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Skating to Where the Puck is Going: 10 Strategic Insights for Nephrology Practices from CMS CY'25 Proposed Policy Changes

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9 August 2024

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Introduction

On July 10, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that announces and solicits public comments on proposed policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, effective on or after 1 January 2025.

The headline proposed rule change is the reduction of average rates under the Physician Fee Schedule, which has understandably caused concern across all specialties. However, a deeper analysis of the proposed policy changes reveals nuanced and significant developments that are particularly relevant to nephrologists and nephrology practices.

Given these developments, I have taken the time to analyze the proposed policy changes, the accompanying RFIs that CMS has released, and reflect on what these proposals could mean for nephrology practices—especially if these changes are enacted for 2025 after the comment period, which ends in September 2024. It is my hope that this white paper not only sparks conversations among nephrologists, practice owners, managers, and other stakeholders, but also increases engagement from nephrology providers during the comment period. As the great Canadian hockey player Wayne Gretzky once said, *"Skate to where the puck is going, not where it has been."* This paper aims to help nephrologists think about the future of their practices and identify the necessary transformations to position themselves for continued independence, improved patient care and outcomes, and maximized financial performance.

Without further ado, let's dive into the ten considerations nephrology practices should keep in mind regarding the proposed policy changes for CY2025 Medicare Physician Fee Schedule:

1. Reduction in Average Payment Rates by 2.93%

Proposed Policy Change:

CMS proposes a reduction in average payment rates under the PFS by 2.93% for CY 2025 compared to the average rates for most of CY 2024. This reduction is primarily due to the expiration of the temporary 2.93% increase for CY2024, resulting in a new proposed conversion factor of $32.36—a decrease of $0.93 from CY 2024.

Reflection/Discussion:

The downward trend in fee-for-service reimbursement rates has been anticipated for some time. This proposal, which affects all specialties, reaffirms that expectation. A confirmed rate reduction will likely have ripple effects on the net margins of practices, especially as staffing costs continue to rise due to the burnout epidemic and the dwindling supply of skilled staff. Practices that remain heavily reliant on fee-for-service revenues will be more adversely affected than those with a diversified mix of value-based contracts. Many experts view this proposal as a strategic push by CMS to encourage providers to transition towards value-based contracts, aligning with CMS's goal of enrolling 100% of its beneficiaries in value-based arrangements by 2030.

For nephrology practices, the key takeaway is the necessity to begin planning for reduced reliance on fee-for-service revenues by adopting value-based (risk-sharing) contracts. Additionally, there will be increased pressure to maximize performance on quality-based incentive programs such as MIPS, which I will discuss in further detail later in this paper.

2. Improving Ambulatory Specialty Care

Proposed Policy Change:

CMS is issuing a Request for Information (RFI) to solicit feedback on the design of a potential ambulatory specialty care model that would leverage the Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) to increase specialist engagement in value-based care and expand incentives for primary and specialty care coordination.

Reflection/Discussion:

This proposal highlights two core CMS priorities for the next few years: the push towards value-based care and enhancing coordination between primary care providers and specialists. Over the past six months, I have had numerous conversations with primary care providers about their advanced CKD patients and with nephrologists regarding their interactions with primary care providers. These discussions revealed a mirrored problem: nephrologists have noted a dramatic decrease in referrals from primary care providers, while many primary care providers, especially in FQHCs, struggle to have their CKD patients evaluated by nephrologists early enough.

The key takeaway for nephrology practices is to assess and improve their coordination with primary care providers, particularly in closing the referral loop. Technological tools (outside of your current EHR) may prove beneficial and utilizing care coordinators—whether in-house clinical staff or third-party care management providers—will likely be essential if participating in this proposed ambulatory specialty care model.

3. Telehealth Services

Proposed Policy Change:

CMS proposes allowing interactive telecommunications systems, including two-way, real-time audio-only communication technology, for telehealth services furnished to a beneficiary in their home when the physician is capable of using video technology, but the patient is not capable or does not consent to its use. Providers may also continue conducting these telehealth visits from their home, using their office address as the site of the visit in reimbursement claims.

Reflection/Discussion:

This proposal, which has broad implications across specialties, aims to increase the utilization of remote patient visits by allowing telephone calls to be billed as telehealth visits. This change is particularly significant for patients in rural areas who lack broadband connectivity or are uncomfortable with video technologies. Earlier this year, my organization engaged with an FQHC that faced challenges in increasing the proportion of CKD patients who had been evaluated by a nephrologist. Key obstacles included the distance between patients in rural areas and nephrology practices, limited transportation options, and lack of broadband connectivity. If this proposed change is implemented, it could transform the relationship between FQHCs and nephrology practices. For instance, nephrology practices could offer telephone consultation appointment slots for patients at rural health centers, providing a valuable service from the comfort of the physician's home office.

4. Dental & Oral Health Services

Proposed Policy Change:

CMS proposes adding two ESRD-specific scenarios to the list of clinical situations under which fee-for-service Medicare payment may be made for dental services:

- Dental or oral examination in the inpatient or outpatient setting prior to Medicare-covered dialysis services for beneficiaries with ESRD.
- Medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, dialysis for beneficiaries with ESRD.

Reflection/Discussion:

This proposed change is a welcome development. Nephrology practices can leverage this to enhance patient engagement as they approach ESRD. It will be essential for practices to support patients in coordinating dental care referrals and follow-up. Building relationships with trusted dental care providers and integrating dental care referrals into your kidney disease education program could also improve patient outcomes and participation in education programs, which currently have low uptake in many practices.

5. Care Coordination Services in RHCs & FQHCs

Proposed Policy Change:

CMS proposes several changes related to reporting Care Coordination services in Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs) to better align payment for these services with other entities furnishing similar care. Specifically, CMS proposes that Chronic Care Management (CCM), Transitional Care Management (TCM), General Behavioral Health Integration, and Psychiatric Collaborative Care Management be billed by reporting individual CPT & HCPCS codes rather than the single HCPCS code G0511.

Reflection/Discussion:

The implications of this proposed change for nephrology practices are not entirely clear at this point. However, it appears that CMS aims to clarify billing for Care Coordination services, which can only be billed by one practitioner per calendar month. For example, if a patient receives TCM from an FQHC and CCM from their nephrology practice within the same month, this change could enhance billing accuracy and claims reimbursement by clearly defining who provided each service. This could lead to increased provision of Care Coordination services and greater utilization of these reimbursement codes by specialists such as nephrologists.

6. Rural Health Clinics Conditions for Coverage

Proposed Policy Change:

CMS proposes to explicitly require that RHCs & FQHCs provide primary care services rather than being "primarily engaged" in furnishing these services, as indicated in sub-regulatory guidance. This would not prevent RHCs or FQHCs from providing specialty services but would clarify that they must provide primary care services.

Reflection/Discussion:

This proposal is crucial for nephrology practices currently certified as Rural Health Clinics. Under the new changes, practices that do not provide primary care services may lose their certification and the enhanced reimbursement rates that come with it. Affected practices should consider adding primary care services, either by directly hiring a PCP or through strategic partnerships. Depending on the final rule, there may be acceptable ways to offer primary care services via telehealth.

7. Modifications to MIPS Value Pathway (MVP)

Proposed Policy Change:

CMS proposes three additions to the quality measures in the Optimal Care for Kidney Health MVP:

- Ambulatory palliative care patient's experience of feeling heard & understood

- First Year Standardized Waitlist Ratio (FYSWR)
- Percentage of Prevalent Patients Waitlisted (PPPW) & Percentage of Prevalent Patients Waitlisted in Active Status (aPPW)

Reflection/Discussion:

This proposal underscores CMS's commitment to increasing kidney transplantation, in line with the Advancing American Kidney Health Initiative's ambitious targets. The proposed measures, particularly the First Year Standardized Waitlist, can be optimized by increasing kidney disease education adoption within your practice and developing a kidney transplant education protocol. These efforts can be enhanced by utilizing care coordinators who can engage with relevant patients and conduct frequent check-ins. The overall trend is clear: CMS is integrating elements from value-based care demonstration programs into fee-for-service models. Even practices not participating in value-based programs must begin building the capabilities necessary to succeed in capitated and risk-sharing contracts, regardless of their preference to remain in fee-for-service.

8. Addition of Episode Cost Measures in MIPS

Proposed Policy Change:

CMS proposes adding six new episode-based cost measures (one acute inpatient and five chronic condition measures) to the 29 existing cost measures at the group and clinician level, with a 20-episode case minimum. Three of the six proposed additions are kidney-related:

- Chronic Kidney Disease
- End-Stage Renal Disease
- Kidney Transplant Management

Reflection/Discussion:

This proposed addition of episode cost measures reinforces previous points about kidney disease being a focal point in CMS's CY2025 proposals. Strategies for optimizing performance on these new measures (if added) will become clearer as more information is released about cost calculation at the group and physician level. However, it is reasonable to assume that a key target of this proposal is optimal dialysis starts.

Developing a holistic plan for improving the proportion of optimal starts among your patient population, at both individual clinician and group levels, is imperative. Depending on the financial implications of the new episode cost measures, there may be a strong business case for investing in remote physiologic monitoring and elevated care coordination for high-risk patients to achieve higher rates of optimal dialysis starts.

9. Advanced Primary Care Management

Proposed Policy Change:

CMS proposes to establish coding and make payments under the PFS for a new set of Advanced Primary Care Management (APCM) services, described by three new HCPCS G-codes. The proposed APCM services would incorporate elements of several existing care management and communication technology-based services into a bundle that reflects the essential elements of advanced primary care delivery, including Principal Care Management (PCM), Transitional Care Management (TCM), and Chronic Care Management (CCM). The new APCM codes would be stratified into three levels based on the number of chronic conditions and Qualified Medicare Beneficiary (QMB) enrollment, reflecting both patient medical and social complexity.

The new G-codes and corresponding proposed monthly rates are:

- GPCM1: $10 per month for patients with one or more chronic conditions
- GPCM2: $50 per month for patients with two or more chronic conditions
- GPCM3: $110 per month for dual-eligible patients with two or more chronic conditions

CMS proposes that, beginning January 1, 2025, physicians and non-physician practitioners (NPPs) who use an advanced primary care model of care delivery could bill for APCM services when they are the continuing focal point for all needed health care services and responsible for all the patient's primary care services.

Reflection/Discussion:

A major caveat to this proposal is that it is unclear whether non-PCPs, like nephrologists who manage a significant portion of their patients' overall health, will be able to claim APCM services. Assuming this will extend to nephrologists, this proposed change could revolutionize the implementation of care coordination services within your practice. The

fixed monthly rate, as opposed to current CCM reimbursement tied to specific minutes spent per patient, could enable you to adopt a proper population health management approach, improving patient outcomes and optimizing revenues.

For instance, if you have 500 patients who qualify for GPCM2 ($50 per month), this could translate to an additional $300,000 per year in revenue for your practice. This potential revenue stream could be used to build a comprehensive care management program in-house or outsourced to a vendor who can provide care management services on your behalf for a share of the revenues. Additionally, the fixed fee structure (akin to capitation payments) could allow you to utilize generative AI tools in your care coordination program, improving patient engagement and adherence to therapy and lifestyle recommendations.

It is advisable to stay informed about these proposed changes and assess whether your practice qualifies and can benefit from the available financial rewards. CMS expects the utilization of these proposed new codes to be low (CMS is expecting this to be billed for only 0.5% of Medicare beneficiaries according to reports), which aligns with the low utilization rates of CCM, RPM, etc. This observation is consistent with our findings from speaking to providers across the country—there is a remarkable lack of knowledge and understanding about such opportunities for enhanced patient care and financial performance.

10. Advance (Pre-paid Shared Savings) Payments to ACOs

Proposed Policy Change:

CMS proposes establishing a new "prepaid shared savings" option for eligible Accountable Care Organizations (ACOs) with a history of earning shared savings. Eligible ACOs that apply and are approved to receive prepaid shared savings would receive advances of earned shared savings, which they can use to make investments that benefit beneficiaries, including those in underserved communities. These investments could include direct beneficiary services and investments to improve care coordination and quality through staffing or healthcare infrastructure.

Eligible ACOs include those participating in Levels C-E of the BASIC track or the ENHANCED track with consistent prior success in earning shared savings in the Shared

Savings Program. These ACOs would be eligible for quarterly payments to invest in staffing, healthcare infrastructure, and additional services for beneficiaries.

At least 50% of prepaid shared savings would be required to be spent on direct beneficiary services not otherwise payable in Traditional Medicare but expected to improve or maintain the health or overall function of the beneficiary. Examples include meals, transportation, dental, vision, hearing, and Part B cost-sharing reductions. Up to 50% of the prepaid shared savings can be spent on staffing and healthcare infrastructure.

Reflection/Discussion:

This proposal builds on the Advance Investment Payments—upfront $250,000 payments that CMS offered to ACOs in 2024 at the beginning of the performance year to support and incentivize participation in the Medicare Shared Savings Program. The new proposal entails ongoing quarterly advanced payments, 50% of which can be used for direct beneficiary services (e.g., meals and transportation), and the remainder for infrastructure (e.g., technology) and staffing (e.g., care coordination).

While this update may not directly apply to many readers, it offers insight into CMS's evolving thinking about shared savings programs. Many nephrology practice owners have expressed dissatisfaction with partnership agreements they have signed with various ACO enablers, with a growing determination to execute shared savings programs independently, without sacrificing independence and financial rewards. If this phenomenon of advanced investment payments and prepaid shared savings expands to CKD programs in the future, it could support nephrology practices seeking to participate independently, reducing reliance on ACO enablers. These prepayments could represent new cash flow opportunities, enabling necessary infrastructure and staffing investments to maximize savings and financial performance.

In the meantime, nephrology practices might be able to capitalize on this trend within a fee-for-service context. At my organization, we offer third-party care management services to nephrology practices, enabling them to utilize CCM, PCM, and RPM reimbursement codes. About nine in ten practices report either not using these codes or underutilizing them. The key obstacles relate to care coordination staffing and technology infrastructure to provide the services adequately. To address this, we are trialling offering upfront payments to nephrology practices partnering with us to optimize their care coordination services. These upfront payments made to practices are based on the estimated annual revenues the practice could derive if we successfully optimize their care

coordination service delivery over 12 months. We believe this offering will benefit practices' bottom lines, increase their engagement in care coordination, and most importantly, improve patient outcomes. If you are interested in partnering with us, please contact me to learn more about the trial program. For practices who already have an ongoing relationship with a third-party care management service organization, you can consider tabling this idea to your partners during your next round of negotiations. CMS is setting the precedent and there is a high likelihood that well-capitalized private companies will follow their lead if there is significant demand from practices.

Conclusion

The proposed CMS policy changes for CY2025 present a critical juncture for nephrology practices. While some changes may be challenging, they also offer opportunities to reimagine and enhance care delivery, patient outcomes, and financial performance. By carefully considering and preparing for these changes, nephrology practices can position themselves for continued success in a rapidly evolving healthcare landscape.

To conclude, here is an excerpt from an insightful article on the proposed policy changes, by Townhall Ventures' Andy Slavitz and Andie Steinberg:

> *"In fact, physician practices serious about providing better care at a lower cost to Medicare patients have a meaningful opportunity with the recent release of the CY 2025 Medicare Physician Fee Schedule proposed rule: additional payments from Centers for Medicare and Medicaid Services (CMS) for taking better care of traditional (non-MA) Medicare patients. In fact, depending on the acuity mix of patients in a practice, a physician practice's revenue can increase by as much as 5%, with much of that flowing to the bottom line. In the case of a physician practice with a large panel who sees a mix of dual eligible and chronic Medicare patients, this could drive hundreds of thousands of additional dollars. For value-based physicians who anticipate a reduction in Medicare Advantage reimbursement from payers, this is a welcome relief.*
>
> *Putting the math aside, we believe it is crucial to pay attention to the signals behind this policy. Based on our analysis and conversations with leaders at CMS, we see this as a significant step towards mainstreaming value-based*

care, a concept that was the exclusive province of providers who participated in special innovation programs…until now. While traditional Medicare has previously incorporated value-based care potential through models like the Medicare Shared Savings Program (MSSP) and Accountable Care Organizations (ACOs), these changes integrate these principles more deeply and broadly into traditional fee-for-service (FFS) settings. Physicians should no longer need to see their Medicare Advantage and traditional Medicare patients as being part of two entirely different models with varied objectives and incentives. Instead, these changes encourage the integration of and investment in population health, prevention, early intervention, and care coordination across an entire practice. Moreover, implementation should be relatively manageable for providers already practiced in providing high-value care."

The key takeaway is that every nephrology practice needs to have a clear strategy for how they intend to provide adequate care coordination to their entire population – regardless of the traditional Medicare or Medicare Advantage split. Building such a competency – either internally or through partnerships – will be key to thriving in the fast-evolving world of reimbursement policies. The proliferation of generative artificial intelligence tools and new payment mechanisms (such as the APCM mechanism and advanced quarterly shared savings payments) makes building your practice whilst maintaining your independence a more feasible undertaking. The practices who recognize and act on these subtle but significant inflections will be the winners in the coming years.

About the Author

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