP creates a bias toward in-center hemodialysis.

For the KTB, CMS states that:

KCF practices are eligible for a bonus payment for every aligned beneficiary who receives a kidney transplant, whether from a living or deceased donor, and does not return to dialysis. KCF practices would also receive the KTB payment when an aligned beneficiary receives any future FDA-approved products that replace physiological kidney function.

As noted in CMS’ press releases on the KCF from July, the amount of the KTB payment is set at \$15,000 per transplant, paid to the KCF practice. The KTB will be disbursed to the KCF practice as follows: \$2,500 one year after transplant, \$5,000 two years after the transplant,

and \$7,500 three years after the transplant, as long as the transplant remains successful.

Like the mandatory ESRD Treatment Choices (ETC) model, the KCF model utilizes a performance-based adjustment (PBA) system for determining bonus payments based on quality and utilization of services. CMS notes in the rule that the PBA could increase a KCF practice’s revenue by up to 30 percent of its combined CKD QCP and AMCP, or, on the other hand, reduce that revenue by as much as 20 percent of those payments.

Two distinct sets of performance measures will be used in calculating the PBA:

- Quality Gateway – a set of quality measures, with performance thresholds, designated to reflect appropriate clinical care and patient experience for the affected population, and
- Utilization Measures – aimed at incentivizing efficient and appropriate provision of health care services for the patient population.

Within the PBA, participants will be evaluated on a Relative Performance (RP) Component (both with other KCF practices and possibly with all nephrology practices nationally), and a Continuous Improvement (CI) Component based on improvement measures relative to prior performance. As with the ETC, the performance periods would be continually adjusted six- month periods, with a table included displaying the periods over the three performance years currently scheduled. CMS also provides detail on the magnitude of the bonuses or penalties, but in short there are eight levels of penalty or bonus, with the top six being positive or upward adjustments and the bottom two downward, with the range extending from +30 percent (maximum upside potential) to a -20 percent (downside risk) adjustment.

Quality Strategy

In the Quality Strategy section of the document, CMS outlines the two types of measures it will use, the Quality Gateway measures and the Utilization Measures.

The measures included in the Quality Gateway are:

- Gains in Patient Activation (PAM) Scores at 12 Months; NQF #2483
- Depression Remission at Twelve Months – Progress Towards Remission; NQF #1885
- Controlling High Blood Pressure; NQF #0018

The utilization measures are:

- Optimal ESRD Starts; NQF #2594 – The percentage of new ESRD patients during the measurement period who experience a planned start of renal replacement therapy by receiving a preemptive kidney transplant, by initiating home dialysis, or by initiating outpatient in-center hemodialysis via arteriovenous fistula or arteriovenous graft.
- Hospitalization Costs – This measure assesses the risk-adjusted ratio of observed-to-expected inpatient admission and observation stay discharges during the measurement year based on an average cost measure per hospitalization, adapted from the Standardized Hospitalization Ratio (SHR) measure approved by NQF. During PY0, CMS will consider whether any additional adjustments to its current specifications would be needed given the specific characteristics of the Model’s patient population. In that case, CMS would determine whether re-specifications would be appropriate for the Model, and, accordingly, whether to include the revised measure in the utilization measure set in PY1 or PY2 and subsequent years.
- Total Per Capita Costs (TPCC) – This measure is a payment standardized, annualized, risk adjusted, and specialty adjusted measure that evaluates the overall cost of care provided to beneficiaries attributed to solo practitioners and groups and is currently used as a cost measure in MIPS.

Benefit Enhancements

The waivers or ‘benefit enhancements’ that CMS provides in the RFA are in the following areas: (1) KDE; (2) Telehealth; (3) Post-Discharge Home Visits; (4) Home Health; (5) Home Health Services Certified by Nurse Practitioners; and (6) Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit. As noted, any fraud and abuse

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Voluntary Kidney Models

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waivers that might be provided by the OIG or DOJ are yet to come, but some provisions from the recent proposed rules on physician self-referral and anti-kickback statutes may be applicable to the KCF activities.

The Comprehensive Kidney Care Contracting (CKCC) Options (for KCE Entities)

As noted, there are numerous provisions in both the KCF and the KCE sections of the RFA, including the CKD QCP, the AMCP, Benefit Eligibility, and the Benefit Enhancements that are aligned if not identical, and thus will not be re-summarized below.

Regarding what is different, CMMI begins this section by noting that “KCEs must be comprised of nephrologists and/or nephrology practices, and transplant providers (i.e., a transplant center, transplant surgeon, transplant nephrologist, and/or organ procurement organization (OPO)), and may include other providers and suppliers that help to coordinate the care for beneficiaries with late stage CKD (stages 4 and 5) and ESRD, including dialysis facilities.”

CMS states that it will be creating a Graduated Option loosely based on the existing one-sided risk track of the CEC Model in its first year, a Professional Option based on the Professional Population-Based Payment option of the CMMI Direct Contracting (DC) Model, and a Global Option based on the Global Population-Based Payment option of the DC Model.

Sections addressing the Legal Entities, Contracting Requirements, Governance and Applicant Eligibility seem to mirror closely what was developed for the ESCO program. The Applicant Eligibility section does note that transplant providers may participate in multiple KCEs, while nephrologists and dialysis facilities may only participate in a single KCE and can be added to the model as KCE participants only at the beginning of each performance year, a restriction that does not apply to other types of participants. Also, all KCE participants must be physically located in the KCE’s market area.

CMS also presents the three options potential applicants can utilize to participate in the CKCC: the Graduated Option that has no downside risk, the Professional Option where participants take on 50% risk, and the Global Option where participants will be at risk for 100% of the total cost of care for all Medicare Part A and B services for aligned beneficiaries.

Each payment model will use the same benchmark process, which will include the following steps: (1) Determine the baseline/historical expenditure; (2) Apply trending and geographic adjustment factor (GAF); (3) Incorporate regional expenditures; (4) Risk adjust; and (5) Discount and quality adjustments. The benchmarks will be calculated prospectively and given to KCEs at the start of each performance year and may be adjusted to account for CKD progression.

One other substantial difference between what was outlined for KCFs versus KCEs in the RFA is the depth to which financial issues such as assets, minimum savings rates, minimal loss rates, risk corridors, financial assurances, and stop loss are addressed, which is understandable given that in the KCF CMS will reimburse nephrology practices similarly to how this has been done in the past, while administering the program for the KCE entities will be much more similar to the more complex arrangements associated with the ESCOs.  

More information about the voluntary payment models will be shared during the 2020 RPA Annual Meeting.

RPA Guidance Questions on the Benefits and Challenges of Participation

Listed below are the questions that RPA recommends that nephrology practices carefully consider to determine whether participation in the KCF/CKCC voluntary models is appropriate for them.

- **Patient Composition:** Is the practice’s census of patients sufficient to support the minimum of 500 late stage CKD and 200 ESRD aligned Medicare beneficiaries necessary to participate in the model, taking into account the categories of patients excluded from the minimum number, and the impending policy change allowing ESRD patients into Medicare Advantage (and thus being excluded from participation) in 2021?
- **CKD Patient Encounters:** Will the requirement for the practice to have at least two interactions with 500 CKD patients every six months affect the ability of the practice to satisfy the 500-patient minimum?
- **MCP Payment:** For practices that typically see their ESRD patients four times monthly, will the de facto 25% reduction in payment for treating those persons be adequately offset given some of the other beneficial features of the payment model (such as the transplant bonus and the presumed designation as an advanced alternate payment model)?
- **CKD Payment:** For late stage CKD patients, will the quarterly capitated payment for that care (approximately \$240 quarterly/\$80 monthly) account for the staff required and other expenses associated with providing those services?
- **E&M Services:** Will the quarterly capitated CKD MCP payment be more or less than the practice currently bills for E&M services which would no longer be separately billed?
- **E&M Claims:** For late stage CKD patients, does the practice have the capacity to administer the requirement to submit claims for E&M services (for data collection and quality purposes) that will not be reimbursed?
- **Data Reporting:** Does the nephrology practice have the data reporting and ‘wrangling’ capabilities necessary to submit required quality metrics to CMS? Since the practice will need to begin administering and tracking the patient activation survey for late stage CKD and ESRD patients and for depression remission for CKD patients (which are not typically part of a nephrology practice’s workflow), does the practice have the capacity to absorb the administrative overhead necessary to capture the new quality data?
- **Benefit Enhancements:** Does the practice have the resources necessary to effectively administer the benefit enhancements such as those pertaining to KDE services and telehealth?
- **Payment Penalties:** Given that under the Performance-Based Adjustment (PBA) a certain percentage of practices will experience payment penalties, does the practice have the financial wherewithal to absorb such penalties if necessary?  

2020 Medicare Fee Schedule

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(angioplasty) and 36905 (thrombectomy with angioplasty) experience 2.5% and 3.0% increases when these services are provided in the physician office setting.

Importantly, CMS also made final its decision to allow billing of the TCM codes (CPT codes 99495 and 99496) in conjunction with the adult outpatient dialysis codes (CPT codes 90960, 90961, 90962, 90966, and 90970); previously, billing the TCM codes for ESRD patients had been prohibited. What this means for a nephrology practice is that if you follow a patient after discharge and comply with the documentation and other requirements of the TCM codes, you can bill Medicare and be reimbursed approximately \$187.67 for CPT code 99495 (this is the 14-day post-discharge code) and \$247.93 for CPT code 99496 (the 7-day post-discharge code). More specific information on billing and coding of the TCM codes is included in the Coding Corner article on page 23.

Regarding revaluation of the outpatient E&M code families for 2021, CMS stated 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, including ESRD monthly services (CPT codes 90951 through 90961), and solicited comment on the issue. RPA’s comments on the proposed rule outlined the numerous times that the ESRD MCP building block codes (CPT codes 99212 and 99214) had been increased in value since the creation of the MCP, and accordingly urged CMS to revalue the MCP based on the increases to its component building blocks. The final rule states that “We thank commenters for their thorough recommendations and look forward to considering these recommendations for future rulemaking.” RPA will track this issue if and when CMS considers it in future regulations.

General Medicine Issues

On issues related to all of medicine, the conversion factor for 2020 was finalized at the proposed level of \$36.09, a \$0.05 increase over the \$36.04 CF for 2019, and CMS finalized its proposal to accept the RUC recommendations for both E&M coding structure and valuation and not implement the proposed arrangement outlined in the 2019 fee schedule proposed rule that collapsed payment amounts for the higher-level codes into a single level for services rendered beginning in January 2021. This decision sustains a huge victory for medical care in general, although it appears that the specialty-specific impact of the change for nephrology is projected at -2% for 2021. While this impact is of concern, 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 subject to change prior to 2021.

CMS also finalized proposals to reduce 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.

The final rule also confirmed CMS’ proposal to create separate coding and payment for Principal Care Management (PCM) services, but with some changes. 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.” Additionally, CMS noted 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 included the monthly capitated ESRD codes among these excluded services, with which we agree. RPA comments on the proposed rule noted that “the PCM codes could prove to be useful in the care of CKD patients not yet on dialysis, and thus (we) believe the proposed PCM codes would provide another avenue toward optimizing care for those patients.”

As for the changes in the PCM services, different codes were assigned to the services, with G2064 being the code for 30 minutes monthly of PCM services provided by a physician, and G2065 for 30 minutes monthly of PCM services performed by clinical staff directed by a physician. Additionally, the RVUs were increased for both services in the final rule over what was outlined in the proposed rule, with the total non-facility (outpatient) RVU for G2064 being 2.55 (for an allowed reimbursement amount of \$92.03, unadjusted for geography), and the same RVU for G2065 being 1.10, resulting in an allowed reimbursement of \$39.69, unadjusted for geography.

CMS also finalized its proposals regarding physician supervision requirements for physician assistants (PAs) and review of notes by medical students. Regarding PAs, CMS states that, in the absence of any state rules, CMS is revising “the current supervision requirement to clarify that physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services. Such physician supervision is evidenced by documenting the PA’s scope of practice and indicating the working relationship(s) the PA has with the supervising physician(s) when furnishing professional services.” For review of notes

by medical students, CMS will now allow physicians and other qualified clinical staff to “review and verify (sign and date), rather than re-documenting, notes made in the medical record by other physicians, residents, medical, physician assistant, and APRN students, nurses, or other members of the medical team.”

Changes to MIPS

The MIPS section of the final rule’s quality section was less positive for nephrology. RPA comments on the MIPS quality component of the proposed rule noted our appreciation of CMS’ efforts to streamline programs and reduce provider burden but highlighted our concern that the rate at which such changes are being proposed and implemented is counter to CMS’ own goals. RPA stated that MIPS must be allowed to mature, and dramatic changes as proposed with the elimination of specialty-specific measures and the development of the MIPS Value Pathways (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 MIPS.

MIPS performance thresholds and category weights for the 2020 performance period are:

- Performance threshold: 45 points; exceptional performance threshold: 85 points (increased from 2019)
- Quality performance category weight: 45% (unchanged from 2019)

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- ▶ Cost performance category weight: 15% (unchanged from 2019)
- ▶ Promoting interoperability performance category weight: 25% (unchanged from 2019)
- ▶ Improvement activities performance category weight: 15% (unchanged from 2019)

Quality Measurement Issues

Unfortunately, despite the objection of RPA and others in the medical community, CMS finalized the removal of all nephrology-specific measures from MIPS.

- ▶ MIPS 328 Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10 g/dL
- ▶ MIPS 329 Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis
- ▶ MIPS 330 Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Day
- ▶ MIPS 403: Adult Kidney Disease: Referral to Hospice

As such, nephrology practitioners will have to choose from MIPS measures that are focused on internal medicine, unless they report via the RPA Qualified Clinical Data Registry (QCDR).

Increasing Data Threshold for Quality Measures

CMS finalized their plan to adopt a higher data completeness threshold for the 2020 MIPS performance period, such that MIPS eligible

clinicians and groups submitting quality measure data on QCDR measures, MIPS CQMs, or eCQMs must submit data on at least 70 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for the 2022 MIPS payment year. RPA expressed concern that increasing the data completeness threshold from 60 percent to 70 percent would increase reporting burden on clinicians with no clear benefit to patient care and disproportionately impact small practices.

Acute Kidney Injury Requiring New Inpatient Dialysis – Cost Measure

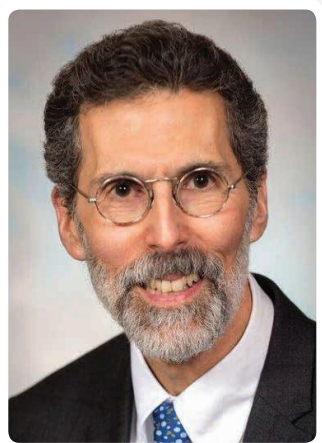
Despite RPA and the medical community's concerns regarding the patient level variability in acuity/intensity of care required and attribution issues with the measure, CMS finalized the new AKI cost measure.

MIPS Value Pathways (MVPs)

In the final rule, CMS indicates that it plans to go forward with its proposal to implement MVPs in performance year 2021. MVPs would be a defined set of measures and activities, including problematic population-health measures, centered on a condition or procedure. Recognizing comments from RPA and the medical community that opposed the mandatory nature of the MVPs, CMS noted that it had not yet determined whether it would make MVPs mandatory in 2021 and will continue to work with stakeholders to take an incremental approach to determining its policies for 2021. 🌟■

ABIM Adds New Option for Maintenance of Certification Exam

By Lawrence Weisberg, MD



The American Board of Internal Medicine (ABIM) announced in August its plans to introduce a longitudinal assessment option for maintenance of certification (MOC), starting in 2022. This initiative is in response to feedback from diplomates, who expressed a desire for more flexibility and convenience in meeting their MOC requirements beyond the current options of the traditional long-form assessment (i.e., the 10-year exam) and the recently adopted Knowledge Check-In (KCI).

RPA heard from nephrologists who took the 2-year KCI. They noted advantages and disadvantages of the KCI compared with the traditional 10-year exam. On the plus side, nephrologists found it more convenient and less disruptive – they could take the KCI in the comfort of their home or office and didn't have to take a day off from seeing patients. On the downside, they found the intensity of studying to be similar to that for the 10-year exam. Nephrologists also recognized that they would need to engage in that intensity every two years for the KCI rather than every 10 for the long-form exam. Lastly, they weren't certain that the KCI accurately reflected the practice of nephrology.

Data from ABIM show that slightly more than half of all diplomates chose to take the long-form assessment in 2019. [Note: The nephrology KCI was not offered in 2018.] The average age of those taking either option was the same – 49 years old. Most of those who took the KCI did so remotely, rather than at a testing center.

ABIM is developing the longitudinal assessment format based on research showing that continuous, spaced participation in assessment exercises leads to “stickier” knowledge acquisition than studying continuously for an infrequent high-stakes exam. This is consistent with an approach that prioritizes “testing FOR learning” over “testing OF learning.”

While many details have yet to be determined, the new longitudinal assessment is expected to roll out for all specialties in 2022, making the last year for the nephrology KCI 2020, as it is offered every two years (other specialties may be able to take the KCI until 2021.) Over the next year, ABIM will develop the model by seeking input from the internal medicine community, through surveys and interviews, online communities, and feedback provided to ABIM staff at society meetings. Key in the model development will be an effort to link assessment content to individual society educational materials. RPA has been actively engaged in these discussions through participation on the Liaison Committee on Certification and Recertification and the ABIM Subspecialty Board on Nephrology.

In its proposed longitudinal assessment model, ABIM plans to release several questions each quarter, similar to the very popular models recently introduced by the American Board of Pediatrics and the American Board of Family Medicine. The longitudinal assessment option is intended to allow physicians to answer questions “any place, any time,” using content resources they typically use in their practice, rather than being limited to Up to Date, which is the primary content source for the KCI. Diplomates may answer one question or several at a time. They will receive immediate feedback on their answers, with explanation and links to relevant content. In this way, physicians will have an opportunity not only to demonstrate their knowledge, but to acquire it. ABIM plans to summate a diplomate's performance every five years, looking not only at average performance but also at trends. There will be some level of customization, which may include some core questions, but also targeted questions that may be developed around practice profiles – such as private practice nephrologists or interventional nephrologists. Psychometric approaches to scoring as well as a scalable model that works for all specialties are still in development.

RPA will provide additional information as it becomes available. ABIM will maintain the traditional long-form assessment so that diplomates may choose what works best for them. Please share any questions or concerns about the MOC process with abeckrich@renalmd.org and on the RPA CONNECT platform. ■

From Capitol Hill

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sports. As a DC area native and hometown sports nut who only roots for the local teams, this is sweet, sweet stuff.

Sure, that's great, but what in the name of Great Caesar's Ghost does this have to do with health policy? Well, it's been a pretty unlikely twelve-month period in the organized medicine/kidney policy world as well. As this is being written a few weeks before 2019's end, it is just about a year since CMS made the decision in the 2019 ASC final rule to reverse a proposal to apply site neutral payments to the two highest volume dialysis circuit (vascular access) procedure codes, CPT codes 36902 and 36905 (balloon angioplasty services). CMS' decision to reverse its original proposal deferred proposed cuts for 2019 of 55% for 36902 and 54% for 36905. These would have been devastating reductions for nephrology practices with arrangements to provide vascular access services under the ASC designation, and in candor at the time those of us tracking this thought it was a 50/50 chance at best that CMS would come to this determination. Even more unlikely, CMS did not even propose this change for the 2020 ASC proposed rule, when every expectation was that this provision would be included, and strategic discussions among stakeholder groups on how to respond were underway. Whew, crisis averted (at least for now).

Another seemingly improbably chain of events began in March when HHS Secretary Alex Azar testified at a hearing of the House Appropriations Subcommittee to discuss the FY 2020 HHS budget request that "that the savings generated by averting dialysis would be greater than the cost required to extend coverage for immunosuppressant drugs." In the words of former Vice-President Joe Biden, this was a big (expletive deleted) deal, since whenever something is a saver the chances of passage go through the roof. Subsequently, the office of the HHS Assistant Secretary for Planning and Evaluation (ASPE) assigned a figure of \$73 million of savings to the immuno bill, followed a few weeks later by a report from the HHS Office of the Actuary (OACT) that estimated the savings at \$300 million. Numbers of this magnitude generally mean that if bill language can be agreed upon and a legislative vehicle presents itself, the provision will be enacted.

The problem is, we're still not there at press time. Political intelligence indicates that introduction of a bill *could* happen any day, and again, if that happens the likelihood of enactment increases exponentially. This is because a short term agreement to fund the government through December 20, 2019 was agreed upon in November, meaning that another Christmas tree, I mean legislative vehicle, will have to occur at year's end to avert a shutdown (something Congressional leaders in both parties want to avoid). So, if the bill is introduced and if the new vehicle is necessary, the immunosuppressive drug bill could help pay for a small part of it and thus be enacted. It is still a long shot but not impossible. The similarities between the Nats' title and the immuno bill are that: (1) it feels like it's been since 1924 that the community has been pursuing this; (2) given where we were in early March, this would be an extremely unlikely victory; and (3) the celebration, if enacted, among the kidney community would resemble the National's victory parade.

This brings us to the summertime and the release of the Executive Order (EO) Advancing American Kidney Health by the Trump Administration. While there was talk of new payment models for kidney patient care since the end of 2017 (when RPA's ESRD Clinical Episode Payment Model was recommended for implementation by the Physician-Focused Payment Model Technical Advisory Committee—PTAC, buttressed by the ESCO experience), the actual release of the EO, if not unlikely, was at least enervating. The degree of attention being paid to kidney disease care and the appropriateness of the initiative's overarching goals (increased use of home dialysis, improved

rates of transplantation, increased organ supply, advances in the development of artificial kidneys, and better, more comprehensive CKD education) were welcome developments in a community unaccustomed to pledges of positive change. Regardless of what one feels about the subsequent rulemaking for the mandatory model and RFA for the voluntary models (and to be clear, the view from here is that CMS/CMMI missed the mark in numerous ways on both counts), the effort to shake up the status quo is something that hasn't happened in decades. Additionally, even if, for example, the final rule for the mandatory model is never released (and it most likely will be), the mere publication of the proposed rule combined with the existence of the draft rule on organ procurement organizations (currently awaiting release by the Office of Management and Budget—OMB) is likely to spur at the very least discernible improvement in the areas of home dialysis and transplantation. Recall that when Obamacare was enacted, the bending of the Medicare cost curve began almost immediately—before implementation actually happened—simply because of the looming prospect of governmental scrutiny of provider behavior, not the actual scrutiny itself. If this dynamic were to recur in kidney care, the mere existence of the proposed rule could increase uptake of home dialysis and transplantation, before the models ever begin operating.

Not all of the unlikely events of 2019 were positive. In September, the California legislature passed a bill intended to limit dialysis facility profits, but with the effect of seriously compromising the availability of charitable premium assistance for kidney patients in the state. This was unlikely in that, while previous versions of the bill had been passed by the legislature, those were never signed into law, and in November 2018, a similar ballot measure on the issue was soundly defeated at the polls. Nevertheless, the bill was introduced again and passed this year; Governor Gavin Newsome promised during the 2018 campaign that he would sign such a bill if it came across his desk, and he did so in October. RPA joined many kidney and state-based organized medicine groups in opposing the legislation.

The final somewhat unlikely occurrences of the year were part of the 2020 Medicare Fee Schedule final rule. First was the announcement in the 2020 rule that in 2021, CMS would adopt recommendations

from the AMA's CPT Editorial Panel and the Relative value Update Committee (RUC) to revise the coding structure and valuation for outpatient E&M services (CPT code families 99202-99205 and 99211-99215). While these changes seemed to be in the cards for some time, the fact that only a year ago, all of organized medicine was going cuckoo bonkers over the CMS proposal to collapse payment for these families of services into a single rate makes the achievement fairly remarkable. The second change seemed to come out of nowhere, when CMS included the ESRD MCP codes (CPT codes 90951-90962) on a list of code families with which the TCM codes could be billed. This change makes all the sense in the world, as the services were in CMS' eyes underutilized and of course why shouldn't they try to optimize TCM for dialysis patients leaving the hospital so as to reduce readmissions among this patient sub-population, but just because things makes sense doesn't mean CMS is going to do them.

It's probably not too much of a stretch to say that health policy-wise, 2020 will not be as consequential (and unlikely) as was 2019 (almost definitely this will be true in kidney policy, since the huge changes are already somewhat baked in). As for the Nationals, the bard of Washington baseball, *Washington Post* sports columnist Thomas Boswell, has reported that while only seven of the last 50 World Series champions have won the Series the next year, 12 of them have made it to the Series the next year, a 24% rate. I'll take that. Happy New Year. ■



2020 RPA Annual Meeting Prepares Nephrologists for Practice Success

By Ronald Hyde, MD, Program Chair



The RPA continues to defend renal physicians and patients even as the medical landscape we occupy and the rules under which we labor change faster than you can say MIPS. Early career and seasoned nephrologists face rapidly evolving government payment schemes, complex risk models, and novel care delivery systems.

These challenges can be met with fear, but a trip to the RPA Annual Meeting in Baltimore features an exceptionally gifted and diverse cadre of speakers who will

present a program designed to educate attendees to enhance practice adaptability and success. How will we conquer the future?

After our traditional, information packed Year in Review and Legislative Update, the RPA Annual Meeting plunges into a robust discussion of the Advancing American Kidney Health Initiative. You will have a much better understanding of the elements of the initiative and what it means for our community. We build on that information with a dive into the different payment models associated with the initiative, so we can individually decide on the strategy that works best for each practice. This will include a focus on two major clinical elements: increasing utilization of home therapies and transplantation in your practice. Meanwhile, we dissect what we have learned from the ESCO experiment and where that is headed.

In 2020, we are thrilled to explore the modern communications that are revolutionizing our field, headlined by Nephtwitter guru Joel Topf, and the disruptive innovations associated with new market strategies employed by Cricket, CVS and Strivehealth.

The Lou Diamond keynote lecture illuminates the intersection of patients, modern technology, and social/cultural attitudes about aging and life prolongation, with noted author Sharon Kauffman discussing her extraordinary book “Ordinary Medicine.” The role of Palliative Care in respecting patient choice and autonomy will also be explored.

There will be an array of intriguing workshops to help you improve documentation, increase patient engagement, and set up home hemodialysis programs, as well as workshops on leadership and entrepreneurship, dialyzability of unusual compounds, and a cooking demo for kidney friendly cuisine.

Our clinical closing day focuses on some of the most intriguing recent advances in our field: reversing diabetes and the promise and dangers of the SGLT2 inhibitors in our high-risk population of patients.

The RPA Annual Meeting is a time to reconnect with colleagues and enhance business and clinical acumen. Contributors to RPA’s Political Action Committee (PAC) will attend a reception with a distinguished member of Congress who will share an insider’s perspective of pending legislation affecting kidney care. Details regarding the annual meeting program and pre-meeting workshops may be viewed at www.renalmd.org. 🌟📺

RPA is headed back to Baltimore

March 19-22, 2020

REGISTRATION IS NOW OPEN

The 2020 Annual Meeting is the one place where you will **Learn, Engage** and be ready to **Transform** your practice!

RPA Recognizes Corporate Patrons

The RPA corporate patrons program is designed to augment the alliance between stakeholder industries and the RPA, since corporate members of the nephrology community play an important role in optimizing patient outcomes. Gifts from corporate patrons are for scientific or educational purposes. During the year RPA leaders meet with representatives from corporate patrons participating companies to discuss areas of mutual concern and interest. This informal dialogue benefits industry and the association. Potential donors should contact the RPA office to obtain additional information. Links to all of our corporate patrons’ sites may be found at www.renalmd.org.

RPA is pleased to acknowledge the support provided by all of our corporate patrons in this issue of *RPA News*.

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Laminate Medical Technologies
Medibeacon, Inc.
OPKO Pharmaceuticals



Public Policy News Briefs

- ▶ **2020 ASC Final Payment Rule Released**—On November 1, CMS issued the final rule for the Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center Payment Systems (HOPPS/ASC). In it, the Agency finalized its decision to not implement site-neutral payments for the two high volume dialysis circuit procedure codes, CPT codes 36902 and 36905 (both are balloon angioplasty services). As a result, code 36902 will be increased by 7% for 2020 and 36905 will increase 5%. Additionally, CPT code 36904 (thrombectomy) was designated as a device-intensive service for 2020, and this will result in a 44% increase for that code.
- ▶ **CMS Issues 2020 ESRD PPS Final Payment Rule**—In late October, CMS issued the 2020 final rules for the ESRD Prospective Payment System (PPS), and set the payment rate for a dialysis session at \$239.33, an increase of \$4.06 over the 2019 rate; this payment will be made for both ESRD and AKI sessions. An additional third year was added to the transitional drug add-on payment adjustment (TDAPA) for calcimimetics in order to collect sufficient claims data for rate setting analysis, but at a reduced payment rate of 100% of Average Sales Price (ASP); the previous payment rate was ASP +6%. The Agency also finalized the proposal to establish in future years a transitional add-on payment adjustment for innovative dialysis equipment and supplies under the ESRD PPS similar to TDAPA, known as the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES).
- ▶ **California State Bill Affecting Charitable Assistance for Dialysis Patients Signed into Law**—On October 13, California Governor Gavin Newsome signed State Assembly Bill 290 on charitable premium assistance in dialysis into law. Previous versions of the bill, framed by proponents as limiting dialysis facility profits but which will have the effect of all but eliminating charitable premium assistance for low-income dialysis patients, were either defeated by voters on the ballot last November or vetoed by then-Governor Jerry Brown. Despite statements by the bills’ proponents that the legislation will not force the discontinuance of charitable assistance in California, the American Kidney Fund has stated that federal regulations preventing them from releasing the personal information of their grant recipients, as required by the bill, will force them to cease operations in the state. RPA joined many kidney and state-based organized medicine groups in opposing the legislation. ■



ACCEPTED FOR MOC CREDIT

Participate in RPA QAPI MOC Program to Earn ABIM MOC Credits



Medical Directors and Attending Nephrologists at participating dialysis organizations can earn 20 Practice Assessment Maintenance of Certification (MOC) credits through ABIM for attending Quality Assessment and Performance Improvement (QAPI) Meetings.



Register at <http://tinyurl.com/RPAQAPIMOC>
Questions should be directed to rpa@renalmd.org.

Legal Issues: HHS Eases Fraud and Abuse Rules; Civil Monetary Penalties Rules and Stark Law Exceptions

By James B. Riley, Jr., and Timothy J. Fry



On October 9, 2019, the Department of Health and Human Services (HHS) announced two proposed rules to significantly amend the federal Anti-Kickback Statute (AKS), the Civil Monetary Penalties Law (CMP Law) and the Physician Self-Referral Law (Stark Law).

The proposed rules stem from HHS’ regulatory sprint intended to incentivize value-based arrangements and patient care coordination by expressly permitting certain activities that could be deemed problematic under current law. Collectively, the proposed rules, respectively released by HHS’ CMS and the HHS Office of Inspector General (OIG), will revise existing AKS safe harbors, modernize electronic health records (EHR) and cyber security donations under both the AKS and the Stark Law, clarify the in-home dialysis telehealth exception to the CMP Law, significantly revise and clarify the Stark Law and add protections for value-based arrangements.

The proposed changes are likely to reduce burdens for nephrologists and other healthcare providers within the healthcare industry and provide greater flexibility under the federal fraud and abuse rules, CMP Law and Stark Law exceptions while, at the same time, ensuring that the revisions are not misused to perpetrate fraud and abuse or Stark Law violations.

AKS Safe Harbor Revisions

Outlined below are the OIG’s proposed changes to existing AKS safe harbors and three key takeaways to assist healthcare providers in navigating these potential revisions, which are then supplemented with OIG proposals that were consistent with CMS proposals.

1. **Proposed revisions to the warranty safe harbor would expand the scope of protected warranties.** The OIG proposed several key revisions to the warranties safe harbor, including but not limited to: (i) extending coverage for bundled warranties (as described in more detail below); (ii) capping the amount of warranties and prohibiting terms that condition warranties on exclusive use or minimum purchase requirements, which the OIG considers improper inducements; (iii) addressing clinical outcome-based warranties on conditions that will be forthcoming (i.e., comments were solicited to develop this provision); and (iv) developing a definition of “warranties” that incorporates items or services critical to the healthcare industry but which are not currently encompassed by other statutes or case law.

In the proposed revisions, the parameters around bundled warranties received considerable attention. Prior guidance from the OIG had effectively limited the safe harbor to warranties for single items, thereby excluding warranty arrangements that pertain to bundled items and services. To promote beneficial and innovative arrangements, the OIG proposed expanding the safe harbor to protect bundled items and services. The proposed rule demonstrates OIG’s caution with respect to this proposal and includes various safeguards that could practically limit the use of this safe harbor on a broader level. For example, the OIG proposed that all federally reimbursable items and services in a bundled warranty arrangement be reimbursed by the same federal healthcare program and in the same payment. The OIG also proposed that (i) the bundled arrangement include at least one *item* in the bundle (i.e., cannot bundle only services); (ii) the remuneration a manufacturer or

supplier may pay to any party (other than a beneficiary) must be limited to the cost of the warranted items or services; (iii) manufacturers and suppliers must not be allowed to condition bundled warranties on the exclusive use of such items or services; and (iv) manufacturers and suppliers not be allowed to impose minimum-purchase requirements.

The OIG further clarified that the proposed modifications would not protect free or reduced-priced items or services that sellers provide either as part of a bundled warranty agreement or ancillary to a warranty agreement. The OIG specifically requested comments from commentators on the conditions and safeguards that should be included in a final rule with respect to the warranty safe harbor to ensure flexibility and use of this safe harbor while simultaneously mitigating fraud and abuse risks.

2. **The OIG proposed to ease rural mileage and other restrictions under the local transportation safe harbor.** In recognizing the importance that transportation often plays in patient access to care, quality of care and care coordination, the OIG proposed to modify certain conditions that currently limit use of the local transportation safe harbor. Specifically, the OIG proposed to: (i) increase the distance patients residing in rural areas may be transported, from 50 miles to 75 miles; and (ii) remove all mileage limits on transporting a patient from a healthcare facility from which the patient has been discharged to the patient’s place of residence. In connection with these proposals, the OIG requested from commenters information regarding patients within the commenters’ communities who cannot obtain care within the existing mileage restrictions and whether eliminating the distance limitation on transporting discharged patients should be extended to cover any destination of such patient’s choice.

In addition to these proposed revisions, the OIG explicitly clarified that this safe harbor historically has applied to ride-sharing services. Lastly, in recognizing that transportation for non-medical purposes may help improve patients’ health, the OIG expressed a willingness to potentially expand the safe harbor to permit transportation for certain non-medical purposes (e.g., transportation to apply for food stamps or housing assistance) as a means to foster innovative arrangements that could improve health outcomes. In weighing this consideration, the OIG requested that commenters provide insight as to whether such expansion should be limited to certain beneficiary populations.

3. **The proposed rule would add flexibility to the personal services and management contracts safe harbor by eliminating and modifying existing restrictions and potentially extending protections to outcomes-based payments.** The OIG proposed several modifications to the personal services and management contracts safe harbor in an effort to remove barriers to care coordination and value-based arrangements. Specifically, the OIG proposed to: (i) remove the requirement that contracts for part-time arrangements specify the schedule, length and exact charge for the intervals of time worked under the arrangement; (ii) substitute the requirement that aggregate compensation paid under an arrangement be set in advance, with a new requirement that only the methodology for determining compensation be set in advance; and (iii) permit outcomes-based payments under an arrangement if certain conditions are met.

Notably, the proposed removal of the part-time arrangement restrictions would permit providers to receive safe harbor protection for services provided on an as-needed basis and more closely align the safe harbor with the personal arrangements exception to the Stark Law. Similarly, the proposed modification of the “set-in-advance” compensation requirement would more closely align with the Stark Law in that the parties would no longer be required to specify the total compensation to be paid over the duration of an arrangement. If finalized, these changes would provide regulatory protection (assuming all other elements are met) to providers that need periodic management and personal services arrangements but are unable to predict the exact frequency (e.g., medical director services).

The proposal to permit outcomes-based payments would align the personal services and management contracts safe harbor with the current evolution of payment models for healthcare. While the outcomes-based payments proposal opens the door for rewarding agents for improving patient or population health, or reducing payor costs while improving quality of care, the proposed safe harbor would exclude arrangements that relate solely to achievement of internal cost savings for the principal. The OIG, however, proposed to limit the scope of this protection, specifically excluding pharmaceutical manufacturers; manufacturers, distributors and suppliers of durable medical equipment, prosthetics, orthotics and supplies; and laboratories. The OIG is also considering, but requested comment regarding, whether to also exclude pharmacies (including compounding pharmacies), wholesalers and distributors of pharmaceutical products, and pharmacy benefit managers from this safe harbor.

“The proposed changes are likely to reduce burdens for nephrologists and other healthcare providers within the healthcare industry and provide greater flexibility under the federal fraud and abuse rules, CMP Law and Stark Law exceptions while, at the same time, ensuring that the revisions are not misused to perpetrate fraud and abuse or Stark Law violations.”

Flexibility for EHR Items and Services, Donated Cybersecurity Tech

Summarized below are proposed rules, focusing on (i) proposed changes to the EHR items and services exception to the Stark Law and EHR safe harbor to the AKS, and (ii) a proposed new exception to the Stark Law and safe harbor to the AKS related to the donation of cybersecurity software and services. The EHR donation protection already exists, but CMS’ and OIG’s changes are likely to ease certain burdens for healthcare providers for these donations.

- 1. **CMS and OIG proposed adding cybersecurity technology and services to the EHR exception and safe harbor and adding a stand-alone cybersecurity technology and related services exception and safe harbor.** CMS and OIG noted that the digitization of healthcare delivery and rules designed to increase interoperability and data sharing in the delivery of healthcare create numerous targets for cyberattacks. They further acknowledged that the cost of cybersecurity technology and related services has increased dramatically, to the point where some providers and suppliers are unable to invest in, and therefore have not invested in, adequate cybersecurity measures.

CMS and OIG explained that, as proposed, the new cybersecurity exception and safe harbor are broader than their EHR counterparts are, as they require fewer conditions and can be utilized in lieu of the EHR protections. For example, the cybersecurity exception and safe harbor do not share the condition of a 15 percent required contribution from recipients that exists under the EHR exception and safe harbor.

As proposed, the cybersecurity exception and safe harbor allow for the donation of cybersecurity technology and related services provided that certain conditions are met, including the following:

- a. The technology and services are necessary and used predominantly to implement and maintain effective cybersecurity.
- b. The donor does not (i) directly take into account the volume or value of referrals or other business generated between the parties when determining the eligibility of a potential recipient for the technology or services or the amount or nature of the technology or services to be donated; nor (ii) condition the donation of technology or services, or the amount or nature of the technology or services to be donated, on future referrals.

- c. Neither the recipient nor the recipient’s practice (nor any affiliated individual or entity) makes the receipt of technology or services, nor the amount or nature of the technology or services, a condition of doing business with the donor.

CMS and OIG are also considering an alternative proposal that would narrow donations for certain cybersecurity hardware only when the donor has determined that the hardware is reasonably necessary based on a risk assessment of its own organization and that of the potential recipient.

- 2. **CMS and OIG proposed modernization updates to EHR interoperability provisions.** The existing rules prohibit a donor from taking any action to limit or restrict the use, compatibility or interoperability of EHR items or services. CMS and OIG proposed modifications adopting the term “information blocking” from the 21st Century Cures Act, which generally means interfering with, preventing or materially discouraging access, exchange or use of electronic health information. CMS and OIG clarified that *both* engaging in information blocking related to donated items or services *and* using those items or services to engage in information blocking are prohibited. Further, under the existing rules, software that was once government-certified but is not certified at the time of donation is protected. The proposed rule would revise this provision to require that the software be certified at the time of donation to be protected.
- 3. **CMS and OIG proposed changes to the EHR cost-sharing requirements.** CMS and OIG requested comments on whether to eliminate or reduce the 15 percent cost-sharing requirement within the EHR exception and safe harbor for small or rural physician organizations, or, alternatively, to reduce or eliminate this requirement for all physician recipients. CMS and OIG are additionally considering eliminating or reducing the percentage for updates to previously donated software or technology (i.e., requiring a contribution for the initial investment only). These considerations are based on comments that CMS and OIG received describing the 15 percent contribution requirement as burdensome and preventative to some recipients in adopting EHR technology.
- 4. **CMS and OIG proposed to allow donation of replacement technology.** The current EHR exception and safe harbor do not protect the donation of replacement technology when the replacement is for “equivalent items or services.” In previous rule comments, one commenter asserted that the current exceptions lock physicians into vendor agreements by forcing a choice between paying full price for a new system or continuing to pay 15 percent of the cost for substandard technology. This proposal by CMS and OIG, if adopted, would allow donations of replacement EHR technology.
- 5. **CMS and OIG proposed to either eliminate or extend the EHR exception and safe harbor sunset provision.** The Stark Law EHR exception and AKS safe harbor concerning EHR items and services were originally scheduled to sunset on December 31, 2013. In 2013, both CMS and OIG extended the sunset date to December 31, 2021 but retained the idea that this exception would be obsolete once EHR technology was universal and would then be eliminated. If adopted, these proposed rules would eliminate the sunset date, expressing CMS’ and OIG’s continued interest in promoting EHR technology adoption. OIG explained that a need for this protection persists as new parties enter medical practice and EHR technology ages, with new opportunities like cybersecurity. Alternatively, CMS and OIG could simply extend the sunset date, and they are seeking comments on this matter.

One significant reason for CMS and OIG’s protection of cybersecurity technology donations was a recognition that any “weak link” in a health system could be the target of cyberattacks. Such an attack could impact an entire health system.

Civil Monetary Penalty Law Changes and In-Home Dialysis Telehealth

The CMP Law imposes penalties against any person offering or transferring remuneration to a federal healthcare program beneficiary that is likely to influence the beneficiary’s selection of a particular provider. Past congressional action and OIG regulatory changes have removed certain behaviors from the definition of remuneration. Examples of excepted remuneration include (a) certain copay waivers, (b) primary care delivery incentives and (c) items or services improving an individual’s ability to obtain government services in

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certain circumstances. By meeting such exception from the definition of remunerations, providers delivering these services that meet the regulatory language will not receive fines under the CMP Law.

The proposed rule formally implements the Budget Act of 2018 amendments to the beneficiary inducements CMP definition of “remuneration” to include in-home dialysis telehealth. Specifically, OIG proposed “an exception for the provision of certain telehealth technologies related to in-home dialysis services to the definition of ‘remuneration.’” OIG stated Congress’ intent to allow ESRD patients who receive home dialysis to obtain monthly ESRD-related clinical evaluations via telehealth technologies, so long as certain other conditions are met.

OIG proposed to define “telehealth technologies” subject to the exception as “multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner used in the diagnosis, intervention or ongoing care management, paid for by Medicare Part B, between a patient and the remote healthcare provider. Telephones, facsimile machines, and electronic mail systems do not meet the definition of ‘telehealth technologies.’” Importantly, OIG said it would not consider smartphones to be “telephones” if they have two-way video conferencing applications, and therefore could meet the exception.

To take advantage of this new exception to the definition of “remuneration” in the beneficiary inducements CMP Law, the ESRD patient must receive the telehealth technology after January 1, 2019; the ESRD patient must be receiving home dialysis that is paid for under Medicare Part B; and the technologies must be furnished by the patient’s provider or dialysis facility. As clarification of the statute, OIG plans to require that any such technologies come from the provider or facility that is *then-providing* services like home dialysis, telehealth visits, or other ESRD care to the patient. The intent is to prevent someone from attempting to steer a patient to a particular provider or supplier and form a clinical relationship through such telehealth technology.

In addition, the proposed rule mirrors the statute to require that “(i) the telehealth technologies are not offered as part of any advertisement or solicitation; [and] (ii) the telehealth technologies are provided for the purpose of furnishing telehealth services related to the individual’s end stage renal disease.” Providers should be aware that OIG proposed to also require that any provided telehealth technology (a) significantly add to the provision of the beneficiary’s telehealth services in connection with his or her ESRD; (b) not be of excessive value (e.g., cannot provide a \$600 smartphone when a \$300 smartphone would adequately run the technology); and (c) not be “duplicative of technology that the beneficiary already owns if that technology is adequate for the telehealth purposes.”

Other safeguards OIG will consider before finalizing this proposed rule, and for which it solicited comments, include the following:

- ▶ Whether to require providers and dialysis facilities to provide telehealth technology consistently, either to all Medicare Part B ESRD patients or to all patients who meet certain criteria;
- ▶ Whether to limit the provision of telehealth technology to only those patients who do not currently have the kind of technology necessary for telehealth services;
- ▶ Whether to require an explanation to patients, in writing, about why they are receiving the technology and any “hidden” fees related to the technology; and
- ▶ Whether to require providers and dialysis facilities that provide telehealth technology to “advise patients when they receive such technology that they retain the freedom to choose any provider or supplier of dialysis services and to receive dialysis in any appropriate setting.”

Proposed Revisions to the Stark Law

Perhaps the most significant changes from the two proposed rules comes from CMS modernizing and clarifying the strict liability Stark Law. CMS sought to provide greater flexibility under the Stark Law without increasing program risk. Accordingly, CMS provided additional clarification and bright-line rules in the proposed rule, based

“Perhaps the most significant changes from the two proposed rules comes from CMS modernizing and clarifying the strict liability Stark Law. CMS sought to provide greater flexibility under the Stark Law without increasing program risk.”

in part on knowledge gained from overseeing more than a thousand Self-Referral Disclosure Protocol filings. Described in the remainder of this article are CMS’ proposed changes to modernize its Stark Law regulations and five key takeaways to assist healthcare providers in navigating these potential revisions.

1. **CMS proposed a new exception for limited monetary physician compensation, under \$3,500 per year.** CMS seeks to add a new non-monetary compensation exception, which would allow physicians to be paid \$3,500 or under per calendar year (adjusted for inflation), in the aggregate, without a signed agreement or compensation being set in advance. CMS, however, would still require that the compensation (a) not take into account the volume or value of referrals or other business generated, (b) not exceed fair market value, and (c) be commercially reasonable.

Note, importantly, the \$3,500 limit, as proposed, would not apply to compensation for items or services outside of these arrangements if that compensation is itself protected under a different exception. CMS also suggested this exception might allow compliance at the outset of an arrangement before being replaced by another exception.

2. **Changes to the group practice definition may necessitate certain revisions to a group’s compensation plan.** The nuanced, technical definition of “group practice” is a critical concept under the Stark Law, as Congress created certain exceptions for referrals within group practices, including the in-office ancillary services exception, understanding that internal DHS referrals are commonplace and foster continuity of care and patient convenience. Therefore, even minor changes to the group practice definition can have significant impacts necessitating changes to physician compensation. Most significantly, CMS proposed to change limits placed on acceptable profit sharing and productivity bonuses that do not directly vary based on the volume or value of DHS referrals and still meet the group practice definition.

First, CMS proposed a new, deemed-compliant profit-sharing methodology for group practices participating in a value-based enterprise (discussed below). Current law provides three deemed-compliant methodologies that the agency considers to be not directly based on the volume or value of DHS referrals. This new proposal would add another deemed-approved methodology for remuneration paid to a physician based on his or her DHS referrals in the context of value-based arrangements.

Second, CMS proposed several clarifying revisions to the profit-sharing rules. Perhaps the most important clarification is CMS’ continuing intention that “overall profits” means the profits derived from *all* the DHS in aggregate and not categories of DHS (i.e., the group cannot assign physicians into separate or overlapping imaging, physical therapy and outpatient prescription drug pods). CMS also appeared to prohibit a common approach — to split different DHS categories within a single pod in different compliant manners (i.e., within the same pod, using pro rata for imaging, and basing physical therapy on personal production). Commenters are likely to provide what they consider non-abusive examples of such approaches.

3. **CMS clarified key terms to simplify compliance.** CMS, recognizing that common elements of numerous Stark Law exceptions are not always understood, sought to clarify several terms.
 - a. **“Commercially Reasonable” Element.** CMS proposed to finally define this term utilizing the key determining question of “whether the arrangement makes sense as a means to

accomplish the parties' goals." From this basic question, CMS proposed two alternative definitions, where the particular arrangement: (i) "furthers a legitimate business purpose of the parties and is on similar terms and conditions as like arrangements" or (ii) "makes commercial sense and is entered into by a reasonable entity of similar type and size and a reasonable physician of similar scope and specialty." CMS requested comments on these alternatives and specifically asked whether parties could make these proposed comparisons.

- b. **"Volume or Value" and "Other Business Generated" Bright-Line Standards.** CMS proposed special rules for each of the "volume or value" and the "other business generated" standards to create more bright-line, objective tests for meeting many exceptions.

- Compensation *from an entity to a physician* would be considered to take into account the volume or value of referrals or business generated only if the physician "receives *additional* compensation as the number or value" of the physician's referrals or business generated to the entity increases.
- Compensation *from a physician to an entity* would be considered to take into account the volume or value of referrals or business generated only if the physician "pays less compensation as the number or value of the physician's" referrals or business generated to the entity increases.
- *Fixed-rate compensation* would also be considered to take into account the volume or value of referrals or business generated if "there is a predetermined, direct correlation between the physician's prior" referrals or business generated (e.g., a hospital bases its fixed amount for medical director services on exceeding a past patient admissions threshold).

To provide these tests, CMS believed it needs to revise certain exceptions by expressly referencing that any referral requirements will not contradict patient choice or a patient's best interest. CMS specifically asked if the academic medical center exception needs this change too.

- c. **"Fair Market Value" and "General Market Value" Definitions.** CMS proposed to provide three separate definitions for "fair market value" that will apply separately to equipment rentals, to office space rentals, and to all other arrangements generally. The definitions do not appear to substantively alter the statutory definition; however, the proposed definitions specifically include that "fair market value" means the "value in an arm's-length transaction, *with like parties and under like circumstances, of like assets.*" CMS further proposed to amend the definition of "general market value" to be more in line with the valuation industry's usage relating "to the value of an asset or service to the actual parties to a transaction that is set to occur within a specified timeframe." This latter change would allow a particular, in-demand orthopedic surgeon sought by professional athletes to, for example, be paid more than a salary survey would suggest, although it may mean less pay for providers in locations with a lower cost of living.

4. **Additional Clarifications to Ease Compliance.** CMS also made numerous other changes and proposals to ease certain Stark Law burdens.

“While these rules apply across the board to all providers, some in particular, such as the expanded distance in the Transportation Safe Harbor and the In-Home Dialysis Telehealth exception will be particularly applicable to nephrologists and their patients. The changes to the value-based arrangements may also allow nephrologists to enter into new relationships with ESRD clinics and other providers to adopt new compensation models.”

- a. **Definitional Changes.** CMS proposed to revise the following definitions, among others;
- i. *Designated Health Services.* For inpatient hospital services, CMS proposed to carve out from "DHS" any furnished service that does not affect Medicare's payment to the hospital under the inpatient prospective payment system (IPPS), such as an X-ray that is ordered after the IPPS rate has been established by the relevant payment rules. CMS requested comment on similar changes for hospitals not paid under the IPPS.
 - ii. *Remuneration.* The current definition of "remuneration" carves out certain items, devices or supplies used solely to collect, transport, process or store specimens for the entity providing it. Under current law, CMS does not protect surgical items in this carve-out; however, CMS proposed to allow surgical items if used solely for one of the six statutory purposes. Notwithstanding this change, CMS continues to believe things like sterile gloves, essential to the specimen collection process, are fungible and therefore cannot qualify for this remuneration carve-out.
 - iii. *Transaction.* The term "transaction" is used in the isolated financial transaction exception for one-time sales of property or a practice. CMS noted that some have used this exception beyond its intended scope to cure noncompliance retroactively. Therefore, CMS proposed to establish an independent definition of "isolated financial transaction" and clarify that it "does not include payment for multiple services provided over an extended period, even if there is only one payment for such services."
- b. **Writing and Signature Requirements.** CMS proposed to codify electronic signature approval for exceptions requiring a signed writing and to allow the 90-day grace period for unsigned writings to be used to satisfy the writing requirement, too. Similar flexibility will be granted under the physician recruitment exception, so a physician practice has to sign the writing only if it is receiving a financial benefit from the arrangement, but not if the practice merely serves as a pass-through to the recruited physician.
- c. **Non-exclusive Rental Arrangements.** Under current law, CMS requires a lessee to have exclusive use of the office or equipment being rented. CMS proposed to clarify that the exclusive use is only against the lessor, such that healthcare providers will have greater freedom to enter into non-exclusive leases, including multiple lessees at the same time, as long as the lessor is excluded.
- d. **Expanding Relevance of Three Existing Exceptions.** CMS proposed to liberalize three exceptions that past rulemaking significantly limited. First, at §411.357(g), CMS proposed a significant rewrite for remuneration unrelated to DHS from hospitals to protect more arrangements. Second, at §411.357(i), CMS proposed to expand the reach of the payments by a physician exception by allowing its use even if another regulatory exception could apply (statutory exceptions still cannot). Finally, CMS proposed to allow the fair market value exception at §411.357(l) for short-term equipment and office space rentals under one year in length.
- e. **Remuneration for Non-physician Practitioner (NPP) Patient Care Services.** CMS proposed to revise an exception allowing a hospital, federally qualified health center or a rural health clinic to assist a physician in hiring an NPP. CMS clarified numerous service area questions, including that the NPP could remain in his or her community and receive this support after first becoming a nurse practitioner. CMS also proposed to require that the NPP and physician arrangement begin *on or after* the commencement of the assistance arrangement.
- f. **Ownership or Investment Interests.** CMS raised two topics with respect to its definition of ownership or investment interests. First, CMS proposed that a titular ownership or investment would not be considered ownership. This may be beneficial for some corporate practice of medicine arrangements, although in many cases, the in-office ancillary services exception already protects the relationship. In addition, CMS asked for comments

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on whether it should also remove employee stock ownership plans, or ESOPs, from its meaning of ownership.

- g. **Decoupling the AKS from the Stark Law.** CMS proposed to remove certain requirements for exceptions that entail AKS or other related law compliance. Although the practical effect may be small, providers will appreciate that this would remove ambiguity from complying with a strict liability statute by meeting an intent-based criminal statute with more limited safe harbors. CMS noted the AKS separately remains a “backstop” for problematic arrangements that would no longer be restricted under the Stark Law.
5. **CMS proposed to replace its “period of disallowance” rule with a general standard.** For purposes of the DHS referral prohibition, CMS has called the period when a referral cannot be made a “period of disallowance.” CMS has now proposed to replace its current complex rule to determine a period of disallowance, with a general principle that the period of disallowance “should begin on the date when a financial relationship fails to satisfy all requirements of any applicable exception and end on the date that the financial relationship ends or satisfies all requirements of an applicable exception.” Providers would determine the ending date on a case-by-case basis. While commenters will likely appreciate the deletion of the overly prescriptive period of disallowance rules, and certain guidance that may allow providers to cure noncompliance without triggering this period, the general guidance provided in the proposed rule will likely lead to further legal development and consideration in the industry, particularly since the guidance may provide additional opportunities to cure past conduct.

Protections for Value-Based Arrangements

As noted at the beginning of this article, these proposed rules stem from HHS’ Regulatory Sprint to Coordinated Care. HHS intended this initiative to incentivize value-based arrangements and patient care coordination. Industry stakeholders have long claimed the AKS and the Stark Law prevented value-based payment model adoption. In response, for Medicare innovation programs and certain government value-based programs, HHS granted fraud and abuse waivers for value-based participants to avoid both the intent-based AKS and the strict liability Stark Law. These waivers, however, did not apply to commercial payor arrangements or provider-driven activities that nonetheless could implicate either the AKS or the Stark Law, including certain capitation, shared savings, gainsharing, and bundled payment programs. CMS and OIG worried that this implication limited its ability to meet the goals of the Regulatory Sprint, and developed these two proposed rules to address these concerns.

In addressing these concerns and supporting the transition away from traditional fee-for service payments to value-based payments and care coordination, CMS and OIG respectively proposed three exceptions to the Stark Law largely consistent with three safe harbors to the AKS to protect remuneration between participants in value-based arrangements. These three proposals vary by the types of remuneration protected, level of financial risk assumed by the parties and types of safeguards. CMS’s exceptions and OIG’s safe harbors would be between two or more participants in a value-based enterprise (VBE) where the VBE either: (1) takes on full financial risk from a payor for patient services related to a target patient population; (2) places meaningful downside financial risk on the physician VBE participant or (3) adopts other value-based arrangements, which could provide only financial upside for a participant, but with the most regulatory burdens.

Each of the three exceptions and safe harbors require VBE participants engage in certain activities with a value-based purpose for a target population (i.e., participants can provide healthcare items or services, but those would only be within the protected conduct if it furthered a value-based purpose for the target population). CMS and OIG both proposed that a value-based purpose would mean (a) coordinating and managing the care of a target patient population; (b) improving the quality of care for a target patient population; (c) reducing the costs to, or growth in expenditures of, payors without reducing the quality of care for a target patient population; or (d) transitioning to payment mechanisms based on quality of care and control of costs of care for a target patient population. Notably, this definition of “value-based activities” could be seen as broad as both CMS and OIG wanted to allow a wide-variety of activities from mandatory post-discharge

meetings to incentives to reduce unnecessary care or shared-savings payments. On the other hand, both CMS and OIG sought feedback to refine their respective positions here. Further, CMS asked if it should mandate that the third prong on reducing costs to payors without reducing the quality of care should require the VBE to achieve quality of care goals already before pursuing cost savings protected by such activities.

Unsurprisingly, with new protections outside of the historic fee for service model, this is not the only place either CMS or OIG are asking for feedback. As the healthcare system shifts from fee for service payments to value-based or care coordinated care, new concepts are necessary to articulate how both the Stark Law and AKS apply in this evolving system. Both agencies propose numerous value-based definitions. Commentators are likely to provide CMS and OIG many potential arrangement examples for consideration before the agencies finalize the rules. We will be curious how much of the initial flexibility CMS and OIG retains. For example, neither CMS nor OIG require a VBE to be an actual entity—instead it can merely be the multiple parties entering into a contractual arrangement to support a value-based purpose for a target population. Such position is not consistent with historic rulemaking, which often focused on legal entities, particularly in the context of the Stark Law, but suggests how both CMS and OIG sought to grant further flexibility in developing their value-based arrangement rules.

OIG also provided for two other value-based arrangement safe harbors beyond those that they share with the CMS Stark Law proposals. OIG proposed a new safe harbor for a provider’s furnishing of certain tools and supports to patients to improve quality, health outcomes and efficiency, such as in-kind items and services to support patient compliance with discharge and care plans and services and supports to address unmet social needs affecting health. CMS did not need to include a similar exception as the compensation is going directly to a patient and would not be remuneration to a physician prohibited by the Stark Law in the absence of an exception. OIG also proposed a new safe harbor for financial arrangements between providers in connection with CMS-sponsored payment models. OIG hoped that by adopting regulatory text there would be less need for waivers in the future.

The proposed changes would offer flexibility for beneficial innovation and improved coordinated care through, for example, outcome-based payment arrangements that reward improvements in patient health. The changes would also make it easier for physicians and other healthcare providers to ensure they are complying with the law by offering specific safe harbors and exceptions for these kinds of arrangements. We anticipate significant consideration of these proposals followed by further developments in the years to come.

Conclusion

Overall, many providers will support these proposed changes, notwithstanding that existing arrangements may need to be adjusted, reformed or terminated to comply with the proposed rules. While these rules apply across the board to all providers, some in particular, such as the expanded distance in the Transportation Safe Harbor and the In-Home Dialysis Telehealth exception will be particularly applicable to nephrologists and their patients. The changes to the value-based arrangements may also allow nephrologists to enter into new relationships with ESRD clinics and other providers to adopt new compensation models.

Comments on the proposed changes were due by December 31, 2019. RPA’s comments are posted at www.renalmd.org. The government will review the comments received and publish a final rule in the coming months. ★■

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How to Conduct a Compensation Audit

By Valerie Treat, CMPE



Many of you have seen, and perhaps participated in, various compensation audits. RPA and other organizations do these surveys to assist HR managers with determining if their staff are paid appropriately for their skills, education, experience and job duties. But how many managers have taken a good look at all positions in their organization to ensure that job titles match the actual work that is done, compared one job title to another, updated the job descriptions to ensure that the

work being done today is what is reflected in the job description, or developed a salary market range for each position?

There are three primary reasons why it is important to ask and answer these questions. First, employees who are not paid market rates are likely to leave your practice for one that does pay them what they are worth. Employees who are valued and paid accordingly are likely to not only stay with your practice, but also excel in their positions. It will also mitigate poor morale and any complaints of favoritism among the staff. Second, physicians/owners are focused primarily on patient care. It is the responsibility of administrators/office managers to keep them updated in the world of HR management, highlighting areas that need improvement and areas that are done well. No physician/owner will be happy learning that they are considered “stingy.” Third, this audit sets up a base from which new positions can be created, determines if cost-of-living raises can or should be considered, and documents employee and employer expectations for each position. If you are part of a large healthcare organization, your HR department may be doing this for you. If not, it falls on you to do the job.

There are several elements to conducting such an audit. First, collect the current data available. This involves a review of personnel files to get a sense of the employee’s work history, examining areas such as position, starting rate, notes of any raises, changes in job duties, and job description, etc.

Next, perform an analysis of the current job description compared to the current job duties required. It is not unusual for a job description to “evolve” over time. An employee who starts with your practice as a receptionist may have evolved into a scheduler or medical records clerk over time. To assist with the process of updating the job descriptions to reflect the work done, you can have the staff complete a questionnaire, or you can conduct interviews with each employee. Consider the job skills and education that are required to perform that position without consideration of the individual who is in the position. For example, if your practice does not need a certified coder, but the individual in the position is a CPC, the job description is not going to list CPC as a requirement for the position, and will not pay a wage commensurate with such a designation. Another example is if your practice does not require an RN for the position, do not place it as a requirement on the job description or pay the individual the rate for an RN.

One of the disadvantages to many of the salary surveys is that job titles are listed, but there are no data concerning skills and education level. At times it feels like we are flying blind or not comparing apples to apples. This is where networking in your specialty organization or local practice management organization is invaluable. Request job descriptions from a colleague(s) to see if there is another job title for your staff’s work, or if the job requires additional duties elsewhere. This will help with writing job descriptions and/or confirm your intuition about the descriptions and duties/education that are required.

Once you have created or revised the job descriptions based on what the individual actually does, the needs of the practice, and other information you have gathered, then it’s time to use the myriad survey data available to develop a market range for each job title for your local area. To do this, review the salary survey data available to you. Also choose a few online job recruitment sites such as Indeed.com or

Salary.com. Use sites that will provide you with adequate information for your specific city, if possible. Using state data is an option if nothing more geographically specific is available, but be cautious of how much weight you give that data. In Alabama, state salaries vary widely because the western half of the state is largely agricultural, and the northern part of the state is highly technical. Using your best judgement, develop a reasonable market range for each position. This is an example of a chart you can create with your locality’s salary benchmarks for specific positions:

Position	Market Range Per hour
Receptionist	\$11.00 - \$17.00
Scheduler	\$13.50 - \$20.00
LPN	\$14.75 - \$23.00
Health Info Clerk	\$12.00 - \$18.00
Patient Acct Rep	\$12.00 - \$19.00
PAR/Coder	\$13.50 - \$21.00

Why is having a market range important? First, it gives the HR manager and/or physicians an idea of how much to offer a prospective candidate and still be within the market range for the position. Salaries are and should be negotiable. Not every candidate will accept what the practice always offers as the starting rate of pay for a position. Depending on experience and skills, the practice may wish to offer something a little higher. Therefore, the market salary is a guideline. Second, it allows the employees to grow within the position. Giving cost-of-living increases without knowing the market range may cause the practice to overpay individuals in the position. This guideline allows the practice and employees to know what the threshold is for each position.

Once the research has been done, job descriptions are updated, and market ranges are established, it’s time to provide the decision makers with a report of your findings. This report should have several sections:

- Purpose – let the decision makers know why you feel this is important to your organization.
- Historical Data – describe how wages have been handled in your organization.
- Method – describe the methods you used to gather information – survey information, website information, etc.
- Analysis – for each position, describe your findings.
- Recommendations – for each position make a recommendation. It can be as simple as “no recommendation at this time” to making a market salary change and why. For those positions where the salary should be increased, recommend doing a “market adjustment” increase for specific individuals. In cases where anyone in a position is overpaid, recommend that no salary increases be made until or unless the market range increases for that position.
- Financial Impact – it’s important that the decision makers understand the financial impact of what you are recommending.
- Final Thoughts – this section is not necessary. However, if you have any opinions other than what the analyses show, include those here.

The last part of the report should include separate tabs for each position. Include a copy of the job description, copies of surveys, and printed pages from the websites to corroborate what you said in the report. Finally, submit your report to the appropriate individual(s) for consideration. Be prepared to answer any questions.

It is my experience that the decision makers will greatly appreciate the research that was done for the report and will likely authorize any recommendations that are made. At the very least, having updated job descriptions and market ranges for the positions will provide better structure and confidence in the HR decisions being made for the practice. ■

Valerie Treat is the administrator at Renal Associates of Montgomery in Alabama. She may be reached at Valerie@renalmgmal.com.

For Early Career Nephrologists: The Many Facets of Engagement

By Shaun Conlon, MD

This is part of a series of articles aimed at “young nephrologists” from Dr. Conlon’s perspective. This column does not represent the views of the RPA.



The RPA recently completed a strategic planning session to guide the direction for the organization for the coming years. One of the themes from this session was an emphasis on the importance of engagement of and with the membership. I have heard the term engagement used multiple times in the past (for example, in the context of burnout). This has sparked my thinking about the different forms of engagement.

Engagement with Our Patients

One of the most important forms of engagement as physicians is with our patients. As nephrologists, we are pulled in multiple different directions in our day-to-day practice – between the office, dialysis unit and hospital, not to mention our administrative responsibilities.

I have changed my office workflow over time to allow myself to maximally engage with my patients during scheduled visit times. I often stay in one examination room while my staff triages the patients in another room and then routes the patients to me. This eliminates the time spent logging in and out of the computer and electronic health record and the time spent walking between exam rooms and my office. This adds up to additional time that I can spend in the room engaging with my patients, so I can better discuss their concerns and guide them through appropriate treatments. I usually put my phone in the “do not disturb” mode when I am in the office. This prevents interruptions while seeing the patients from text messages, emails and phone calls (I do periodically glance at my phone to make sure there is nothing urgent).

When I make rounds at the hospital, I often will sit down in the patient room – the patients and families get a physical cue that I am not trying to rush out of their room and will stay until I have discussed their issues and answered their questions. At the dialysis unit, I try to sit down with each patient during rounds. The patients can then appreciate that I am not trying to rush on to the next person. In both the dialysis unit and the hospital, my interaction with the patients is predominantly without a computer (except for necessary interactions such as reviewing lab results at the dialysis unit) – I think this eliminates one major barrier to engagement.

Engagement Within Our Practices

It is important to understand that you are one part of a successful medical practice. My practice holds monthly meetings with all the physicians and our office manager. We review the finances of the practice, major information that all physicians need to know (e.g. updates regarding our ESCO) and troubleshoot problems. My practice is small (four physicians), so we can all meet each month, but this may not be feasible for large practices. In those settings, a smaller set of the doctors (an executive committee) should also meet regularly and then disseminate important information to all the doctors in the practice. Without these regular meetings, major issues can get missed and not addressed. The lack of the meetings will also inevitably alienate those physicians who are not involved in major decision making for the practice. The new payment models (ETC, KCF, CKCC) will require increasing levels of engagement from each physician to be successful. The physicians will need to understand which patients are included in the model and which metrics are being tracked. The overarching goals of increasing transplantation and home dialysis rates will certainly require active provider participation for success.

Engagement Outside Our Practices

It is important for physicians to have some type of professional engagement outside of their practices. I have gained much insight from my involvement both locally and nationally.

The engagement could be at the local hospital level – involvement in committees or in a leadership role (section or department chair). This involvement helps us understand the issues that the hospital faces and how we can help with these – for example, at my hospital, we have had an unacceptably high rate of catheter-associated urinary tract infections and I am working with the nephrology section on appropriate urinary catheter use. Some physicians may be interested in an eventual administrative role (e.g. chief medical officer) and leadership involvement is often a prerequisite for these positions.

The engagement can go beyond the local level – in a county or state medical society or a national organization (such as the RPA). I have found my involvement in the RPA extremely fulfilling. I have formed relationships with nephrologists around the country and I have a learned how to access and use resources about the newest policy and reimbursement changes within our specialty.

“For a busy nephrologist, taking adequate time for one’s self means realizing the limits of your own bandwidth and being willing to say no if your time becomes excessively constrained—not being able to do this can certainly lead to burnout.”

Engagement with Family and Friends

I am writing this article the week before Thanksgiving. My parents will be coming to stay with us for the holiday week and I will not be seeing patients for most of that week. I plan to work diligently for the rest of this week so that when my parents are here, I can disengage from my clinical duties and engage with them, as there are limited times when I get to see them (they live almost a thousand miles away). I have tried to work efficiently during the day so that I can come home to my family each evening at a reasonable time. When I get home, I put my phone down and don’t pick it up again until after my children are in bed. I try to minimize the time on my phone on my weekends off, so I remain engaged with my wife and children. My sister-in-law lives close to us and we try to regularly get our children together with theirs for meals or activities on the weekends.

Personal Engagement

Lastly, I think it is important to take care of ourselves so we can engage in all the ways that I listed. For me, that means getting adequate sleep, eating healthy and exercising regularly. Many of us have a hobby and should make time to pursue it. For a busy nephrologist, taking adequate time for one’s self means realizing the limits of your own bandwidth and being willing to say no if your time becomes excessively constrained—not being able to do this can certainly lead to burnout.

Engagement will mean different things for each of us. For the new year, think about where you are currently engaged and where you would like to be. We hope that your plans for 2020 include increased engagement with the RPA and we will continue to strive to make the organization inclusive and invaluable to all nephrologists. ■

Dr. Conlon has lived in Atlanta with his wife and family for over a decade. After finishing his residency and fellowship at Emory, he joined Atlanta Nephrology Associates where he is now a partner. Dr. Conlon serves as a member of the RPA Board of Directors.

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Value of RPA PAC Returns Dividends

suffice it to say, 2019 has been a momentous year in the nephrology and kidney policy world. From the pomp and circumstance of the Trump Administration's Executive Order signing ceremony in July and the release of the mandatory kidney care payment model the same day to the rollout of the voluntary payment models in October, there has been no lack of developments on which to report this calendar year. And while the attention to kidney patient care is long overdue, and the Administration's broad objectives commendable, the pursuant rulemaking has resulted in significant stakeholder concern.

The concerns regarding the mandatory model proposed rule were of sufficient substance that they reached Capitol Hill and the ears of the Congressional Kidney Caucus.

In response, Caucus Chairs Suzan DelBene (D-WA) and Larry Bucshon (R-IN) led an effort to develop a letter sent to HHS Secretary Alex Azar and CMS Administrator Seema Verma on October 17, articulating their top-line concerns on the proposed rule. These included:

1. the need to recognize a patient's propensity and choice regarding home dialysis;
2. concern regarding the broad scope of the model to cover 50% of the country;
3. the need to articulate waivers from Stark and anti-kickback laws to facilitate implementation of the model;
4. the necessity to address organ supply issues before holding nephrologists and dialysis facilities accountable for transplant rates; and
5. the absence in the proposed rule of a formal means of assessing patient experience and satisfaction.

The letter was signed by 74 members of the House.

The connection between the House letter on the mandatory payment model proposed rule and the RPA PAC is that, of the 74 House members who co-signed the letter, 24 (nearly 1/3) have received support from the RPA PAC. Raising awareness of issues consequential to nephrologists and the persons to whom they provide care is one of the primary areas of focus for the RPA PAC. This can be manifested in several ways, by supporting appropriators in Congress who address funding for kidney priorities, by helping legislators working on authorizing issues where provisions of importance to kidney disease care are (hopefully) enacted, to helping Congress exercise its oversight

responsibilities when CMS and other agencies propose policies that may have inadvertent negative consequences for nephrology. The Kidney Caucus-led letter falls into this last category, where elected representatives serve as a check on the proposals of any administration that, despite the best of intentions, may not account for the realities of nephrology practice.

Regarding candidates that RPA PAC supported in the last quarter of 2019, these include Reps. Ron Kind (D-WI), a long-time leader on the push to enact lifetime coverage for immunosuppressive drugs, Michael Burgess (R-TX), the GOP health policy thought leader in the House who has the opportunity to rise to Ranking Member of the Energy and Commerce Committee, Suzan DelBene (D-WA), Chair of the

Congressional Kidney Caucus, Derek Kilmer (D-WA) of the Appropriations Committee, Ami Bera, M.D., (D-CA), an internist from the Sacramento area, and Jimmy Gomez (D-CA), an up-and-coming member of the Ways and Means Health Subcommittee. On the Senate side, RPA PAC participated in events for Tim Scott (R-SC) of the Senate Finance Health Subcommittee, Jacky Rosen (D-NV), Roy Blunt (R-MO) and Todd Young (R-IN), who has had a long-time interest in kidney care issues and is a strong proponent of reforming the U.S. regulatory structures pertaining to organ procurement and transplantation.

The RPA PAC exists to help advance the understanding and recognition on Capitol

Hill of the issues that nephrology practices of all sizes face every day in their efforts to treat kidney patients. Oversight efforts, like the letter on the mandatory payment model proposed rule that the Congressional Kidney Caucus drafted and disseminated to House membership and sent to HHS/CMS leadership, are one example of how the consistent, long term, year after year work of the RPA PAC that bears fruit. Please help RPA and the PAC achieve these goals by making a donation to the PAC today at <https://www.renalmd.org/page/PAC>. ■

RPA PAC is a separate, segregated fund established by RPA. Voluntary contributions by individuals to RPA PAC will be used to support candidates for public office regardless of political affiliation who demonstrate their belief in the principles to which the profession of nephrology is dedicated. Contributions from corporations and associations as well as medical practices are prohibited by federal law and cannot be accepted. Contributions to the RPA PAC are not deductible as charitable contributions for federal income tax purposes.





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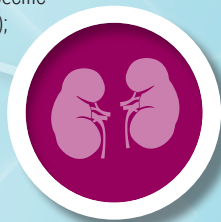
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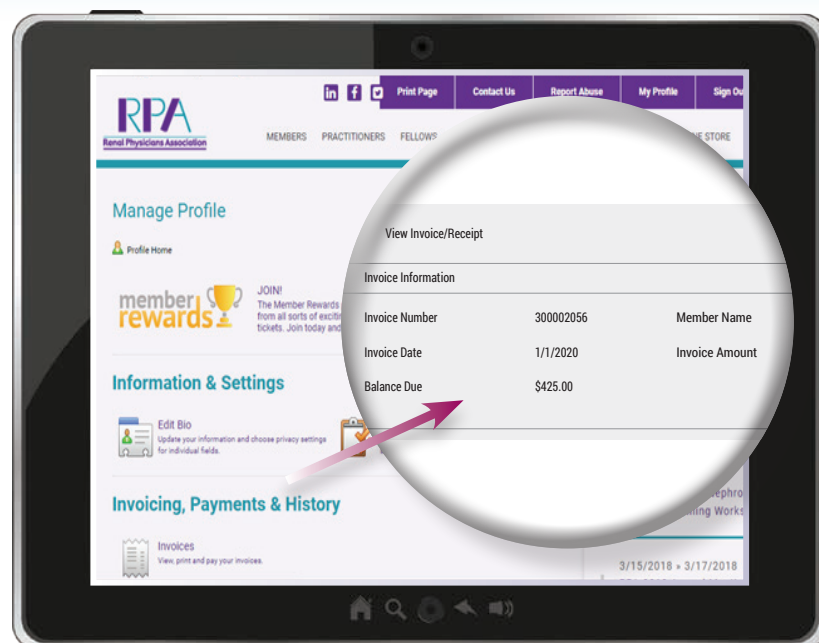


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Transitional Care Management; Home Dialysis

As of January 1, 2020, CMS will allow billing of TCM services provided to ESRD patients for whom a nephrology practice is providing MCP services. Previously, MCP and TCM services could not be billed together for the same patient.

Q I just heard that CMS is now covering services for transitional care for the time after a patient leaves the hospital—is this true? If so, what are the CPT codes, in what situations can they be billed appropriately, how much is the reimbursement, and is there any nephrology specific information I need to know?

A Yes, as part of the 2013 Medicare Fee Schedule (effective January 1, 2013), CMS created CPT codes that represent the services associated with providing TCM from the inpatient status (including acute hospitals, rehabilitation hospitals, and skilled nursing facilities) to the outpatient status (generally meaning the patient's home but also including rest homes and assisted living facilities). The CPT codes are: (1) CPT code 99495, associated with decision making of moderate complexity and a face-to-face visit with the patient within 14 days of discharge; and (2) CPT code 99496, associated with decision making of high complexity and a face-to-face visit with the patient within 7 days of discharge. The complete CPT long descriptors are included below:

- ▶ 99495 Transitional Care Management Services with the following required elements:
 - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge;
 - Medical decision making of at least moderate complexity during the service period;
 - Face-to-face visit, within 14 calendar days of discharge;
- ▶ 99496 Transitional Care Management Services with the following required elements:
 - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge;
 - Medical decision making of high complexity during the service period;
 - Face-to-face visit, within 7 calendar days of discharge.

The complexity of decision making is determined in the same manner as for E&M codes, by using the appropriate documentation guidelines. In general, moderate complexity decision making is associated with the services represented by CPT code 99214, and high complexity decision making is associated with the services represented by CPT code 99215.

To bill for the services, a provider must:

- ▶ Have a face-to-face visit with the patient within the time frames noted above for each patient;
- ▶ Perform medication reconciliation within those time frames; and
- ▶ Have an interactive contact with the patient within two business days of discharge.

Also, the first face-to-face visit is part of the TCM service and cannot be billed separately, but additional E&M services after the first face-to-face visit may be reported separately.

RPA had significant input to the development of these codes through a CPT work group prior to their implementation in 2013 since

nephrology is the specialty with the most experience with non-face-to-face care, and this led to a number of similarities between the MCP and the TCM codes. Like the MCP, the TCM services can be provided and billed by physicians, nurse practitioners, physician assistants, and clinical nurse specialists. Also, like the MCP, billing is “first come, first served”, which is to say that CMS will only pay for one claim for TCM services per hospital discharge, so the provider submitting the claim first will receive payment. Finally, the provider of care must wait for 30 days after discharge to submit the claim for the services, so this is not unlike the MCP where the provider will often wait until the end of the month to bill for the services.

The 2020 national median non-facility (outpatient) Medicare Part B reimbursement allowances for the TCM services will be approximately \$187.66 for CPT code 99495, and \$247.96 for CPT code 99496. Additionally, the question of whether the dialysis facility (Medicare place of service -65) is an approved place of service for the TCM codes has been raised by RPA member practices. At this point, there appears to be nothing in the Medicare claims manual or regulation excluding POS -65 as an approved site of service for the TCM codes, but it is possible that TCM claims with a POS -65 may be scrutinized at the Medicare Administrator Contractor (MAC) level. RPA will be closely monitoring this issue and will be advocating as necessary for the commonsense position that the dialysis facility should be an allowed site of service for the TCM face-to-face visit.

Q If a PD patient has been in the hospital for part of the month, for the time the patient was not hospitalized, can we bill the home dialysis MCP if the monthly visit occurred or should we bill using the daily code?

A As of January 1, 2015, CPT codes 90963-90966 should be used for the billing of the part of the month when a home dialysis patient was not in the hospital as long as the complete assessment was performed and a face-to-face interaction occurred (this change is documented in Medicare Learning Network article MM9265, issued in August of 2015). CMS notes in the article that when they changed the policy for the home dialysis MCP service in 2011 to require that the MCP practitioner furnish at least one face-to-face patient visit per month as a condition of payment, they “inadvertently did not modify billing guidelines for home dialysis (less than a full month) to be consistent with partial month scenarios for center-based dialysis patients. Stakeholders subsequently brought this inconsistency to the attention of CMS as part of the CY 2015 PFS rulemaking cycle.” So, if the nephrology practice gets the complete assessment done in a month when a home dialysis patient was hospitalized and a face-to-face encounter occurred (either during the complete assessment or otherwise), they should bill the age-appropriate full month home MCP code. ■

Editors Note: RPA consciously takes a conservative position when providing coding and billing advice to its members, since the possible unintended consequence of taking a less conservative approach could be a claims audit with the potential of doing tremendous harm to an RPA member's practice. Similar to the FAQ page on the RPA website, this column has been designed as a general information resource. It is not intended to replace legal advice. The responses to the questions submitted to the Coding Corner column have not been vetted by attorneys, and attorneys have not been consulted in the drafting of any of the replies.

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