October 7, 2003

Thomas A. Scully, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 443-G
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-1476-P

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2004, Proposed Rule.

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to ensure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease.

We are writing to provide a final comment and an alternative proposal to the proposed changes to reimbursement methodology for end-stage-renal disease (ESRD) services. This document will provide (1) a review of the concerns stated in RPA's preliminary comment to CMS on the proposed rule, along with several additional concerns identified by our membership in the interim; and (2) an outline of our alternative proposal, with a discussion of why we believe that adopting our alternative proposal would lead to achievement of the goals noted by CMS in the proposed rule.

RPA continues to support the CMS goal of facilitating and optimizing nephrologist-dialysis patient interaction, and it is our full intent to work with the Agency toward that goal. However, we also believe that the proposal as currently constituted is unworkable, may negatively impact some dialysis patients, and is being put on an unreasonably precipitous implementation schedule.

RPA therefore urges CMS to work collaboratively with the nephrology community to formulate an alternative interim methodology for 2004, and then move forward to devise a subsequent, long-term version of the payment methodology that will benefit Medicare ESRD beneficiaries and the nephrology community upon implementation.

Concerns Raised by the Proposed Rule

As noted in our preliminary comments, RPA has the following concerns regarding the proposal outlined in the Notice of Proposed Rule-Making (NPRM):

- Lack of Geographic Exception – The rule does not provide for any geographic exception to the payment based on face-to-face encounters. This may negatively impact nephrologists and patients in both remote rural settings and those urban settings requiring significant "windshield" time for travel to the units. Patient de-selection (or "cherrypicking") could result if the nephrologist is forced to limit her or his patient load to those patients that she or he can be sure of seeing four times monthly.

- <u>Home Hemodialysis and Peritoneal Dialysis Not Addressed</u> – The proposal does not address how home hemodialysis and peritoneal dialysis, modalities that inherently have fewer face-to-face interactions between the patient and nephrologist, will be impacted. Such an omission is of particular concern in that historically HCFA and CMS have sought to create incentives for dialysis patients to receive treatments in the home setting, while the proposed reimbursement methodology would serve as a disincentive for this treatment setting.

- <u>Scheduling Conflicts Beyond the Nephrologists' Control Not Accounted For</u>– For example, nephrologists will be inequitably penalized in those circumstances where patients skip or reschedule dialysis treatments on short notice.

- <u>Disproportionate Payment Difference Between Four or Greater Visit Level and the Two-Three Visit Level</u> - As set forth in the rule, there appears to be an approximate 70% difference in payment for the code representing 4 or greater visits in a month and the 2-3 visits code, yet there is only a 14% difference between the 2-3 visit per month code and the 1 visit per month code. This creates an incentive for nephrologists to provide fewer visits, two rather than three and in some cases perhaps only one visit, if providing four visits in a month's time is not feasible.

- <u>Roles of Non-MCP Physicians or Non-Physician Health Professionals Not Addressed</u> – The rule does not provide guidance on whether non-MCP nephrologists or physician assistants, nurse practitioners, or advanced nurse clinicians can provide one or more of the 'face-to-face' encounters described in the proposal and have these encounters be counted as among the four face-to-face encounters necessary to receive reimbursement for the 4 or more visit level.

- <u>RVU Development Methodology Not Discussed</u> – The rule provides no discussion on how the relative value units (RVUs) for, in particular, the two lower visit codes were developed, nor why the CPT Editorial Panel and Relative Value Update Committee (RUC) processes were bypassed. Such a discussion would be pertinent in that there appears to be rank-order anomalies among the codes (all of the 'G' codes for single visit pediatric codes have more physician work and practice expense RVUs assigned to them than the 'G' codes for the 2-3 visit level for adults).

- <u>Regulatory Impact of Proposal on SGR and Conversion Factor Not Discussed</u> – The rule does not provide projections on how the proposal will impact the sustainable growth rate (SGR) and the conversion factor depending on the distribution of former MCP services among the proposed 'G' codes. If the 4 visits or greater code is disproportionately high, it is likely that the SGR (the target rate of growth) will be exceeded, resulting in a negative conversion factor and pay cut for all of medicine.

- <u>Lack of Clarity Regarding Hospitalization</u> – The rule notes that the 'G' codes will not be used if hospitalization occurs during the month—but the rule does not offer guidance on how to bill for services in this circumstance. While the presumptive default process would seemingly be use of the traditional MCP CPT codes (90918-90921), Addendum 'B' indicates that these codes have been placed into an 'inactive' status.

- Documentation Requirements Not Defined – The rule does not describe or otherwise address what constitutes a visit or what level of documentation is necessary to validate that a face-to-face encounter has occurred.

In the time period since RPA provided our preliminary comments to CMS in late August, we have identified the following additional areas of concern:

- Lack of HIPAA Compliance Due to Inconsistency Between Medicare Carriers and Commercial Payers –The rule does not address implementation of HIPAA transaction and code sets effective October 16, 2003, which mandate uniformity of codes sets being applied to Medicare and other payers. [Typically, commercial payers do not always recognize 'G' codes, and continue to reimburse providers according to AMA-established CPT codes]. It is likely that commercial payers who do not recognize the 'G' codes will reject claims for Medicare secondary billing. Similarly, services billed to commercial insurers as the primary payer may be rejected by Medicare carriers as the secondary payer due to this lack of uniformity.

- Lack of Clarity on ESRD Patient Visits in Other Outpatient Settings –The rule does not address the status of outpatient evaluation and management (E&M) services provided for ESRD patients in settings other than the dialysis facility (currently these services are captured within the MCP and are not separately billable).

- Treatment of Transient Patients Not Addressed –As with other atypical situations, the rule does not provide guidance on how nephrologists should resolve the issue of visits and related billing for traveling patients who will receive their treatment away from their usual site of treatment.

- Potential Impact on Non-E&M MCP Activities –The proposal does not sufficiently account for the potential impact on those services that are not associated with E&M services. Among the most important of these would be patient care coordination conferences, which involve no specific interaction with the patient but play a crucial role in effective management of the patient's renal condition.

RPA's Alternative Proposal

As noted in our preliminary comments, RPA fully supports efforts to optimize the number of face-to-face encounters between dialysis patients and the nephrologists providing their care. We also share CMS' concern regarding the small minority of nephrologists who see their dialysis patients on a less-than-monthly basis. However, RPA believes that rather than disrupt the entire ESRD/renal care delivery and reimbursement system in favor of a proposal that was not submitted for review through the established and well-accepted processes and is not supported by a majority of the renal community, it would be more appropriate to pursue an interim revision to the current system.

RPA's alternative proposal consists of four uncomplicated yet meaningful steps that will substantially address CMS's areas of concerns while maintaining the aspects of the MCP system that work effectively for the nation's ESRD patient population. **First, we urge CMS to table the proposal included in the fee schedule proposed rule.** Tabling the proposal would allow CMS, the renal community, and external affected parties to develop and evaluate a proposal that will address the legitimate concerns raised by the Agency without subjecting dialysis patients to

unknown and potentially unintended hazardous consequences. RPA appreciates CMS' desire to act decisively toward improving the care delivered to ESRD patients, carry out the Agency's fiduciary responsibilities, and address the issues outlined above. However, implementation of a proposal of this magnitude for a patient population as vulnerable as those with ESRD in the timeframe outlined (approximately 120 days) is simply too perilous a course to pursue, and we therefore urge a more deliberative approach.

Second, in consideration of the fact that a documentation requirement for provision of the services captured by the MCP currently does not exist, we support establishment of a simple documentation requirement in the final rule for the 2004 fee schedule. Accordingly, nephrologists would have to be able to submit simple straightforward documentation for the services rendered to those patients for whom the MCP is billed. It is our belief that such a requirement would serve as a powerful incentive to the small minority of nephrologists who currently see their MCP patients on a less than monthly basis to increase their face-to-face interactions to at least this level. At the same time, those nephrologists who are currently providing appropriate care and have effective working relationships with their patients will not have their practices disrupted by such a fundamental change in the system.

Third, RPA would support that more specific language be considered for those bulleted sections of the MCP scope of services document making reference to "periodic" visits and performance of "periodic" physical assessments. [The MCP scope of services can be found on pages 63155-63156 in the final rule on the 1996 Medicare Physician Fee Schedule, published in the *Federal Register* on December 8, 1995]. It is RPA's opinion that collaboratively defining the intervals for these services in a more precise manner will provide additional guidance to nephrologists providing the MCP services. Further, this revision will serve to emphasize the importance of nephrologists participating in face-to-face interactions with their dialysis patients, and raise the visibility of this component within the bundle of MCP activities.

Fourth and finally, RPA is committed to work with CMS to develop a more long-term solution that could be finalized in time to be promulgated in the proposed rule for the 2005 physician fee schedule. We reiterate our support of the CMS goal to increase nephrologist-dialysis patient interaction, and we also believe that a collaborative effort between CMS, the RPA, other renal organizations, and larger organizations such as the AMA and the American College of Physicians (ACP) would result in an alternative approach that would not only achieve CMS' objective but would also have the support of the renal community at large. Such 'buy-in' from the renal community will surely facilitate the success of any proposal of this nature.

RPA appreciates the opportunity to provide comments on the proposals affecting dialysis and the monthly capitated payment in the proposed rule for the 2004 Medicare physician fee schedule, and we stand ready to assist CMS in its future work in this area.

Please contact Robert Blaser, RPA's Director of Federal Affairs, at 202-261-4551, if you have any questions or concerns regarding this correspondence.

Sincerely,

James Weiss, M.D.
RPA President

CC: Tommy G. Thompson
Brady Augustine
Phil Surine