MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Wednesday, January 14, 2004
10:19 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Public comment

MR. HAKIM: Mr. Chairman, my name is Ray Hakim. I'm a nephrologist and also the Chief Medical Officer for Renal Care Group, a dialysis provider. My comments relate to the dialysis provision.

We very much appreciate the Commission's and the staff's noting that we have improved outcomes in certain areas, as Dr. Rowe has mentioned. They are specifically in the dialysis program and not in the ESRD program. But we appreciate that mention.

What perhaps may be important for the Commissioners to realize is that this program has a mortality rate of 25 percent. When I walk into the dialysis unit, and when Jack Rowe was a famous nephrologist, gainfully employed as a nephrologist, every time I walk into the dialysis unit I know that a year from now 25 percent of the patients will not be there. And the issues related to that have been touched on by a number of factors.

Clearly, it's not only high, it's higher than breast cancer, colon cancer. And more importantly, the mortality rate for the dialysis program in the United States is much higher, between 50 and 100 percent higher than it is in other industrialized countries.

So we have to ask ourselves what it is that we here are doing or not doing. I agree with you that attention to nutrition, attention to access factors, and hopefully pre-ESRD, are issues that the Commissioners will focus on.

But to think that this is going to be happening in a budget neutral is illusory, because the presentation by the staff that Medicare provider or Medicare patients have a 2.7 percent margin is simply not sustainable in our opinion. And we have presented data to the staff about that.

The 2.7 percent margin has a 4 percent audit factor established in 1996 and is nowhere representative of the audits that we believe is important. I will stand here next to you and apologize to the staff if there is anywhere near 1 percent audit factor, let alone 4 percent. That's one issue.

The other issue is that this 2.7 percent is based on cost reports that have limitations that have not been addressed by the staff despite our recommendations and suggestions to them. It has limitations established in 1983 for medical director fees, for administrative fees that simply are not reflective of the true costs.

Third, there is also an implication that we can improve efficiency and productivity. I will tell you that there is probably a way in which we can improve productivity. Right now we have one nurse for 12 patients. I suspect back in the office somebody is calculating already can we do it one nurse for 15 patients. We have one dietitian for 100 patients. Somebody is going to figured out maybe we can do one dietitian for 125, 150 patients. So who's going to suffer in that? It's the patients that are entrusted to our care.

I would urge the Commission to really ask the staff to focus on the audit factors, on this productivity issue, and the true cost of providing care because -- and I'm glad Dr. Rowe is back here -- we are, and we have shown data, we are losing money on every time we dialyze a Medicare patients when we include drugs and everything else. And we have shown that data to the MedPAC staff.

So I would urge the Commissioners to really again challenged the staff to come up with a true audit factor, a true efficiency factor, and a true cost report factor.

Thank you.

MR. CHIANCHIANO: I'm Dolph Chianchiano with the National Kidney Foundation.

I wanted to respond to Sheila Burke's question about home dialysis patients and indicate that there have been dramatic increases in quality indicators for PD patients. We'd like to think that has to do somewhat with the National Kidney Foundation practice guidelines. From 1999 to 2002 there was an increase in the percent of patients meeting the National Kidney Foundation guidelines for weekly adequacy for dialysis. For CAPD patients it increased from 55 percent to 68 percent and there are similar patterns for cycler patients.

I also wanted to address some of the comments from Dr. Rowe about managed care plans and dialysis patients and I wanted to explain why dialysis patients, ESRD patients, remain skeptical about managed care. One of the recent developments which I would like to bring to your attention has to do with changes in copayments that managed care plans have imposed. there was one managed care plan that attempted to establish a $50 per dialysis treatment copayment a couple of years ago. That would mean $150 a week out-of-pocket for a dialysis patient which would be impossible for most dialysis patients.

The other concern is also financial, and that is if a dialysis patient decides that they no longer want to participate in a managed care plan, they will not be able to get Medigap insurance to assist them in their payment for their costs.

And then finally, with respect to the demonstration project that Nancy referenced, take a good look at the patient profile of those patients. And also, I might note that one of the two plans that participated was Kaiser and, which of course has a staff model and it might not be applicable to the care of end-stage renal disease patients in other managed care plans.

Thank you.

MS. ZUMWALT: My name is LeeAnn Zumwalt. I'm with DaVita, a national dialysis provider.

I wanted to be brief and support the comments of Ray Hakim as to our economics. I wanted to directly answer Dr. Rowe's question. The private sector does, in fact, supplement and support the Medicare program.

On the access to care issues, we have provided data to Nancy and to Mark Miller that says yes, in fact, we are growing. But the data says where the growth is is where the private patients are. We are not growing in areas where Medicare is expanding and we're not introducing new capital into areas that are predominantly Medicare/Medicaid patient-oriented areas.

Thank you.

MR. JOHNSON: Good afternoon, Seth Johnson with the American Association for Home Care. Appreciate the ability to provide comments prior to the Commission voting on recommending payment changes to the home health benefit later this afternoon.

We urge the Commission to further study the impact of the changes that have been occurring both legislatively and regulatory-wise since the 2002 data that is now widely available has been released.

We know that there's been some suggestions today about the reliability of the data that is currently available and we believe certainly that is the case for the home health data that the Commission and the industry and other government entities have been looking at.

The industry did look at the profitability of the Medicare home health benefit and it showed a profitability of just over 5 percent based on 2002 cost report information. The CMS home health market update, looking at the profitability of the publicly traded companies showed a 2.3 percent profit margin for the home health industry.

We do know, based on the Commission's staff, that over 1 million Medicare home health

beneficiaries are no longer receiving care that were receiving care and that substitution is occurring. There's a lot of changes that are occurring within the home health benefit and the industry doesn't have all of the answers, and I don't think anybody has all of the answers as to what is truly occurring due to the issues surrounding the availability of data that's reliable and taking into account all the legislative and regulatory changes that have been occurring.

We urge the Commission to not make any additional changes to the Medicare home health reimbursement prior to doing a complete and thorough analysis of reliable cost report information.

Thank you.

MR. AUGUSTINE: My name is Brady Augustine and I work as a senior advisor for the Administrator at CMS. I'm also the senior person at the Agency for ESRD.

Dr. Rowe, I want to thank you for your comments. I think the program has gotten away from its intended purpose from 1973, and we're trying to bring it back. We've taken a lot of activities, one example given today is the disease management demonstration project. Another one is in the recent statute, it takes away the incentive to overutilize the separately billable drugs.

So we want to take a more holistic approach to care. A lot of the quality activities that are underway presently in the dialysis industry are those for which profit margins could be increased; i.e., anemia with the use of Epogen. So we're trying to take away that incentive to overutilize separately billables.

As well, we have also -- one of the reasons why there hasn't been really good coordination in holistic care for these patients is because all the payment systems are not aligned. For instance, as you referred to earlier, Dr. Rowe, the MCP -- and being an old managed care person, any time you come up with a capitation system where there are no accountability requirements, it is potentially going to be abused. Between the OIG and the GAO reports that we've received, and also patient input into the Agency, the Agency decided to make a change in the MCP and to require physicians at least for in-center patients to see their patients and provide a comprehensive assessment monthly in order to get paid by the Agency.

So we're trying to get physicians involved. We're trying to get facilities more involved. We have this core court dataset initiative where I will admit the industry has been quite helpful with the Agency in submitting data to us on 100 percent of their patients. As opposed to right now we just get a 5 percent sample for the clinical performance measures project.

So we're looking to expand the data that we get. We of course, are interested in outcomes-based reimbursement for this program. And it doesn't necessarily have to be before the fact. It could be after the fact, depending on the evidence. For example, with vascular access, there's such strong evidence that proper vascular access care will lead to reduced hospitalizations that depending on the evidence and how we look at it, I would not have a problem paying above what they're currently getting as long as we have the evidence to show that we know there will be reduced hospitalizations and will pay for itself.

So there are a lot of ideas bouncing around the Agency. We're very interested in outcomes reimbursement and getting everyone's payment system aligned so that physicians and facilities are all working toward the goal, which is patient-centered care.

Thank you.