MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 4, 2003
10:13 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
NANCY-ANN DePARLE
DAVID F. DURENBERGER
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

MS. GAMBEL: Gwen Gambel, President of Congressional Consultants. We represent a number of dialysis-related clients.

I think this was the very best discussion I've seen and I've been watching these meetings since ProPAC began. Your level of knowledge has really increased and the questions asked of Nancy, and the overall discussion, I think has really improved. That was just a quick aside.

Getting to the points. We really would urge you to use the CMS market basket rather than this jerry-rigged one that was put together by ProPAC so long ago when there was so much less data. The market basket that CMS put together was put together by the same actuaries that put together every single market basket, hospital, et cetera, since CMS created market baskets or HCFA created market baskets.

It has more input factors to it. It has better proxies. And it really is such a better reflection. I can't even understand why you would want to continue to use one that was so jerry-rigged with one-third home health, one-third SNF, one-third hospitals, the labor factors projections when labor is 40 or 50 percent of costs. So we really hope that you will seriously consider using that.

Secondly, I think the industry would be willing to consider -- and I say consider -- being paid on quality incentives but clearly not on a budget neutral basis. And that's because we are absolutely inadequately paid. As Dr. Rowe pointed out, we haven't had an update in 13 years. Our first update will come in 2005, a measly 1.6 percent, which is a little over $1 per treatment. We're not talking big bucks here when we're talking about these increases here.

We are really very, very disappointed about this continued effort to have a productivity offset. As a conditions of coverage we have nutritionists, a dietitian, social worker, and this is wonderful. These are important people in facilities. They are absolutely stretched to the limit. You never find a dialysis facility with more than one social worker or one nutritionist. These are so important for patient outcomes.

Nutritionists sit down with every patient every month and goes over their blood lab results and this is the way to educate the patient so that they will be more compliant and you will have better outcomes. And these people are just stretched to the limit. So this is really very bad for patient outcomes if you keep saying that there's this room for productivity offsets.

The same with the social workers. The social workers have to make sure that the patients get their meds, they have to make sure that there's transportation for these patients so they don't miss their treatments. These are such critical people for patient outcomes. And yet, we only have one of them in each facility because of this inadequate reimbursement. So please think about these productivity offsets.

And then we are really the only provider without an annual update formula? And where's the justification for that? I mean, would you think about hospitals not having an annual update formula as part of their reimbursement? Clearly not.

But we have to compete with these hospitals for our nurses and for our technicians. We have provided Nancy Ray with around the country where dialysis facilities versus hospitals on what is paid and bonuses. Clearly, hospitals can pay on average $5 to $10 more an hour for a nurse. That's a no-brainer where the nurses are going and why we have shortages and why the GAO highlighted the fact that we have nurse shortages.

So we would urge you, please think about an annual uptake recommendation in your recommendations this year, because there's really no justification for us being the only provider without an annual update formula.

Lastly, when we get to the adequacy of the payment, we have provided on the table for you 2002 cost report data which unfortunately Nancy did not get from CMS. We had 70 percent of dialysis providers with their cost reports providing 2002 data to Abt Associates. When Abt Associates took that cost report data, they projected that based on 2002 cost reports, our margins are 0.70 and our payment-to-cost ratio of 1.003. This is total costs, composite and drugs, on just the allowables. When we start looking into some of the non-allowables, like full medical director fees, we're below zero everywhere, margins as well as payment-to-cost ratios.

So we're hoping, we see you're thinking about just a 1.6 recommendation for 2005. Our projections show really a 3.6 percent increase is needed. And again, it's in the handouts. And I urge you to pick up the handout so that you can go over those numbers.

Thank you very much.

MS. SMITH: Good afternoon, my name is Kathleen Smith and I'm the Vice President of Government Affairs with Frizentius Medical Care. We're the largest supplier of items and services to beneficiaries with end-stage renal disease.

I once was the President of the Fast Talkers of America, Dr. Hackbarth, but I think your Commissioner, Dr. Wakefield, has got me beat. But I think I can still manage to be brief.

We have followed with interest over the recent years and

provided information with regard to end-stage renal disease payment reform. And given the Commission's history on that subject, and the fact that the recently passed Medicare legislation does advance that process, I would like to urge the Commission to make a third recommendation in your report this March addressing that topic.

Specifically, we urge the Commission to affirm its recommendations to Congress that the need for accuracy and transparency in rate setting in any new payment mechanisms and to recommend that CMS reevaluate the difference between and the relationship between current treatment costs and payments. Specifically including the validity of outdated cost report rules which result in the arbitrary disallowance of certain truly necessary treatment-related costs.

As part of any serious reform effort it is important that the baseline composite rate be revised to reflect the full cost that we incur in furnishing dialysis services. And further, that the rate be updated annually, using a mechanism similar to the one that CMS just recently developed as Ms. Gambel just commented comment on.

There is a precedent for taking this type of position in payment reform and many of you lived through this and remember it, but just by way of recollecting, when the hospital PPS was implemented, hospitals were subject to certain TEFRA-related cost limits. Those limits were removed, however, in calculation of the PPS base rates. And what I'm here to ask for is that something akin to that be part of the ESRD payment reform mechanism.

I thank you for the opportunity to make these comments.

MR. CINCHANO: Good afternoon. I'm Dolph Cinchano, Vice President of the National Kidney Foundation.

As has been mentioned in Nancy's remarks and remarks around the table, the National Kidney Foundation Guideline Development Program is emblematic of our concern for improving the parameters of care, not only in adequacy of dialysis and anemia management, but also with respect to nutrition, vascular access placement and preservation, and in the area of bone disease.

I'd like to point out however that the performance of dialysis facilities is not the only factor with regard to outcomes in those three particular areas. With respect to nutritional status of dialysis patients, the compliance with dietary restrictions is only part of the issue. The other half of the concern has to do with malnutrition, which is a severe problem among dialysis patients and is implicated in the hospitalization patterns of dialysis patients.

Dialysis facilities have limited ability to impact on malnutrition. Medicare does not pay for most dietary

supplements and the Medicare policy for the most extreme form of dietary supplementation, nutrition that is provided during dialysis treatments is so restrictive that virtually no patients qualify for it.

Similarly, the vascular access placement decisions are made and should be made before the patient comes within the care of a dialysis clinic. The National Kidney Foundation Guidelines call for an increase in fistulas, that is native vascular access, a decrease in grafts, and a decrease in the use of catheters for vascular access.

Interestingly enough, Medicare payment, however, provides an incentive for the use of graphs as opposed to fistulas. So this is an area that perhaps the Commission could address with respect to Medicare payment for vascular access placement.

Finally, with respect to comments from Senator Durenberger, the National Kidney Foundation and its 26,000 patient members are dedicated to empowering patients. But one way to empower them is to provide them with additional education opportunities. So we have been championing a provision to create a new Medicare benefit to educate kidney patients about their treatment options and their role in the treatment process, and to do this education before they ever come within a dialysis clinic.

There was a provision in S.1 which would've created that benefit. It did not survive the conference, however, so we will continue to advocate for that new benefit.

And then lastly, with respect to whether or not ESRD patients should be able to enroll in managed care plans, we have traditionally opposed repeal of Section 1876 and, in view of the fact that that we have yet another demonstration project that CMS is sponsoring which could shed light on the value of disease management and managed care for dialysis patients, I would recommend that legislative change be held in abeyance until we see the outcomes of that study.

Thank you.

MS. COWAN: Hello. Never wanting to stand between hard-working people and a meal, I'll be very brief.

I'm Joyce Cowan from Epstein, Becker and Green, and I represent Amsurg. So shift gears for a minute and think about ambulatory surgery centers, which will be on your plate tomorrow.

We've provided comments to the Commission in the past and really appreciate the opportunity to do so today.

Amsurg is a large national company operating and managing ASCs, over 110 in 28 states. So we think we'll have a lot of experience that will be helpful as the Commission goes forward in continuing to look at this important area. I'm sure you'll be thoroughly briefed tomorrow on the changes that Congress has

made in this area since your last set of recommendations last year. And I think it brings a really exciting opportunity for MedPAC to dig in and look at some of the complex issues with ambulatory surgery centers.

In short, the Congress did three things, basically. They more or less froze payment for the five years. Two, they asked the GAO, if you recall from last year's discussion, we've had a real shortage of data, direct hard data, on ambulatory surgery centers charges, costs, how they compare to hospitals, et cetera, et cetera.

So GAO will be looking directly at that and a number of other issues with an end result game plan of Congress giving HHS the authority to revise completely the current payment system for ambulatory surgery centers, that roll-out to be expected after the GAO report, somewhere between '06 and '08.

So what we would urge the Commission to think about, to help Congress plan to help HHS plan for that '06 to '08 roll-out. There are a lot of really complicated questions in this area. What do we know about ASCs, how large does Medicare payment policy, how large is that role affecting ASC growth, practices, et cetera? Why are private payers big fans of ASCs in many instances? A lot of really intriguing questions that end up affecting, I think, Medicare payment policy.

At Amsurg, with over 110 centers, we'd love to be able to provide whatever experience. We've offered up some of our local sites to staff to come out and visit and get your hands around what's going on in ASCs.

I want to let you get to lunch, so I really appreciate the opportunity to give some comments.

MR. HACKBARTH: We will reconvene at 1:30.