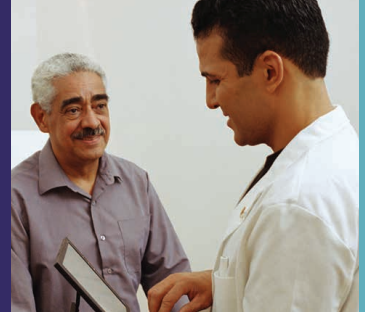

RPA News

November 2019
Vol. XXXVII No. 5

The Advocate for Excellence in Nephrology Practice

RPA Calls on CMS to Refine ESRD Treatment Choices Payment Model

In mid-September, RPA submitted comments on the Specialty Payment Model proposed rule, addressing the ESRD Treatment Choices (ETC) payment model section of the rule. RPA's comment commended the Centers for Medicare and Medicaid Services (CMS) for its ambitious vision for improving home dialysis and transplantation rates but urged the Agency to substantially refine the proposal before implementation. (RPA's comments are posted on the RPA website.) The ETC proposed rule is of course only the first part of the administration's effort to transform kidney care in the U.S. At press time, the Requests for Application (RFAs) for the voluntary Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC) payment models had not been released.

RPA's comments began with a list of potential unintended negative consequences that could result from unmodified implementation of the proposed rule. These focused primarily on the possible impact on communities and dialysis facilities that are already marginalized or with limited resources and implications for patient access and patient choice. ***RPA also raised concerns with the use of hospital referral regions (HRRs) as the geographic designations to be used in the model, noting that there can be a wide degree of demographic and care delivery variability that can occur within an HRR that could hinder the effectiveness of the model.***

Continued on page 4

RPA Medicare Fee Schedule Comments Address Proposed Elimination of Nephrology Measures in QPP, Revaluation of MCP Based on E&M Increases

In late September, RPA submitted comments to CMS on the proposed rule for the 2020 Medicare Fee Schedule. The primary issues RPA addressed were CMS' proposal to eliminate nephrology specific quality measures from the QPP and a response to a CMS solicitation on whether the monthly capitated payment (MCP) code family should be revalued based on increases to component evaluation and management (E&M) codes.

On quality issues, other concerns raised included changes CMS is proposing that RPA believes would be damaging to Qualified Clinical Data Registries (QCDRs) that many specialties formed as a result of the Medicare Access and CHIP Reauthorization Act (MACRA), and CMS' proposal to create what are called MIPS Value Pathways (MVPs) to ostensibly reduce the administrative burden associated with the QPP. Payment and coverage topics addressed in addition to the MCP are the Agency's proposals relating to concurrent billing of transitional care management (TCM) and monthly adult ESRD services, E&M code restructuring and revaluation, and the new Principal Care Management (PCM) codes.

Quality Issues

As noted, the top issue in the quality arena addressed in RPA's comment was the elimination of all nephrology-specific quality measures from MIPS. These include:

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

Continued on page 6

From Capitol Hill

The Duality of Man, and Health Policy

By Robert Blaser, RPA Director of Public Policy

Like many aging baby-boomers, my wife and I have kids who are infinitely smarter than us, which of course is both great and challenging. Our college sophomore is for the moment a math and political science double major, but he also has a philosophical, 30,000 foot perspective on a lot of things, and whenever he hears about a person or groups of people doing seemingly contradictory things, he exclaims "Dad, it's the duality of man!"

The duality of man refers to humans engaging in paradoxical behaviors and the potential for good and evil in all of us (personified in literature by *Dr. Jekyll and Mr. Hyde*). Frequently the catalyst for my son's exclamations will be when a previously exemplary public figure has done something of poor character, and unfortunately, modern society gives him a lot of opportunities to use his favorite phrase. Whether that is because humans of today are more behaviorally inconsistent than we used to be or it is a function of lightning fast information sharing shining a light on bad deeds can be debated, but, as former RPA President Dr. Bob Provenzano often used to say, "It is what it is."

This duality of humankind also manifests itself in the development of health policy. For example, this summer the Trump Administration, through HHS and CMS, released the Advancing American Kidney Health Initiative (AAKHI), and no one could argue with the premise. Promoting home dialysis, seeking to increase rates of kidney transplantation, increasing the supply of transplantable kidneys, advancing efforts to create artificial kidneys, and implementing a massive awareness campaign regarding kidney disease and treatment are tremendously laudable goals, and this Administration should be commended for its vision in identifying these objectives and seeking to achieve them.

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Recognize Excellence in Nephrology Practice

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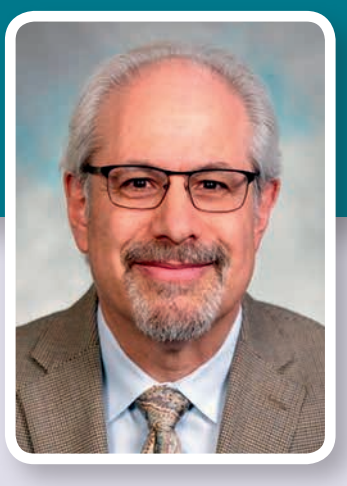
See page 5 for details

President's Message



Jeffrey Perlmutter, MD
RPA President

In my message to you in September, I alluded to anticipating the proposed rules for new payment models of kidney care and described the exciting atmosphere at the announcement of the Presidential Executive Order providing the authority for creating those models. As one would expect, change of the magnitude envisioned in the Advancing American Kidney Health Initiative is neither easy to achieve nor easy to enact. As I write this column, the RFAs for the voluntary kidney care payment models (KCF and CKCC) have not yet been shared with the kidney community. The proposed rule for the mandatory ETC has been scrutinized by the RPA, the broader kidney community and the medical community at large (e.g., the AMA). The ETC is an extensive and complicated payment model, and I thank all who helped craft the RPA's response, which is posted on the RPA website. All of the public comments were received by CMS as of September 16. The proposed start date for the mandatory and voluntary models is January 1, 2020. Given the feedback the kidney community shared with CMS on the ETC and the delayed release of the RFAs for the voluntary models (these were expected by the end of the summer), implementation may be delayed.

Regardless of when the new models are scheduled to go into effect, the RPA stands ready to ensure the success of our members. We had anticipated some of the changes contained in the new payment models. By the time you read this newsletter, the RPA Board of Directors will have participated in a strategic planning session. Because of the expected changes in the practice environment, this will be a challenging but exciting time to plan for the future of the RPA. Our strategic priorities will continue to include advocacy, professional and business success, and high-quality patient care. The last two will be affected by the new payment models. I believe we need to include the success of our profession, nephrology, not just the success of our practices, as part of our strategic agenda. We are experiencing workforce challenges in nephrology and I am committed to having our organization help keep nephrology a viable and desirable choice of specialty.

As noted above, advocacy has been and will continue to be an important pillar of RPA's strategic priorities. This is no more apparent than in our vision to be the recognized advocate for excellence in nephrology practice. This requires us to advocate in all venues where issues important to our constituents are discussed, including on Capitol Hill. I was honored to present the RPA 2019 Special Recognition Award to Representative Jaime Herrera Buetler to acknowledge and thank her for her commitment to the kidney community and legislation that supports our efforts, such as the Living Donor Protection Act for which she was an original cosponsor. Representative Herrera Buetler has first-hand experience with kidney disease (her daughter received a kidney transplant) and therefore understands our issues. The RPA is able to make the personal connections so helpful to our advocacy because of the work of our Political Action Committee, which is non-partisan and supports members of congress interested in legislation that is important to the RPA and the kidney community.

Important stakeholders in the kidney community are the people who experience kidney disease, our patients. The American Association of Kidney Patients (AAKP) appreciated my attendance at its annual meeting in September. Not only is the individual physician/patient relationship important, it is also vital for AAKP to have partners in the physician community, and they know that they have a friend in the RPA. I was impressed by their passion and energy as they declared this "The Decade of the Kidney," and hope we can join them in maintaining the momentum for change initiated by the Executive Order in July.

In addition to the significance of the patients' perspectives, the leadership of RPA must hear from our members to guide the direction of our organization. To that end, I will be visiting nephrology practices to hear your concerns. You will know if I am in your neighborhood because of my Maryland license plate, "RPAPREZ." In October the PREZMOBILE made its first stops at Mountain Nephrology in Asheville, North Carolina, and Metrolina Nephrology in Charlotte, North Carolina. The PREZ will be visiting with Kidney Specialists of Southern Nevada in Las Vegas in January 2020 (sans PREZMOBILE). If you would like to schedule a visit, please contact the RPA office. I look forward to coming to your neighborhood soon. ■

INSIDE THIS ISSUE...

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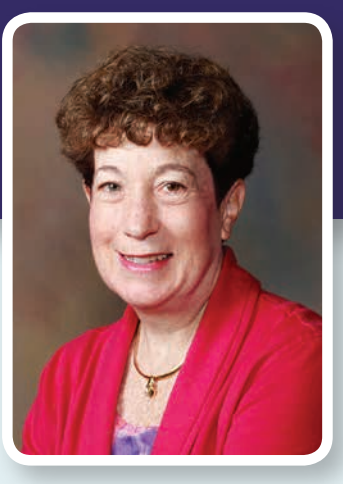
Scan barcode with your phone to visit our website!

Editor's Expressions



Dale Singer, MHA
RPA Executive Director

Leaves are changing colors, the days are getting shorter, Thanksgiving is only weeks away and before we know it, we'll be ushering in a New Year. At this point in the calendar, we begin to reflect on what we have accomplished during the year and are surprised by how fast the previous 10 months have flown by. If you have been reading RPA's emails and the last issue of *RPA News*, you are aware of the unusually high level of activity there has been in the kidney space. During the second half of 2019, kidney-related groups have been grappling with how to best shape the ETC Model proposed by CMS over the summer. While the kidney community, including RPA, was excited by the Administration's announcement of the Advancing American Kidney Health initiative in July, RPA cautioned that the devil would be in the details. When the proposed rule was released several weeks later, RPA's trepidation was realized, because there were many provisions about which RPA and other groups had cause for concern. RPA's comments address these concerns and can be viewed on the RPA website. The article on page 1 highlights how many provisions could negatively impact nephrology practitioners if the rule is implemented as proposed.

As I write this column, we are unsure about how the ETC will evolve and when it will be implemented. Of course, there will need to be a ramp up period and practices that are required to participate in this model will need resources and support. It will also be important for practices to know if they are included in the ETC so they can make informed decisions regarding participation in the voluntary models; however, we are still awaiting the RFAs for the voluntary models, and don't know how those will be structured nor how physicians will be compensated for care.

Separately from the proposed payment models focused on kidney care, CMS has proposed changing the MIPS requirements and creating a new value-based program for all physician specialties known as the MIPS Value Pathways (MVPs). RPA offered comments (posted on our website) on the MVP proposal which is included in the Medicare Physician Fee Schedule proposed rule (see article on page 1). While the Administration has been emphasizing the need for physician performance measures that matter, they are simultaneously proposing removal of specialty-specific measures that apply to the patient populations receiving kidney care.

Against this backdrop of significant upheaval in kidney care payment and delivery, RPA leaders and staff participated in a strategic planning session in late October. As the only national medical professional society that advocates for legislation and regulations enabling nephrology practitioners to deliver high quality, safe kidney care and receive fair compensation for their services, RPA renewed its commitment to offering programs and services to fulfill its mission.

- We are the organization nephrologists, advanced practitioners, and practice administrators turn to for help understanding federal and state legislation and regulations.
- We are the organization providing our members with tools and resources to comply with federal and state requirements.
- We are the organization with the expertise to help you navigate the quagmire of bureaucratic rules and succeed in nephrology practice, whether small, medium or large.
- We are the organization that prepares fellows and early career physicians for practice expectations.
- We are the organization educating Congress, the Administration officials, CMS staff and other government decision makers on the real-world issues affecting nephrologists' ability to deliver high quality, safe kidney care.

RPA continues to evolve as the rules of the game keep changing. RPA is prepared to help practices that are required to participate in the ETC model if and when it comes to fruition, as well as the voluntary payment models when they are announced. RPA will continue to provide guidance to practices participating in MIPs or MVPs, so they get appropriate credit for the care they are providing and associated patient outcomes. At our core, RPA remains true to its original focus when it was founded in 1974—to serve the needs and protect the interests of nephrology practitioners throughout the United States. We are the only organization with this laser focus that is embraced by our volunteers serving on our Board of Directors and committees as well as our staff.

Importantly, we need your continued support through your membership dues. Invoices for 2020 have been mailed. When you renew your membership for the coming year you are continuing to support RPA's unique and important role in the national kidney landscape. Based on our advocacy efforts, in the last year alone we saved nephrologists between $6,000 to $11,000 by convincing CMS to abandon its proposal to compress evaluation and management codes; CMS eliminated its proposal to cut the two highest volume dialysis circuit codes by more than 50%, which would have forced many nephrology practices to close their vascular access centers; and CMS added the patients' home and dialysis facility to the list of approved originating sites for telehealth, expanding access to home therapies.

But don't stop your engagement with paying your dues. Join us at our annual meeting in March to talk with experts about all of the changes affecting the specialty, volunteer to serve on a committee, read the information we send out weekly via email and check our website frequently for updates. Reach out to any of the RPA staff or Board members with questions or concerns. We're here to serve to you and support your success! Here's to another year working together to improve the lives of kidney patients and the health care providers and administrators who help take care of them. Cheers! ■

Step Up to the Plate: Submit Nominations for Service on RPA Board of Directors

As RPA has been reporting, the nephrology field is rapidly evolving, and your professional society is working on influencing those changes while helping our members thrive in practice. By serving on the RPA Board of Directors, you have the opportunity to strategize how to best position nephrology practitioners for success in delivering high quality, safe kidney care. Nominate yourself or a colleague to serve on the Board for a 3-year term beginning in March 2020 and chart the future direction of RPA. Simply complete the nomination form at **www.renalmd.org**, attach the required CV and submit by December 6, 2019. Board members are required to attend four 2-day Board meetings per year as well as participate in the annual meeting, Capitol Hill Day, PAL Forum, various committee meetings and special projects. Nominees should have previous RPA/nephrology leadership volunteer experience. RPA's future is in your hands! If you would like additional information about this exciting opportunity, feel free to contact RPA's executive director Ms. Dale Singer at **dsinger@renalmd.org** or the RPA nominating committee chair and RPA Past President Dr. Michael Shapiro at **rpa@renalmd.org**. ■

ESRD Payment Model

from page 1

CMS solicited comment in the proposed rule on the effective date of the model (CMS proposed an effective date of January 1, 2020 but inquired as to whether April 1, 2020 would be more appropriate). Given the concerns about unintended consequences, ***RPA urged a delay in implementation***, beyond April 1 if necessary, to ensure that changes can be made to ensure that patient care is not compromised. Additionally, ***RPA called on CMS to reconsider the scope of the model (applying it to 50% of the nation)***, given that CMS stated in the proposed rule that this was only necessary to ensure that the model was sufficiently powered to detect changes in transplant rates, and for the home dialysis aspect of the model, it would need vastly few HRRs to sufficiently power the model. RPA's comment stated that this justification simply does not suffice for making a change of such magnitude. ***The Association's comment also addressed the benchmarks established by CMS, noting that an 80% combined (home dialysis and transplanted patients) goal for new ESRD starts by 2025 would be wildly optimistic and is likely to be counterproductive to the agency's ultimate goals.***

On the Home Dialysis Payment Adjustment (HDPA) and the Performance Payment Adjustment (PPA) outlined in the rule, RPA's comments pointed out that the former was insufficient to the task, and the asymmetrical nature and broad range of the latter were likely to result in harsh penalties for many nephrologists and dialysis facilities. In the HDPA provision, CMS proposes a 3%, 2%, and 1% increase structure in years 1-3 of the incentive payment adjustment, and while this is a straight bonus with no downside, the actual dollar amounts are a maximum of about $7.00 in the first year before being reduced, and seem to be arbitrarily determined. ***RPA's comments called for CMS to transparently develop incentive payments for the HDPA that account for the resources necessary for nephrology practices to manage home dialysis care.*** In the PPA, not only do the penalties have the potential to be draconian for nephrologists, they would be assessed in addition to whatever reductions a nephrologist would be subject to under the Merit-based Incentive Payment System (MIPS), such that some practitioners could be penalized twice under separate measurement systems. ***RPA urged CMS to re-evaluate the PPA to determine whether it will achieve its intended goals, account for the likely unintended adverse consequences that will result from its implementation, and, if implemented, to reduce the range of bonuses and penalties and exempt nephrologists in the model from MIPS participation.***

RPA also raised the issue of the impact of the proposed rule on patient choice. While CMS is appropriately seeking to ensure that dialysis patients have access to modality options other than in-center dialysis, such as home therapies and transplantation, paradoxically, the rule seems likely in many cases to hinder patient choice by overly incenting options other than in-center dialysis. RPA's comment stated that "every effort needs to be made to ensure that all patients approaching or already on dialysis are aware of their options for their care, and that all patients who are possible candidates for transplant or who have the home environment, appropriate support, and wherewithal to dialyze at home are given that opportunity." However, concern was also expressed that the proposed model doesn't account for patients who prefer in-center dialysis, and that this was problematic in an era of presumed patient empowerment. Accordingly, ***RPA recommended that CMS consider the potential adverse impact of the proposed rule on patient choice to minimize undue influence to choose other modalities on patients who would prefer in-center dialysis.***

Another noteworthy issue area addressed in the Association's response to the proposed rule was the decision to use organ transplant rates as a measure to evaluate nephrologists and dialysis facilities, rather than activities and processes within their control. The comment noted that the complexities surrounding the organ procurement organizations and the control of transplant centers over organ allocation as well as the selection/acceptance of candidates limit the ability of nephrologists and dialysis facilities to impact the actual transplantation rate. As such ***RPA called on CMS to not use organ transplant rates for evaluating nephrologists and dialysis facilities in the ETC model, and rather identify an alternative methodology for such measurement such as referral rates or wait lists.***

RPA also raised the following issues in its comments on the proposed rule:

- the need for aggregation at the dialysis facility level to reflect the reality of ESRD care delivery;
- the necessity of additional waivers to promote care coordination and to mirror the success of the ESRD Seamless Care Organizations (ESCOs);
- identification of additional exclusions for home dialysis and transplants so that patients with diagnoses not appropriate for home dialysis or transplantation are not included in the denominator;
- the need for increased payment for in-center peritoneal dialysis and home dialysis training to promote transitions to home dialysis;
- exclusion of non-Medicare beneficiaries from transplant attribution to account for the preponderance of transplants occurring among those patients; and
- implementation of payment models in geographies with large integrated health systems to address the interaction of ETC participants with those entities.

The final rule for the ETC payment models is expected to be released sometime before year's end. This could be complicated by the inclusion of the ETC with a separate radiation oncology payment model; CMS may need to decouple the ETC and radiation oncology models if they end up requiring separate timelines for implementation. Additionally, many commenters outlined significant methodological concerns with the proposed rule, and there currently is an effort underway on Capitol Hill among members of the Congressional Kidney Caucus to urge CMS to take its time in addressing stakeholder concerns. Given all of those factors, a January 1, 2020 effective date seems unlikely. RPA will continue to track developments regarding not only the ETC model but also the voluntary KCF and CKCC RFAs and will keep RPA membership apprised accordingly.

Learn More about Proposed Kidney Payment Models

The RPA webinar that was presented in mid-September on New Payment Models Affecting Nephrologists and Kidney Care Delivery is available on RPA eLearning. (**https://tinyurl.com/PAL-kidney-model**) This webinar, featuring RPA Board member Dr. Jeff Giullian, included an overview of what is known to date regarding the ETC Model, as well as the KCF and CKCC voluntary models.

Post questions and continue the conversation about the proposed kidney models on RPA Connect (**https://tinyurl.com/Kidney-Models**).

Follow RPA on Twitter for real-time legislative and regulatory news @RPANephrology

RPA Presents 2019 Special Recognition Award to Rep. Jaime Herrera Beutler

On September 10, RPA President Dr. Jeffrey Perlmutter and RPA staff presented the 2019 RPA Special Recognition Award to Congresswoman Jaime Herrera Beutler (R-WA). To be considered for this award nominees must have: (1) served as an elected or appointed government official at a state or federal level; (2) provided outstanding public service toward improving the delivery of kidney care; and (3) must be recognized through accomplishments which are consistent with RPA's goals, objectives and mission. Representative Herrera Beutler has been a tireless advocate for kidney care, from being an original co-sponsor of the Living Donor Protection Act (H.R. 1224) to serving as the driving force behind a Department of Labor opinion letter in 2018 stating that the Family Medical Leave Act was applicable to kidney donation. In addition, she supports enactment of lifetime coverage for immunosuppressive drugs for kidney patients post-transplant and is an active participant in the Congressional Kidney Caucus. Representative Herrera Beutler is also the spouse of a kidney donor and mother of a kidney transplant recipient. ■

L-R: Robert Blaser, Jeffrey Perlmutter, MD, Rep. Jaime Herrera Beutler and Dale Singer

Recognize Excellence in Nephrology Practice

The RPA Recognition Awards Program provides an opportunity to recognize the expertise and contributions of nephrologists, practice managers, and nephrology practices. RPA will formally recognize and thank those individuals and practices who are selected to receive the awards during the RPA Annual Meeting, March 19–22, 2020, in Baltimore.

All members should consider submitting nominations for the following awards:

- **Distinguished Nephrology Service Award**—recognizes an individual RPA member who exemplifies RPA's mission and goals and has demonstrated local and/or national leadership to that end. *Previous years' recipients were Drs. Richard Hamburger (2005), William Haley (2006), Emil Paganini (2007), John Sadler (2008), Nathan W. Levin (2009), James Edward Hartle (2010), Richard S. Goldman (2011), Alvin H. Moss (2011), Keith Johnson (2012), Thomas Golper (2013), Kline Bolton (2014), Walter Bender, Jr. (2015), Alan Kliger and Derrick Latos (2016), Allen R. Nissenson (2017), Robert Provenzano (2018), and Louis Diamond (2019).*

Past President Dr. Michael Shapiro presented Dr. Louis Diamond (r.) with the 2019 Distinguished Nephrology Service Award.

- **Distinguished Practice Manager Award**—recognizes an individual RPA member who has an active role in managing a nephrology practice for three years or more who exemplifies RPA's missions, goals and objectives and has demonstrated professionalism and competence in nephrology practice management in one or more of the following areas; leadership, innovation, staff motivation and communication, business/financial management, patient relations, process improvement and practice efficiency. *Previous years' recipients include Sharon Rynn, Associates in Nephrology, Chicago, IL (2012), David Doane, Dallas Nephrology Associates, Dallas, TX (2013), Tammy Conger, Knoxville Kidney Center, Knoxville, TN (2014) Suzanne Przybyla, Mid-Atlantic Nephrology Associates, Baltimore, MD (2015); Beth Shaw, Renal Care Associates, Peoria, IL (2016); Beth Irwin, Colorado Kidney Care, Denver, CO (2017); and Annette Wounded Arrow, Renal Care Associates, Peoria, IL (2018).*
- **Exemplary Practice Award**—recognizes a nephrology practice that is uniquely incorporating and supporting suggested practices and strategic efforts of the RPA while meeting the needs of its community. *Previous years' recipients were Denver Nephrology (2005); Associates in Nephrology, Chicago (2006); Scott and White Clinic, Temple, TX (2007) and Arizona Kidney Disease and Hypertension Center (2007); Nephrology Associates of Newark, DE (2008); Kidney Associates of Kansas City (2009); Boise Kidney and Hypertension Institute, Boise, ID (2010); Knoxville Kidney Center, Knoxville, TN (2011); Macon Medical Group, Macon, GA (2012); Kidney Associates, Houston, TX (2013); Balboa Nephrology Medical Group, San Diego, CA (2014); Valley Kidney Specialists, Allentown, PA (2015); Nephrology Associates of Northern Illinois/Indiana (NANI), Oak Brook, IL (2016), Renal and Transplant Associates of New England, Springfield, MA (2017), and Nephrology Associates Nashville (2019).*

Renal Associates, PC (Nashville) received the 2019 Exemplary Practice Award.

A detailed description of each of the awards along with criteria and a nomination form are posted at **https://renalmd.site-ym.com/page/RecAwards. All nominations must be received by January 10, 2020.** ■

Medicare Fee Schedule Comments

from page 1

- 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 Days
- MIPS 403: Adult Kidney Disease: Referral to Hospice

Additionally, RPA opposed removal of the MIPS quality measure on Preventive Care and Screening: Influenza Immunization, even though it is not a nephrology-specific measure. The rationale for opposing the removal of the measures was based on RPA's belief that "MIPS quality measures should be relevant to the daily care provided by clinicians and that the move to primary care-centric measures is detrimental to the care of the nation's kidney patients. **To advance the quality of care for patients with kidney disease, it is critical that nephrologists are measured by specific, relevant, and clinically meaningful measures."**

Other MIPS issues raised by RPA related to a proposed cost measure on acute kidney injury (AKI), changes to the improvement activities (IA) performance category, and changes to the promoting interoperability (PI) category, with the concerns in these areas pertaining to potential inequitable treatment of nephrologists or the burden associated with compliance.

With regard to QCDRs, CMS seems to be de-emphasizing the role of QCDRs in the Medicare quality structure in a way that seems counter not only to the MACRA law that fostered their creation, but to the quality measurement movement broadly. RPA's comments addressed the following sub-topics:

- Requiring QCDR measures to identify a linkage between their QCDR measures to cost measures, improvement activities, or CMS developed MVPs;
- Requiring QCDR measures to be fully developed with completed testing results at the clinician level at the time of self-nomination;
- Requiring QCDR measures to have data collected prior to submission for CMS consideration;
- Requiring QCDR measures to available for to MIPS eligible clinicians for reporting through QCDRs other than the QCDR measure owner for purposes of MIPS;
- Requiring harmonization of QCDR measures;
- Approval of QCDR measures for 2 years;
- Requiring case minimums and reporting volumes for benchmarking after being in the program for 2 consecutive performance years;
- QCDR Audits of PI and IA categories; and
- Use of QCDR measures in MVPs.

RPA's comments on quality issues concluded with input on the proposed MVPs. The Association expressed appreciation for CMS' statement that the MVP guiding principles are reducing burden, providing comparative performance data to patients and caregivers, encouraging improvements in high priority areas, and reducing barriers to APM participation. However, RPA noted that this dramatic change to the MIPS program will actually increase burden on providers and staff by requiring them to understand and implement yet another reporting methodology, which will require provider and staff time, changes in workflow and possible upgrades to their electronic health records system. As a result, health professionals will become more disengaged, and time devoted to patient care will be further reduced.

Payment and Coverage Issues

In an interesting solicitation in the proposed rule, CMS notes that several code families have their valuations based on E&M services as component services, and that since E&M services have been increased for 2021 as part of this rule, inquires whether those code families should be considered for revaluation as well; the MCP codes are among the code families listed in the inquiry. RPA's comment outlined for CMS several instances over the last 15-20 years that the E&M codes received increases in value that were not subsequently applied to the MCP codes, and accordingly called for CMS to adjust the ESRD monthly service codes to reflect previous increases in underlying E&M services. The comment noted that with the emphasis on kidney care as exemplified by the Advancing American Kidney Health Initiative, **"providing nephrology practices with additional resources to provide care to dialysis patients (only by providing increases in value commensurate with value adjustments for their underlying building blocks) would be of tremendous benefit to outpatient kidney disease care."**

CMS also proposed to make the TCM codes billable for ESRD patients in 2020 (this is currently prohibited) and to create principal care management (PCM) codes that would be similar to the current chronic care management (CCM) codes, but for a single chronic diagnosis (the CCM codes are for multiple chronic diagnoses). RPA strongly supported both proposals, and on the proposed TCM change, urged CMS to make the TCM codes billable in place of service (POS) 65 (dialysis facilities) when provided to ESRD patients, since it is our understanding that in the ESCOs, TCM services provided in the dialysis facility contributed to improved patient outcomes through reduced hospitalizations.

RPA's comments also included support for CMS' decision to adopt recommendations from the CPT Editorial Panel and the Relative Value Update Committee (RUC) for restructuring and revaluing the E&M code families (effective in 2021). These were rigorous and robust processes open for participation to all of organized medicine (RPA contributed to this effort), so the decision to adopt the recommendations is logical and appropriate. RPA's comments also commended CMS for their ongoing commitment to reducing the administrative burdens placed on physicians by E&M documentation requirements.

RPA's comments are posted on the RPA website. The final rule for the 2020 Medicare Fee Schedule is expected to be released this month.

RPA Comments on 2020 Medicare Physician Fee Schedule Proposed Rule

1. Opposed removal of nephrology-specific measures from MIPS
2. Noted the value of QCDRs and opportunities to maximize their use
3. Highlighted increased burden on clinicians resulting from proposed MVPs
4. Recommended the need to adjust the MCP to reflect previous increases in underlying E&M codes
5. Urged that TCM codes could be billable in dialysis facilities
6. Supported proposed use of TCM and PCM codes for ESRD patients
7. Supported CMS' decision to restructure and revalue E&M code families
8. Commended CMS for commitment to reduce administrative burdens due to E&M documentation requirements

From Capitol Hill

from page 1

The table was set for the most noteworthy, historic step forward in kidney policy in more than 45 years.

Of course, like the old saying goes, there's many a slip between the cup and the lip, and regrettably, the execution of the AAKHI thus far has not inspired confidence. The day of the rollout of the initiative, CMS released a proposed rule on specialty payment models that included the ETC payment model (which is mandatory for 50% of the country). CMS also that day announced that RFAs for other nephrology-centric payment models (KCF and CKCC), would be out by summer's end. So far, so good.

However, once analysis of the proposed ETC rule got underway in earnest, substantial concerns began to emerge. The article on page 1 highlights RPA's concerns with the proposed rule as outlined in RPA's comments that were submitted to CMS in September. These include the scope of the mandatory model, potential unintended negative consequences of its implementation, the deep penalties for nephrologists and associated dialysis facilities not attaining prescribed goals, implications for patient choice, and the use of organ transplant rates to evaluate model participants, among others. Elsewhere, the Congressional Kidney Caucus is drafting a letter urging CMS to act deliberately in moving forward with the rule, the AMA has recommended that CMS eliminate the bonus/penalty provisions of the model (leaving exactly what?), and the Medicare Payment Advisory Commission (MedPAC) is calling on CMS to shelve the entire proposal and go back to the drawing board. As for the voluntary models, at press time, the RFAs that were promised by the end of summer had yet to be released.

So yes, the Administration held a splashy, good-news PR event that publicized legitimately momentous positive news for the kidney community, and followed that up with pretty disappointing rulemaking (thus far). But in terms of the duality of man/duality of health policy, they've got nothing on Congress. When we last left the miasma on Independence Avenue, optimism abounded with regard to health policy legislative initiatives on drug pricing/oversight, surprise billing, prior authorization, and pertinent to kidney disease, immunosuppressive drug coverage (about which HHS Secretary Alex Azar gave a loud shout-out during the July AAKHI rollout event).

Well, a month into the fall legislative period, the optimism is less bountiful. In no huge surprise, the pharmaceutical industry has flexed its lobbying muscles and the chances of meaningful reform in that space occurring are not great. (Although in more normal times, this would have been interesting to watch, since House Speaker Nancy Pelosi's (D-CA) plan to rein in drug prices included more areas of commonality to what President Trump proposed doing earlier in 2019 than what Congressional Republicans have been advocating for so far this year.) On surprise billing, the House sponsors of the No Surprises Act (H.R. 3630), Energy and Commerce Committee Chair Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR) were excited to have their bill sail out of the E&C Health Subcommittee this summer, only to see it become the subject of a dark money advocacy campaign funded by private equity firms that have acquired physician staffing and emergency transportation companies; Chair Pallone and Ranking Member Walden launched an investigation into these firms in September, but for the moment, the bill has stalled. Regarding prior authorization legislation, the Improving Seniors' Timely Access to Care Act of 2019 (H.R. 3107), sponsored by Reps. Suzan DelBene (D-WA), Mike Kelly (R-PA), Roger Marshall, MD (R-KS), and Ami Bera, MD (D-CA) has gained an impressive number of co-sponsors (72) in a relatively short period of time, and has a lot of organized medicine advocacy power behind it, but it has not advanced out of committee and there is currently no Senate companion bill.

This brings us to the immunosuppressive drug bill, which was a source of much hopefulness in mid to-late summer. Recall that in May, two separate cost estimates came out of the Administration establishing the initiative as a cost saver, to the tune of $73 million according to the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), and $300 million per the CMS Office of the Actuary (OACT). Two things to note here: first, the OACT estimates traditionally are quite aligned with what comes out of the Congressional Budget Office (CBO), so that's a major positive given the higher OACT number, and second, once something is scored as a saver, it gets close to being a no-brainer, given that in our budget-neutral world, that money can be used to pay for something else. A recent kidney-specific example is the provision covering outpatient AKI services that was included in a major trade bill (too long a story for this column) a few years ago. The Obama Administration included the measure as a saver in its FY 2016 budget request, and the provision was enacted as part of the trade bill about four months later. Given that, the glide path for immunosuppressive drug legislation would seem to be smooth.

This is where the duality thing comes into play. In the perfect being the enemy of the good department, there is some disagreement among the stakeholder organizations advocating for the bill as to whether additional refinements to the legislation should be made before moving it forward. Some groups want any necessary changes to be made before any legislation is introduced, even though this has the potential to not only delay progress but even possibly eliminate the chances of introduction and enactment happening this session of Congress. RPA is firmly on the side of striking while the iron is hot, taking advantage of this moment when the Administration and Hill sponsors are firmly in favor of moving forward, and addressing minor issues as part of rulemaking. This is especially true given that the 2020 elections have the potential to grind the legislative process to a halt.

Speaking of bringing the legislative process to a grinding halt, the elephant in the room is the impeachment inquiry announced by Speaker Pelosi on September 24 (and I'll let you draw your own conclusion as to whether it is the Republican elephant in the room, or if Democrats are making asses of themselves). Leaders of both parties in both chambers continue to indicate that committee work will continue, but it is not difficult to envision that whatever path the impeachment activities take, they will suck the air out of the proverbial room. If so, the outlook for progress on anything gets bleaker.

That said, STAY IN THE FIGHT, DON'T GIVE UP THE SHIP, AND NEVER SAY NEVER. If and when an immunosuppressive drug coverage bill is introduced, an RPA grassroots alert will be issued immediately. When that happens, contact your members of Congress early and often to urge them to cosponsor and vote for the bill. The odds are that some sort of Medicare extenders package will need to be enacted before year's end, and if the immuno bill gets out and on the table, it has a great shot of being included in the final bill.

It is important to remember that half of the duality construct is that good things happen, too. With a bit of good fortune and effective advocacy, the immunosuppressive drug coverage bill that the kidney community has been waiting on for years might be one of those good things. Please engage in the RPA advocacy efforts when that happens. Happy Thanksgiving. ■

LEARN ENGAGE TRANSFORM

RPA is headed back to Baltimore!

The **RPA 2020 Annual Meeting** is created for Kidney Practitioners by Kidney Practitioners! This meeting is the one place where you will **Learn**, **Engage** and be ready to **Transform** your practice! Join your colleagues and expert thought leaders as we chart the future with deep dive trending topics that will put your practice on the fast track.

This is the only place to learn about a broad array of practice management and clinical topics—

- How will the Advancing American Kidney Health Initiative affect your practice and your patients?
- Are new Payment Models keeping you up? Let's talk about it.
- Meeting your practice's Financial Targets
- Real-world management of Hyperkalemia: Practice Patterns and Patient Perspectives

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Why should you attend the RPA Annual Meeting?

> *I would **never** miss the opportunity to attend the RPA Annual Meeting. In my community, I know zero Nephrology practice managers. When I come to the meeting, I see that I am not alone and that we are all facing the same issues. I appreciate learning from and with my peers who come from every walk of life with all levels of experience. The sessions are engaging and informative, so I come away with great ideas every year and most importantly, with a renewed sense of purpose to guide my practice in delivering the best care for our patients.*
>
> —*Stacey Loomis, CMPE, Midwest Nephrology Associates, St. Louis, MO*

Don't miss out on this opportunity to **learn** from expert leaders, and **engage** with your peers to prepare to **transform** kidney care delivery.

Maximize your meeting experience...

Register for an interactive pre-conference workshop—

- Fundamentals of Nephrology Coding and Billing
- Leadership Workshop focusing on negotiation and communication techniques (in collaboration with the American Association for Physician Leadership)

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2020 RPA Annual Meeting

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RPA
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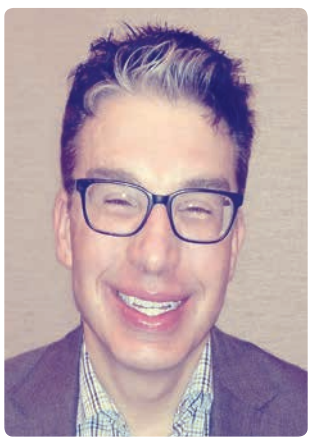
The Kidney Quality Improvement Registry: Novel Research Initiatives

By Michael J. Fischer, MD



The RPA Kidney Quality Improvement Registry (RPA Registry), the only CMS-approved nephrology-specific QCDR owned by a specialty society, was launched by the RPA in 2015. Since that time, the RPA Registry has a practice-based data network that longitudinally links nephrologists across the nephrology community and includes real-time customized continuous performance monitors, provider- and practice-level comparisons and benchmarking, performance gap analysis, links to quality improvement tools, and other improvement activities. In addition to satisfying the clinical data registry reporting measure of the MIPS promoting interoperability component and supporting MIPS quality measures, the QCDR is used to develop and test custom measures. In 2019, the RPA Registry supported 30 CMS-approved MIPS measures and ten custom measures that reflect important aspects of nephrology care, allowing nephrology practitioners to be measured by specific, relevant, and clinically meaningful measures.

QCDRs and Research

Clinical data registries such as the RPA Registry are observational databases that hold information about a patients' health status, conditions, procedures, therapies, and outcomes. These data may be used to assess and improve the quality, efficiency, and safety of patient care. Typically, these data are from the electronic health records of participating providers. Since the registry's inception, RPA has worked with Premier Inc., which serves approximately 4,000 hospitals and health systems, 165,000 other providers and organizations, and provides platforms for numerous registries and QCDRs, as our technology partner. Recently, RPA has embarked on collaborations with industry partners to conduct prospective pragmatic research studies on timely and significant matters that impact the care of patients with kidney disease.

> *"In addition to being a tremendous resource for quality assessment and quality improvement for nephrology practices, the RPA Registry is a platform for novel research initiatives into important clinical areas that impact patients with CKD and their providers."*

Hyperkalemia and Adults with CKD

In adults with chronic kidney disease (CKD), hyperkalemia is not an uncommon complication. Depending on its severity, it can put a patient at increased risk of cardiac arrythmias. Although implementing a low potassium diet is part of the management of this CKD complication, it is not always enough. Therefore, in the past several years, novel medications have been developed to treat chronic hyperkalemia in CKD patients.

To better understand the impact of hyperkalemia on the lives of patients with CKD, in 2018, RPA launched a year-long retrospective observational study, funded by a grant from Relypsa, using a module of the RPA Registry to gather information and data from a variety of practices and patients to examine two key objectives. First, to develop an understanding of clinical care patterns in managing non-acute hyperkalemia by gathering prospective and real-world practice information on physicians managing non-acute hyperkalemia. Second, to develop an understanding of the impact of elevated potassium levels and treatment on patient experience and quality of life (QoL) via a patient survey. RPA recruited a faculty workgroup, composed of members from its RPA Registry workgroup and Quality, Safety and Accountability Committee, for this project. RPA identified 11 geographically diverse nephrology practice site locations for the study, each of which recruited approximately 30 patients for the QoL survey. In contrast with the typical approach of industry sponsored studies, this collaborative study was a direct survey of CKD patients by their physician's office staff. We believe that this novel approach leveraging the KQIR and the physician/patient relationship will provide a new perspective to this area. We anticipate preliminary findings to be released later this year.

Bone and Mineral Disease in Adults with CKD

In adults with CKD, there remains tremendous uncertainty around managing bone metabolism disorders, such as secondary hyperparathyroidism. Although relevant laboratory studies are routinely obtained as part of care for adults with CKD, how such tests are interpreted and how they inform management of bone metabolism disorders are an area of clinical uncertainty. Currently, treatment parameters for CKD Mineral Bone Disease (MBD) as outlined by expert recommendations and clinical practice guidelines are not completely aligned with what is known about morbidity and mortality outcomes. In addition, there seems to be a wide variation in physician behavior regarding CKD-MBD. As such, there are no clinically meaningful metrics of conformance with CKD-MBD recommendations for the average nephrologist, yet the kidney community believes that there are clinically relevant outcomes worthy of achieving.

Therefore, RPA has recently begun a study examining bone metabolism disorders in patients with CKD, funded by a grant from Amgen. The objective of the project will be to elucidate real-world perceptions and nephrologists' actions around guidelines for managing calcium, phosphorus, parathyroid hormone (PTH), and Vitamin D (e.g., MBD) in CKD patients. The plan is to conduct a prospective observational study to develop evidence that may inform future accountability and outcome measures for the treatment of bone and mineral disorder. Via chart review of patients with CKD, RPA will examine real-world clinical actions as reflected in timing of various MBD lab data measurements, medications prescribed, and chart notes by providers among CKD patients. In addition, using structured interviews, RPA will determine nephrologists' and advanced practitioners' perception of the practicality of current guidelines and the relative importance of these MBD issues in patients with CKD. RPA will recruit ten nephrology practice sites in geographically diverse locations across the United States. This project is designed to collect evidence in an attempt to work toward the development of clinically relevant measures of care. In doing so, RPA will provide data that is not otherwise available to gain an understanding of the typical clinician behavior with regard to MBD. Additionally, by focusing on, and potentially advancing the understanding of MBD issues, it will help to align physician behavior (via measurement) with what is known about the science of MBD as it relates to morbidity and mortality. RPA will evaluate the "real-world" difference between current guidelines, protocols and medical management of these patients.

Opportunities Utilizing the RPA Registry

In addition to being a tremendous resource for quality assessment and quality improvement for nephrology practices, the RPA Registry is a platform for novel research initiatives into important clinical areas that impact patients with CKD and their providers. The collaborations with RPA, Premier Inc., and industry partners represent the beginning of a new trajectory toward furthering our understanding of optimal ways to care for patients with CKD. ■

Dr. Fischer is nephrology section chief at Jesse Brown VA Medical Center and a research health scientist at the Center of Innovation for Complex Chronic Healthcare, Edward Hines Jr. VA Hospital in Chicago. He is also a professor of medicine in the nephrology section at the University of Illinois Hospital and Health Sciences System. Dr. Fischer also serves as vice chair of RPA's Quality, Safety and Accountability Committee. He can be reached at **Michael.Fischer3@va.gov**.

Earn MOC Credits for QAPI Participation

Don't miss your opportunity to claim 20 Maintenance of Certification (MOC) credits from the American Board of Internal Medicine (ABIM) for participating in monthly Quality Assessment and Performance Improvement (QAPI) meetings at your dialysis facility. Nephrologists have until January 31, 2020 to earn MOC credits for 2019 QAPI participation.

The RPA QAPI MOC Program allows nephrologists to claim MOC credits for the work they are already doing as part of the Coverage for Coverage (CfC). CfC requires that dialysis facilities hold monthly QAPI meetings where clinical quality data is used to evaluate the effects of the interventions. Although Medical Directors are expected to lead the QAPI process, all of the dialysis facility's credentialed attending physicians may participate in the QAPI process for MOC credit.

Since its launch in late 2016, more than 1,500 nephrologists have earned MOC credits via the RPA QAPI MOC Program. Medical Directors and attending nephrologists at participating dialysis organizations who take part in at least 5 QAPI meetings in a 6-month period during 2019 are eligible for the program.

Nephrologists affiliated with any of the organizations listed may register and view detailed instructions at **www.renalmd.org/RPAQAPIMOCProgram**. The RPA QAPI MOC Program fee is $50 per physician, per year, paid by the participating nephrologist. RPA membership is not required to participate.

Upon registration, RPA collects data directly from participating nephrologists including the facility name, dates of participation and the topic(s) reviewed via a portal in the RPA Kidney Quality Improvement Registry, which is supported by RPA's information technology partner, Premier Inc. No clinical data is shared with RPA. Following verification by the facility, RPA transmits the verified data of the nephrologist's participation to ABIM, and ABIM issues the MOC credit.

Nephrologists are notified that their MOC credit has been assigned via an automated email from ABIM. They may also access their Self-Evaluation Activity Report on the ABIM website to confirm the MOC credit has been granted. **To earn MOC credits for 2019, complete your submission no later than January 31, 2020.** Contact **abeckrich@renalmd.org** with any questions.

The following dialysis organizations are participating in the 2019 program:

- American Renal Associates
- Aspirus Hospitals and Clinics
- Atlantic Dialysis Management Services
- Berkshire Medical Center
- Branson Dialysis/Harrison Dialysis
- Centers for Dialysis Care
- Chattanooga Kidney Centers
- DaVita, Inc.
- DCI
- Dialyspa
- Dialyze Direct
- Fresenius Kidney Care
- Greenfield Health Systems
- Laurel Canyon Dialysis/Santa Clarita Dialysis
- Loyola Center for Dialysis
- Satellite Healthcare
- Tift Regional Health System Dialysis Center
- U.S. Renal Care
- University of Virginia

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*.

AstraZeneca Pharmaceuticals
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DaVita Kidney Care
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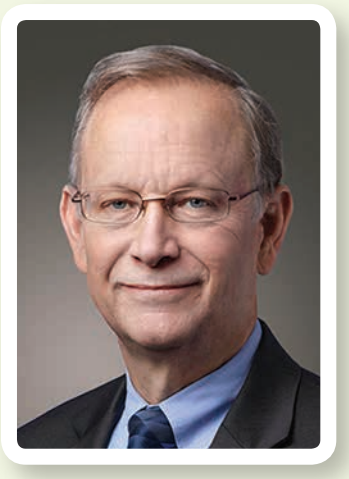
Legal Issues: CMS Simplifies Self-Referral Regulations

By James B. Riley, Jr.



In June 2018, CMS filed a notice in the Federal Register expressing its desire to make changes to the regulations promulgated pursuant to the Stark Law and published a request for information (RFI). Since that time, CMS has published two simplifications to the Stark Law that appear to reflect the Agency's desire to remove unnecessary obstacles and pitfalls for providers. Hopefully, more will follow.

The Department of Health and Human Services (HHS) and CMS indicated in the Federal Register that it was working to transform the healthcare system into one that pays for value. To accelerate this transformation to a value-based system, that effort included care coordination. CMS identified some aspects of the physician self-referral law as potential barriers to coordinated care and committed to work towards simplifying and addressing those perceived barriers.

The RPA commented on the RFI in August 2018 and specifically discussed certain Stark Law provisions that it perceived were barriers to nephrologists participating in care coordination objectives for kidney patients. While the actions taken by CMS since last summer do not expressly address the items that were identified in the RPA comments, there have been at least two changes that were helpful to the provider community, including nephrologists, which are described below.

In addition, there have been other actions taken by CMS that are not so helpful which broaden its powers relative to what it perceives to be an undue risk of fraud or waste or abuse in the Medicare program. These changes expand the prohibitions for participating in Medicare, which are summarized below as well.

Change to Stark Law Signature Exception

Effective January 2019, CMS implemented a helpful change to the signature exception to the Stark Law.

The exception under the Stark Law for compensation arrangements requires, among other things, that they be in writing for a period of a minimum of one year and that the writing of the parties show clear intent, by execution of a document, to abide by the terms of that particular compensation arrangement. In many instances, however, often due to administrative oversight, initial writings are either not adequately documented and signed by the parties or, alternatively they may have been subject to termination but the parties continued to operate under an agreement despite the fact that it may have terminated according to its terms.

In modifying this requirement for certain exceptions, CMS has provided more flexibility to reflect the intent of the parties. Thus, under the prior signature exception, there was a 90-day grace period for noncompliance with the signature requirement as in the personal service arrangement exception and fair market value exception. Reimbursements for any referrals during the grace period were allowed. However, a limitation on the use of the exception was only allowed once in a three-year period. This limitation was imposed so that in order to provide the incentive to parties to not allow a continued recurrence of the same administrative deficiency. Nevertheless, in the most recent regulation the revision to the signature exception eliminates the once in a three-year period, thus providing some further protections to the parties in these arrangements in the event of inadvertent failure regarding the signature requirement.

CMS Proposes Welcome Changes to the Stark Law Advisory Opinion Process

CMS recently issued its annual Physician Fee Schedule and Quality Payment Program Proposed Rule for calendar year 2020. Among other things, it addressed potential changes to the Stark Law physician self-referral advisory opinion process.

Under the current rules, CMS has issued only 15 advisory opinions unrelated to a specific physician-owned hospital topic in 20 years. In the proposed rule, CMS explained that it intends to simplify the process for requesting advisory opinions and will provide the public with meaningful advice regarding whether a specific arrangement violates the Stark Law, signaling a willingness from CMS to increase use of the process.

If finalized, these changes to the advisory opinion process would be effective on January 1, 2020. There are five key takeaways regarding the proposed changes, which the healthcare community may welcome if the process is used more often to navigate the complex, strict liability statute.

Proposed Changes to Stark Law Advisory Opinion Process

- Procedural Changes for Requesting Advisory Opinion
- Shortened Timeline for Issuing Advisory Opinion
- Hourly Fee Structure and Fee Cap for Preparation and Issuance of Advisory Opinions
- Expanded Reliance on Advisory Opinions
- Limited Rescission Authority

1. Procedural Changes to the Process for Requesting an Advisory Opinion

If implemented, the proposed rule will modify procedures for requesting an advisory opinion from CMS on a Stark Law issue. In an effort to ease restrictions on the issuance of advisory opinions — which currently prohibit CMS from issuing an opinion on the same, or substantially the same, course of action that is under investigation or has been subject to a proceeding involving a government entity, such as HHS — the proposed rule would allow CMS to consult with the HHS Office of Inspector General and Department of Justice to exercise discretion as to whether issuance of the advisory opinion is appropriate. Additionally, CMS is considering easing a strict requirement that questions be based on existing arrangements or arrangements that the requestor has actual plans to enter into. Notably, CMS indicates in the proposed rule that to consider a request, it must describe the arrangement at issue in sufficient detail, otherwise CMS will refrain from issuing the opinion until further information is provided or, in the alternative, may reject the request.

Although CMS is not currently proposing to expand the process to include hypothetical fact patterns, it is soliciting comments on whether it should do so in the future. Furthermore, CMS proposes to modify the certification requirement to clarify that the certification must be signed by an officer authorized to act on behalf of the requestor, though CMS is also considering removing the certification requirement altogether. Finally, CMS proposes to eliminate the reference to the provision of stock certificates as part of the advisory opinion request submission, as these are typically electronic and may not necessarily list the name of the owner. The vast majority of the proposed procedural changes appear to be in an effort to ease the current burdens that requestors face and the restrictions that currently limit CMS in issuing opinions.

2. Shortened Timeline for Issuing Advisory Opinions

Currently, CMS operates on a 90-day timeframe for most advisory opinion requests, though it does reserve the right to extend beyond the 90-day window in cases that involve complex legal issues or highly complicated fact patterns. Under the proposed rule, CMS would shorten its response time to 60 days, which would begin on the date that CMS formally accepts a request for an advisory opinion. The 60 days would be tolled, however, if the requestor revises the request or complies and presents additional information. CMS seeks comment on whether the final rule should include a further expedited review option for requestors. The healthcare community may be skeptical of this effort as Stark Law questions often are at the intersection of the law and complex Medicare billing rules. Based on current practices, including a significant backlog of CMS reviews of Stark Law self-disclosures, it seems unlikely that expected reviews will be possible, but CMS noting this as a possibility suggests a new emphasis to

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Self-Referral Regulations

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timely respond to requests and aid the healthcare industry on these complex issues.

3. Hourly Fee Structure and Fee Cap for Preparation and Issuance of Advisory Opinions

Currently, CMS charges requesting parties a consolidated final payment based on costs associated with preparing an advisory opinion. In the proposed rule, CMS proposes to adopt an hourly fee of $220 for preparing an advisory opinion, which it believes accurately reflects the costs incurred by the agency. As mentioned above, CMS is also considering the addition of a further expedited pathway for requestors seeking an advisory opinion on a 30-day timeline. For such expedited requests, CMS proposes a rate of $440 per hour, which it believes reflects the extra resources needed to prepare the opinion on an abbreviated timeline.

To manage costs for requestors and to "prevent unfair surprises to requestors at the end of the process," CMS is open to implementing a fee cap and is seeking comments on the appropriate amount of such cap as well as whether it should eliminate the initial nonrefundable $250 fee that must be included with each request for an advisory opinion. These proposed changes signal CMS' desire for input from the healthcare community as to the fees that requestors would be willing to pay as well as an effort to strike an equitable outcome while still encouraging more requests.

4. Expanded Reliance on Advisory Opinions

Currently, as it relates to reliance on an advisory opinion issued by CMS, only the requestor can rely on the opinion, even though the relationship often involves numerous parties. In its proposed rule, CMS proposes to clarify that all parties to an arrangement subject to a favorable advisory opinion be permitted to rely on the opinion, regardless of whether they were an actual requestor of the opinion. Under this proposal, if CMS determines that an arrangement does not violate the Stark Law, the determination would apply equally to any individuals and entities that are parties to the specific arrangement.

CMS also proposes to clarify that the Secretary will not pursue sanctions against any individuals or entities that are parties to an arrangement CMS determines is "indistinguishable in all material aspects" from an arrangement that was the subject of a favorable advisory opinion. In other words, CMS will clarify that the healthcare community can use advisory opinions to guide behavior in structuring similar deals — making advisory opinions more important/helpful to the greater community. The question as to whether an arrangement is indistinguishable in all material aspects to an arrangement discussed in a favorable opinion may be submitted as the subject of a separate advisory opinion. Even without this, however, the healthcare community will appreciate this additional guidance. CMS proposes to recognize that individuals and entities may "reasonably rely" on an advisory opinion as nonbinding guidance, which CMS acknowledges is already common practice, but would, if finalized, be expressly permitted.

5. Limited Rescission Authority

Current regulations authorize CMS to rescind or revoke an advisory opinion; however, to date, CMS has not rescinded one advisory opinion. CMS is soliciting comments on whether the Agency should retain a more limited rescission authority that would only apply when (1) there is a "material regulatory change" that impacts the conclusions reached or (2) the recipient of a negative advisory opinion requests that CMS reconsider the opinion in light of new facts or new law. Particularly, with it loosening reliance on such opinions, this rescission change could be important, impacting many relationships.

Overall, the foregoing proposed changes are encouraging. CMS appears to have listened to the healthcare community's concerns, including those voiced in a recent request for information, that the advisory opinion process had not historically been utilized for this complex law. In addition, CMS is requesting further comments on the process, suggesting a final rule that may give more flexibility and reliance opportunities. Indeed, CMS expressed its desire to issue more opinions since the Stark Law requires providers to meet an exception, and, thus, favorable opinions will remain narrow and have less chance for abuse than a non-strict liability statute.

CMS Broadens its Powers to Ban Organizations from Medicare

In early September 2019 (84 Fed. Reg. 47794; September 10, 2019), CMS finalized a rule regarding Medicare enrollment. The rule enables CMS to bar or remove healthcare providers and suppliers from participating in Medicare if they are "targeted bad actors" that may be modestly affiliated and that pose "an undue risk of fraud, waste or abuse." The final rule, published on September 10, 2019, requires providers and suppliers to disclose to CMS certain relationships with affiliated entities in their enrollment applications that have previously been sanctioned by federal healthcare programs, including for failure to pay essentially every type of debt including "failure to pay student loans." The final rule also gives CMS a basis for administrative action to revoke or deny Medicare enrollment if (i) a provider or supplier circumvents program rules by coming back into the program, or attempting to come back in under a different name; (ii) a provider or supplier bills for services/items from noncompliant locations; (iii) a provider or supplier exhibits a pattern of practice or practice of abusive ordering or certifying of Medicare Part A or Part B items, services or drugs; or (iv) a provider or supplier has an outstanding debt to CMS from an overpayment that was referred to the Treasury Department.

CMS may prevent applicants from enrolling in the program for up to three years if a provider or supplier is found to have submitted false or misleading enrollment information. Further, CMS can now block providers who are prevented from re-entering the Medicare program for up to 10 years, and if revoked for a second time, CMS can now block program re-entry for up to 20 years.

CMS administrator, Seema Verma, has indicated that this rule facilitates a more proactive approach to enforcement stating, "For many years, we have played an expensive and inefficient game of "whack-a-mole" with criminals – going after them one at a time – as they steal from our programs… These criminals engage in the same behaviors again and again… Now, for the first time, we have tools to stop criminals before they can steal from taxpayers."

It appears that while the goals of CMS are noteworthy, this is a very broad regulation likely to create problems within the healthcare community because the definition of affiliates can include not only entities but individuals within a provider organization about which the provider has no express knowledge. It remains to be seen to what degree CMS will respond to comments and concerns which are likely to be expressed by the provider community to this new rule.

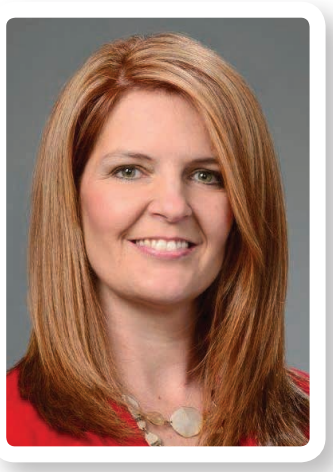
Conclusion

The actions taken by CMS to clarify what are potentially technical noncompliance with exceptions under the Stark Law and to make the advisory opinion process more helpful to the provider community are laudable. However, the broadening of the regulations relating to exclusion or denial of billing privileges in the Medicare program are likely to create problems and unintended consequences unless they are modified to be more selective in scope. Nephrology practices should carefully review this new rule in advance of filing any new or renewed enrollment applications. ■

Mr. Riley is a partner in the McGuireWoods Healthcare Practice and legal counsel to the Renal Physicians Association.

Seven Tips to Make 2020 Your Best Year Yet

By Jennifer Huneycutt, CPA, CMPE



The new year is just around the corner and now is the perfect time to take actions that will ensure that 2020 gets off to a great start. Here are seven things you can do now to make 2020 your best year yet.

1. Review 2019 financial performance and conduct tax planning with your accountant

Go ahead and get a meeting on the books before the end of the year with your accountant. Since most practices use cash basis accounting, they often work hard to zero out their net income at the end of the year by using cash to accelerate anticipated purchases, pay bonuses to employees, and make distributions in some manner to physician owners. There are many variables that need to be considered when deciding the amount of cash to spend and how to spend it. These include profit sharing calculations, current tax law, cash needs at the beginning of the upcoming year, and the practice entity type. Careful planning should be performed to ensure that the practice has enough cash to get through the leaner months at the beginning of the year before patients have met their deductibles. Preparing now will eliminate surprises come first quarter 2020 and April 15th.

2. Conduct a physical plant walk through

Face it, nephrology practices can lose sight of how appealing (or not) the office setting can be. I've heard stories of having patients sit on telephone books to have their blood drawn. I've seen the stained and broken chairs in the waiting rooms, the exam tables from 1972, peeling wallpaper, beat up walls and where John let us know he "was here" by carving it into the waiting room side table. When is the last time you sat in your waiting room? We all know that patient satisfaction is a growing component of how the physician's quality is determined. Even though John's pocketknife and lack of artistic skill has nothing to do with your ability to develop and implement a treatment plan delaying the progression of kidney disease, the office appearance can contribute to a patient's perception of your care. Take a walk through your office and make note of what may need to be updated, repaired or replaced. Use a year end cash surplus to make needed changes or do the legwork to plan for it in your 2020 budget. Your patients and employees will thank you.

3. Ensure Medicare ID numbers are in the new format

This is a huge one for 2020! In April 2018, Medicare began replacing the patient's Health Insurance Claim Number (HICN), a policy number based on social security number, with a Medicare Beneficiary Identifier (MBI), a randomly generated 11-character policy number consisting of both numbers and letters. Both the HICN and MBI serve to identify the patient for Medicare when submitting claims. Practices can use either the HICN or MBI when filing claims for dates of service through December 31, 2019. Starting January 2020, Medicare will deny any claim that does not use the new MBI format. To ensure that claims processing and cash flow is not delayed, practices should review the ID number format for all patients with traditional Medicare prior to the end of the year. Any active patient with a Medicare ID number in the HICN format should be replaced with the new format. New numbers can be obtained through each Medicare Administrative Contractor's online portal using current patient information.

4. Develop your strategy for dealing with deductibles and new insurance

Each new year brings sizeable deductibles for those with high deductible insurance plans and even traditional Medicare deductibles increase. At press time, 2020 Medicare Part B deductibles have not been announced. However, current projections indicate they will increase from the 2019 amount of $185 to $197 in 2020. Consider the number of ESRD patients that you treat that are covered by traditional Medicare. If you have 100 ESRD patients and 75 of them have traditional Medicare, you are putting nearly $15,000 in MCP services at risk of not being collected if your insurance claim is the first to be submitted for the year. Many practices will hold these claims and wait until the patient has met their deductible before filing. This strategy must be carefully planned to ensure the practice has access to cash while waiting for these claims to be processed. It also takes quite a bit of coordination in your business office to ensure claims are held and released at the proper times. Another important change to note regarding Medicare deductibles in 2020 is that patients who are newly eligible for Medicare in 2020 and going forward will no longer have access to Medicare supplement plans that cover the Medicare deductible. This means that, in future years, a larger part of that $15,000 previously mentioned will be at risk as a growing number of supplemental policies will not cover the Medicare deductible.

This is also the time of year when many patients have new insurance information. While office staff should be validating insurance eligibility at every visit, insurance changes will be particularly active at this time of year. Consider checking the deductible status for all patients with high deductible plans and collecting in full at the time of the visit. This approach requires the front desk staff to have access to fee schedules for each carrier and know what visit levels are being charged before the patient leaves. Another strategy is to collect a flat amount up front when the patient has yet to meet their deductible. The amount should be based on type of visit, historical coding patterns and carrier fee schedules in order to maximize collections without creating a significant credit balance issue for the practice.

Lastly, practice providers will need to exercise patience as the registration process may take a little longer at the beginning of the year. A few extra minutes at the front desk can mean the difference between getting paid in full and promptly providing the service for free.

5. Review your 2019 MIPS performance status and look ahead to 2020 requirements

As you round out the year, you'll want to be sure you have everything on track to report your MIPS details to avoid penalties in 2021. In order to avoid a 2021 reimbursement reduction, providers will have needed to earn a minimum of 30 points across the four quality payment program domains of quality, cost, improvement activities, and promoting interoperability. Start by checking the QPP participation status of each provider by going to https://qpp.cms.gov/participation-lookup and entering the provider's NPI number. This site will tell you whether the provider is required to report. Even if your practice is part of an Advanced Alternative Payment Model and you expect to be exempt from MIPS, it is still best practice to check the participation status and print or screenshot the results demonstrating each provider's exempt status. Some practices may be eligible to apply for a promoting interoperability hardship exception. For practices with extreme circumstances, the QPP extreme and uncontrollable circumstance exception application is available. The submission deadline for each of these is December 31, 2019. To learn more about the QPP and how to avoid penalties visit https://qpp.cms.gov/about/qpp-overview.

6. Map out the 2020 practice calendar

Every year we know providers are going to take time off. We know when the holidays are going to fall. We know that a physician will take 1 in 5 call. We know we must report on MIPS. Having these types of recurring items mapped out for the upcoming year will ensure that matters, big and small, will not get missed. With a plan, we can also be prepared with the right resources at the right time to execute on the important things.

Continued on page 14

Seven Tips

from page 13

Some practices plan their call and vacation for the entire year in advance. This method ensures that a practice has enough provider resources available to enable the engine to keep running consistently and providing a steady income stream throughout the year. It also enables the practice to schedule important meetings and events allowing all stakeholders to be present. A well thought out calendar will put into perspective all that it takes to run a successful practice and keep the practice focused on what must be accomplished when the inevitable fires come.

Items to Consider When Planning Your Calendar

Vacation Requests Timeline
Call Schedule Completion Timeline
Schedule Rotation Completion Timeline
MIPS Reporting Timeline
PAMA Reporting Timeline
Practice Annual Meeting
Physician Staff Meetings
Non-Physician Staff Meetings
Manager/Board Meetings
Executive Committee Meetings
Strategic Planning Meeting
JV Manager Meetings
Retirement Committee Meetings
Compliance Committee Meetings
External Committee Meetings
RPA Annual Meeting
Coding/Documentation Audit Plan
Security Risk Assessment
OSHA Training
HIPAA Training
Technology Upgrades
New Dialysis Units
Provider Recruitment
Company Celebrations
Employee Evaluations
Health Insurance Renewal
Budget Approval
Business Insurance Renewal
Malpractice Renewal
Medical Director Agreement Expiration/Notice
Facility Lease Expirations
Managed Care Contract Negotiation/Notice
Facility Improvements

7. Prepare your 2020 budget

Now that you have reviewed 2019 performance, planned the 2020 calendar, and conducted your physical plant walk through, it's time to work on the 2020 budget. Using the past as a guideline and what you reasonably know about the future, go ahead and make your best predictions regarding revenue and expenses month-by-month for 2020. This is one of the most useful tools a practice can have at their disposal. If we think about the things that can disrupt a practice, one could argue that uncertainty of physician compensation caused by the ups and downs that come from running a physician practice can be one of the biggest distractions. All it takes is one lean month and questions begin to arise about practice stability and whether the right people, policies and procedures are in place. People can deal with what they know. It's the unknown that makes things so dicey. A good budget can help the practice predict which months will require more cash. Things like three-payroll months, insurance renewals, and retirement plan funding can all put added pressure on a practice's cash flow. Knowing this information in advance can allay fears by allowing practice leadership to effectively predict and communicate annual compensation estimates and how the cash will flow from month to month.

2020 is right around the corner. At a time when so much in the practice and business of medicine is rapidly changing, taking the time to look ahead and plan your year by following these seven tips will enable you and your practice to minimize surprises and be ready to pivot when the unexpected occurs. ■

Jennifer Huneycutt is the Executive Director of Metrolina Nephrology Associates in Charlotte, North Carolina. She may be reached at **jhuneycutt@metrolinanephrology.com**.

RPA Renal Physicians Association ★ Political Action Committee

Playing the Long Game

When this November 2019 issue of *RPA News* is posted on the RPA website or arrives in your mailbox, it will be one year and a couple of days ahead of Election Day 2020, and that milestone reminds us that participation in advocacy activities such as support of the RPA PAC constitutes 'playing the long game.' In the context of strategy, playing the long game, of course, refers to not obsessing over short term or immediate developments in service of achieving a bigger goal or objective farther down the road. Contributions to the RPA PAC allow RPA as an advocacy organization to play the long game in supporting elected officials who are sympathetic to the concerns of nephrology and can reasonably be expected to be in Congress for the foreseeable future. RPA's plan is to develop relationships with these legislators to ensure success in the long game and facilitate their help in enacting legislation benefitting the kidney community broadly and nephrologists and their patients specifically. Please help RPA play the long game effectively by contributing to the PAC.

Since early September, RPA PAC has supported candidates who are either currently key players or are rising legislators of whom much is expected. In September 2019, RPA PAC participated in fundraisers for Congresswoman Jaime Herrera Beutler (R-WA), the member whose daughter is a kidney transplant recipient and who is the 2019 recipient of the RPA Special Recognition Award (see article on page 5). Additionally, RPA supported Reps. Greg Walden (R-OR), ranking member on the House Energy and Commerce (E&C) Committee, Tony Cardenas (D-CA, and also on the E&C Health Subcommittee) and John Lewis (D-GA, who as well as being an American icon is an original co-sponsor of the Chronic Kidney Disease Improvement and Treatment Act of 2019 and a long-time advocate for kidney issues in Congress). In addition to discussing kidney issues, Mr. Walden also updated attendees on the status of his bipartisan legislation co-authored with E&C Chair Frank Pallone (D-NJ) to address surprise billing about which he still feels optimistic regarding enactment in 2019. Mr. Cardenas noted to the group at his event that due to family history he is a strong advocate for early diabetes care, and he was well aware of the relationship between diabetes and CKD.

The highlight of the fall was a trip to Detroit to speak to over 25 nephrologists from three area practices (Nephrology and Hypertension PC, of Flint, Michigan Kidney Consultants, and St. Clair Specialty Physicians). This event was arranged by RPA Secretary-Treasurer Dr. Keith Bellovich and RPA member Dr. Stephen Clyne and featured a presentation on the proposed CMS CKD payment models from RPA Board member Dr. Jeff Giullian and an update on all other legislative and regulatory developments in the U.S. kidney world by RPA Director of Public Policy Rob Blaser.

Following his presentation, Mr. Blaser discussed the history and operations of the RPA PAC, as well as the strategies pursued by the PAC Board and recent success stories. These included how the work of the PAC contributed to legislative victories on SGR repeal, AKI coverage in the outpatient setting, provision of outpatient home ESRD monthly services via telehealth, and mandated survey and certification for dialysis facilities waiting months, if not years, for surveys and certification, among others.

Informed readers know that some of the successes noted above happened several years ago. This confirms the necessity of playing the long game. RPA worked for years on issues such as outpatient AKI coverage and telehealth for home dialysis, and these sustained efforts, buttressed by the small group interactions with key elected officials made possible by the RPA PAC, led to big wins for the specialty. Please help achieve more meaningful victories for nephrology by contributing to the RPA PAC at **https://www.renalmd.org/page/PAC**, and helping RPA overall play the long game.

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.

Public Policy News Briefs

- On September 27, RPA submitted comments to CMS on the proposed 2020 Hospital Outpatient Prospective Payment System/ Ambulatory Surgical Center payment rule (HOPPS/ASC). This is the rulemaking that establishes **payment policies for ambulatory surgical centers (ASCs)**, and thus governs what Medicare pays for vascular access care represented by the dialysis circuit code family. The ASC comment addressed the code family's ambulatory payment classifications (APCs) and device intensive designations, as well as valuation for percutaneous fistulas.

  On the same day, RPA sent comments to CMS on the **2020 ESRD Prospective Payment System** (PPS) proposed rule, which discussed provisions relating to the transitional drug add-on payment adjustment (TDAPA) in the PPS, and the need to promote innovation in dialysis facility reimbursement. Both comment letters are posted on the RPA website.

- On September 10, **California State Assembly Bill 290** passed in the State Senate and was subsequently signed by Governor Gavin Newsome. This is the state legislation that opponents believe would vastly compromise charitable premium assistance efforts in California. RPA participated in advocacy opposing the legislation. Governor Newsome had pledged to sign legislation of this nature as part of his gubernatorial campaign.

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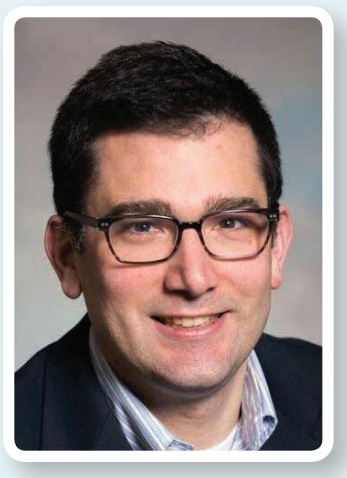
For Early Career Nephrologists: Challenges with Value-Based Care

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.



There has been a rapid shift towards value-based care over the past several years. I have watched these changes evolve rapidly in the short time since I completed my nephrology training. I think about the equation [value = quality/cost] when evaluating any of the various value-based programs we are exposed to in medicine. Unfortunately, the current programs have had a number of shortfalls in their ability to measure and appropriately reward providers for the provision of value.

> *"Value-based care is unlikely to go away, so we will need to adapt to ongoing changes in the payment system. It can be stressful and difficult to adapt to the changes that have been occurring at a rapid rate."*

Practice Transformation Costs

The payment for our services has been largely transactional for many years. We perform a service, submit a bill for that service and are paid relatively quickly (often within weeks) for that service. It's not surprising that our practices are structured around making this process efficient – we maximize the number of patients we can see in a specific period of time and then complete billing and documentation requirements quickly. The processes that are needed to thrive in a value-based world are different.

Success in any of the new kidney payment models that were announced this summer will require practices to optimally manage the transition from CKD to ESRD. To do this well, the practice will need a way to identify their late stage CKD patients, select which of those patients are at high risk of progression to ESRD and then shepherd those patients through a series of steps that lead towards a successful transition to ESRD. This includes education about CKD in general, dialysis modalities and renal transplantation. The patients then will need to be referred to other providers (e.g., vascular surgeons and/or transplant centers) so that they have a functioning access in place when the time for dialysis arises or they have a chance to receive a pre-emptive kidney transplant. To do this well, there needs to be a technological platform to track the patients – this functionality does not exist in most current electronic medical record systems, so either those systems will need to be modified or the practice will need to invest in another system for this purpose. Additionally, staff in our practices will be needed to manage this population of patients – they will need to make referrals, schedule appointments, follow up with patients after those appointments and arrange for other needed tests (e.g., testing needed for renal transplant listing). The cost for managing the CKD population (technological and staff) may be substantial and isn't directly reimbursed by the current value-based programs.

From what we understand, participation in the comprehensive kidney care contracting (CKCC) model will require even more investment in population management. Not only will the practices need to develop the systems I described above for the CKD to ESRD management, but they will also need to understand the total cost of care for their patients and then figure out what measures they can take to lower that cost. The cost data provided by Medicare will need to be analyzed—I suspect many practices do not employ someone currently with the skill set needed to do this analysis. Given that hospitalizations are a large share of a patient's total cost of care, the practice will need to develop systems to keep the patients out of the hospital when possible. This will involve urgent visits for patients with acute issues such as worsening renal function, electrolyte abnormalities or volume overload. If patients are hospitalized, it will involve arranging for close follow up after discharge to lower the risk of re-admission. Again, the cost of developing these processes are not directly reimbursed by the current value-based programs.

Limitations of a Short Time Horizon

Many of our actions caring for kidney patients do not have an immediate impact on the cost of their care. This makes it difficult for practices that may invest in new systems or processes to affect an outcome that may not occur for many years. The rapid change in the structure of the current value-based programs further complicates this – if the programs do not run for a sufficient timeframe then the practice may never get the anticipated return on their investment.

We all recognize that blood pressure control is important for our patients as it will lower the risk of eventual cardiovascular disease and slow the progression of their CKD. However, much of the work we do in controlling our patients' blood pressure now will not accrue a benefit for years if not decades.

Renal transplantation is the optimal treatment for ESRD for many of our patients. We should endeavor to make this treatment option available to as many of them as possible through education and early referrals for transplant evaluation. However, except for those patients with living donors, most of the patients that I refer now for transplant evaluation will not receive a kidney transplant for many years due to long wait list times. These wait times will likely increase based on recent trends. Thus, much of the work we do now to increase transplantation rates will not have an impact on cost for many years.

Using Cost as a Proxy for Quality

I (along with many of my colleagues) am concerned about the structure of the forthcoming ESRD Treatment Choices (ETC) model as currently proposed. The model imposes substantial rewards or penalties depending on providers' rates of home dialysis and transplantation. I worry that the cost-cutting that will occur with this model will not uniformly translate into increased quality of care for our patients. I completely agree that transplantation is the best modality to treat ESRD (though the RPA and others have raised questions about whether it is fair to hold providers accountable for the actual provision of the transplant since that is outside their purview). However, home dialysis is a more difficult issue. There are no randomized controlled trials that demonstrate that home dialysis is superior to in-center dialysis. The comparisons to other countries' home dialysis rates are not fair—in the U.S. we don't place limitations on who can receive dialysis and thus treat an older and sicker ESRD population than many other countries. In addition, some countries with higher home dialysis rates than the U.S. do not give patients a choice in the selection of dialysis modality. If the ETC model is implemented in its current form, I worry that providers will inappropriately steer patients to home dialysis.

Riding the Waves of Change

Value-based care is unlikely to go away, so we will need to adapt to ongoing changes in the payment system. It can be stressful and difficult to adapt to the changes that have been occurring at a rapid rate. I find that knowledge about the programs helps me to better deal with these changes. I became involved in the RPA as a fellow because I was impressed with their education about and assistance with complying with these types of issues. The organization will continue to provide guidance to its membership on how to adapt to these ongoing changes to ensure the future success of 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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TRICIDA

CODING CORNER

Observation Setting, Home Dialysis Training, Transitional Care Management

Q How do I bill for services rendered to an ESRD patient in the observation setting?

A First, it is worth stating from the outset that patients in observation status are considered outpatients by CMS. Therefore, many general outpatient "rules" exist for these hospitalized (non-inpatient) patients. If the patient is an MCP patient in your practice, ESRD-related visits furnished in hospital observation status count as outpatient MCP encounters, so these visits will count towards the total number of encounters submitted for the MCP (CPT codes 90960-90962). The treating practitioner should describe (i.e., document) in the medical record the type of ESRD-related service rendered in the observation setting. If the patient is a visitor to your practice, the practice can either bill as a transient patient for the days the practice is responsible for the patient's care using the daily MCP code by age (CPT codes 90967-90970), or the practice can bill appropriate outpatient E&M code for services required, performed, and documented (but not including dialysis), with the understanding that the bar for appropriate documentation is higher for traditional E&M care than for dialysis care.

Q One of our MCP patients recently came to the ER with shortness of breath and chest pains and we were called to order dialysis. During dialysis the patient became critically ill. Given that we were responsible for that patient and our documentation shows we spent 35 minutes at the bedside, are we still not able to bill for that visit? Do we code it as a critical care service with the place of service as out-patient and is that OK?

A For observation patients, care given related to ESRD patients is considered covered under the MCP, as noted above. The gray area is related to other issues. For example, if the patient is critically ill because they have, as an example, pneumonia, and the physician appropriately documents that, the practice could bill for an E&M visit (if they are treating the pneumonia as in the example) or critical care time if the patient truly is critically ill. In a critical illness scenario, the likelihood is that the admission (assuming a transfer to the ICU) would change to a full inpatient admission even if the patient died during the episode. In that case the critical care time would be appropriate, as long as someone else (such as an intensivist) is not trying to bill for the same time. If the patient is not admitted as an inpatient, then the MCP codes would show up as conflicting with the critical care codes in the Correct Coding Initiative (CCI) screen, so they should not be used together since the CCI edits will stop them from paying anyway.

Q Does Medicare still pay for home dialysis training? I believe that the code for billing it is CPT code 90989 but I heard that as of January 1, 2019, they were no longer covering these services—can you advise me on the current status of this code?

A Medicare definitely still covers home dialysis training. The codes and descriptors for the two services (completed and incomplete course) are CPT code 90989—dialysis training, completed course, and CPT code 90993—dialysis training, course not completed (per session). For the completed course (which is considered to be 25 training sessions), the date of service must be the date that training was completed, the frequency (or days/units) must be reported as "1," and the service should not be billed until the course has been completed. The allowed dollar amount is a flat fee of $500, subject to deductible and co-insurance requirements.

CPT code 90993 should be used when the training course was not completed. The date(s) of service must be the date(s) each training session occurred, and the frequency in days or units must be the number of training sessions that occurred. Regarding reimbursement for incomplete home dialysis training, the Medicare allowable reimbursement amount is a prorated amount of the complete course amount, subject to deductible and co-insurance requirements. For example, given that the 25-session completed course (CPT 90989) flat fee is $500, the "per session" amount would be $20 ($500 divided by 25=$20). If 15 sessions were performed, the allowed dollar amount would be $300 ($20x15).

Medicare also reimburses for home dialysis retraining using CPT code 90993, but the instances of when this would be allowable would be rare. It should not be billed for ongoing services that would be considered part of the original training; for example, answering the patient's questions regarding the machine the patient has already been trained to use would not be an acceptable justification for billing retraining services. For reimbursement to even be considered, documentation must be submitted with the claim indicating the reason why retraining was necessary. Reasons that may be considered acceptable are: (1) a change in equipment (to a machine the patient was not previously trained to use); (2) a change in the type of dialysis (e.g., hemodialysis to peritoneal dialysis); or (3) a change in the setting or dialysis partner.

All of this information is explained in the Medicare claims manual at **https://www.cms.gov/Regulations-and-uidance/Guidance/Manuals/Downloads/clm104c08.pdf**.

Q I read in the September issue of *RPA News* that CMS will be allowing transitional care management codes to be billed on our practice's monthly dialysis patients. How will this work, and what about other care management services and kidney patients?

A Yes, in the 2020 proposed fee schedule rule released in July, CMS did propose 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). This was due to significant underutilization of these services and a likely recognition that TCM services would be beneficial to ESRD patients (and the Medicare program overall) in the context of reducing hospital readmissions. As for how it will work, it won't be officially determined until the final rule is released.

While the prohibition on billing TCM services on ESRD patients is proposed to be removed, it remains in place for the CCM codes (CPT codes 99487-99491). Thankfully, CMS had the wisdom to never apply the prohibition to the advance care planning (ACP) family of counseling services (CPT codes 99497-99498). All of these services can be provided to CKD patients not yet certified as having ESRD. ■

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.*

Do you have a coding question?

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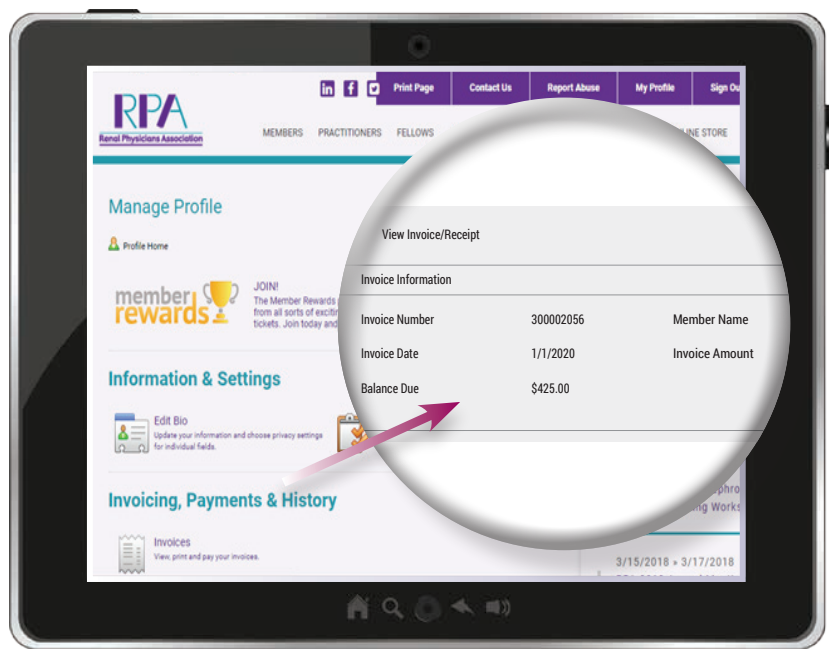

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