

CDC Report

Friday, November 19, 2004

Oakland, California

Legislative Report: Michael Arnold presented the following up-date from Sacramento:

The election results were a mixed outcome for the Governor. He was unsuccessful in his efforts to replace the incumbent Democrats he wanted removed but was successful in most of the initiatives he supported. The Assembly now has 48 Democrats and 32 Republicans, the Senate has 25 Democrats and 15 Republicans.

Elizabeth Hill, legislative analyst, told the legislators earlier this week that the state will carry over a \$7 billion deficit into next year. The Governor will not support tax increases so the budget deficit will have to be managed with spending cuts. This is a structural deficit that will continue to increase as it is revenue related. It has been dealt with superficially by the use of temporary measures that will not work in the long term. The Governor has three strategies that are of interest to the renal community.

- The California Performance Review (CPR) effort with recommendations to save \$32 billion over the next ten years. Most of the CPR provisions will likely not make it through the legislature.
- Medi-Cal redesign. It is unclear what will be included in the redesign at this time. It is expected that the January budget will include some of the provisions. Michael Arnold stated that the Aged, Blind and Disabled (ABD) population will likely be moved into Medi-Cal managed care. Michael further stated that we should lobby to assure that dialysis patients are carved out of this requirement.
- Refinance proposal for hospitals. Under the Certified Public Expenditures (CPE) program, counties are responsible for the provision of healthcare for indigent patients as a last resort. Counties are reeling under the cost of indigent patients. The refinance proposal would allow California to pull in more federal money (possibly \$1-2 billion). CMS is not buying into the plan at this time. If the refinance money does not come through, the ESRD community will be back in the "line of fire" for Medi-Cal reimbursement cuts.
- A sample letter to legislators was included in the packet of information that all attendees received. Michael Arnold recommended that facilities have legislators visit prior to the first of the year. These visits are important in terms of the strength of our position in lobbying to protect our patients.
- Peter Crooks stated that his experience is that patients in Managed Care Organizations (MCO) have better outcomes than in fee for service. He feels that CDC should not necessarily try to have our patients excluded from Medi-Cal managed care. Michael Arnold stated that there are different models of Medi-Cal managed care. Tom Paukert responded that he has had a positive experience with a particular provider of managed care through Medi-Cal with regard to his patients. He stated that private insurance companies should be discouraged from entering the managed care arena. Jan Anderson stated that Kaiser Permanente is a provider as well as a payor and that patient outcomes are much better in this arena than they are in a payor-only arena. Managed care versus managed cost. Peter Crooks stated that perhaps we should define managed care, or work to ensure that our patients under Medi-Cal managed care programs be handled only by a program that includes disease management. Jan Anderson responded that she is concerned that under the current budget constraints, the special case management issue will not occur and it might still be better to try to exempt our patients from managed care under Medi-Cal. Kelly Wright suggested that we work to have ESRD patients carved out of Medi-Cal managed care for 2-3 years until Medicare decides how to handle our dual-eligible patients. Karen Dyer suggested that the CDC Board convene a sub-committee, including Peter Crooks and Tom Paukert, and we can work to develop a long-term position on this issue. Jan Anderson stated that 3 years would be a good period of time for deferral because when the full Medicare drug benefit becomes effective, it will cost more than is anticipated and will ultimately cost the state Medicaid agencies more as well.
- Michael also included a memo from attorney Brad Tully with Hooper, Lundy and Bookman, Inc. Mr. Tully identified a new OIG Advisory Opinion (04-16) that will soon be released on the topic of laboratory processors in ESRD facilities. The advisory will state that arrangements involving the provisions of specimen processors to ESRD facilities without charge present an unacceptable level of risk under the Medicare anti-kickback statute. Michael Arnold recommended that facilities have their own attorneys review the issue.

Regulatory Report: Karen Dyer reported that subsequent to the last Oakland meeting, at which two Contra Costa county surveyors told the Board that the state no longer licenses free-standing home dialysis training facilities, there have been issues with the Los Angeles county health department. Two free-standing P.D. facilities in L.A. county which were recently surveyed were told that they were still being licensed. With the assistance of Michael Arnold, Eric Stone of L.A. county is now aware of the new licensure status. It is possible that this issue might continue to arise in other county health department offices and we will have to deal with individual issues as they arise.

NRAA Report: Cindy LaMunyon submitted the following report for the Board.

NRAA has spent a lot of time recently trying to understand the implications of the Medicare Modernization Act (MMA) and how it will be operationalized. There is a “calculator” in the members only section of the NRAA web site to assist providers in assessing the prepayment reimbursement under MMA for each patient. Reimbursement will differ by patient based on parameters such as height, weight, age, etc.

Sue Vogel stated that Kidney Care Partners (KCP) has held recent conference calls regarding MMA. KCP is sending letters with comments and is encouraging their membership to do the same.

Cindy also reported that NRAA heard this week that the new Conditions for Coverage have been sent back to the Office for Management and Budget (OMB).

Network Report: Lynn Field-Edinger reported for Network #17. She stated that the Network conducted Cannulation Camp in October with 167 attendees. The Modesto- Fresno area will be targeted next with camp in March, 2005.

Arlene Sukolsky sent the following statement to the CDC Board with Lynn. *CMS recently required the Network to terminate its training program for working with the nonconforming patient, and to notify facilities that some of the training materials were “not authorized” and therefore should not be used.*

It is the opinion of CMS that many of both new and old materials, including model forms, were developed by using CMS funds, but were never submitted to CMS for approval. In the governmental mind, this is interpreted as portraying our forms and models as official CMS policy. Therefore, their definition of “unauthorized.”

Part of the Network plan is to remove its name and/or logo from some of our long-standing forms, and present them as suggestions to the facilities. We are in the process of reviewing all forms.

CMS has asked us to desist from training, and we are waiting for details from them as to the extent of this directive.

Carol DiRaimondo, Medical Review Board chair for Network #17, stated that there were Board meetings yesterday. The Board of Directors for the Network (Jimmy Roberts, MD, Carol DiRaimondo, MD and Arlene Sukolsky) spoke with CMS by conference call. There are many changes in CMS. Carol stated that the Medical Review Board, the Board of Directors and Arlene are still committed to working with challenging patients while recognizing the rights of beneficiaries.

Medicare/ Medi-Cal Report: Cindy LaMunyon reported as follows.

Dr. Barry Straube will be speaking on MMA in the afternoon session of this meeting but Cindy shared some bullet points regarding MMA.

The final rule was published on November 6

There will be a 1.6% composite rate increase effective January 1, 2005

The top 10 reimbursable drugs will be covered at the average acquisition cost (AAC), the remainder will be covered at the average selling price (ASP) plus 6% (there will be a 2 quarter lag in the calculation of the “average”).

A fifty cent administration fee may be charged for the administration of Epogen (A4657)

There will be an 8.7% drug add-on to the composite rate

The case-mix adjustment will be effective April, 2005 and gender and disease were eliminated from the calculation. Age, body mass index (BMI) and body surface area (BSA) will be used for the case mix adjustment.

At this time, we are unsure how MMA will affect the state Medicaid agencies. Cindy suggests that CDC post an example of reimbursement on the web site.

There will be an alternative for pediatric facilities, they may elect to either accept a 162% composite rate or take an exception but not both.

The home training exception will remain

Effective 4-1-05 treatment rates will be reimbursed at 0.9116 of composite rate.

Cindy shared her concern about NHIC, the Medicare part A carrier, and how they will operationalize MMA. She stated that we may have to watch the fiscal intermediaries and carriers to be sure the correct amount is being paid.

Sheryle Paukert stated that she has an Access database that was developed by her computer consultant that will calculate reimbursement after the patient's height is input. She feels certain that her consultant would be willing to sell the program if anyone has an interest. Her e-mail address is: nvcd@sbcgolbal.net. The HMA-PM has fallen out of sight and some feel that with MMA it may go away.

Medi-Cal Report - Dr. Farber has completed a draft EPO policy and the CDC Board has requested the opportunity to review it. Kelly Wright stated that the draft policy refocus is on a 3-month rolling hematocrit average of 39. She suggested adding an adjudication process that would address hematocrit levels of greater than 39 in which providers could proactively indicate that the EPO dose was reduced or held or that the rolling average would not be greater than 39. Kelly also stated that we have now lost Dr. Farber's attention and need to get it back. She suggested perhaps an in-person visit and also a letter to his supervisor complimenting him on the hard work he has put into the draft policy. Michael Arnold will draft the letter and Kelly will make an appointment with Dr. Farber.

CDC Program Committee: Mary Brattich reported that the Annual Meeting is set for April 7-9, 2005 at the Wyndham Hotel in Palm Springs. Preliminary brochures will go out in January. Mary reported that John De Palma, M.D. wants to include a 4-hour seminar on pain management to be held before or after the meeting and include continuing medical education units (CME). Mary stated that while this is a laudable idea, we have already committed to Lori Hartwell for the afternoon following the meeting. Carol DiRaimondo stated that 12 hours of CME in pain management are required for physicians each 3 years. Carol stated that she thinks this is a good idea but perhaps for next year's education meeting in Northern California instead of at the annual meeting. Michael Arnold suggested partnering with someone who does pain management seminars and Mary Brattich stated it could be added as an afternoon session following a Board meeting. This could also be coordinated with a push for physician membership in CDC. Peter Crooks suggested that the pain management seminar be conducted in a multidisciplinary approach.

Other Business: Tom Paukert, M.D. distributed a draft resolution for discussion. He would like for CDC to issue a statement to vendors regarding the ASP and small providers. He stated that Group Purchasing Organizations do not have the clout that the Large Dialysis Organizations do and thus the small provider sometimes pays more for drugs than they are reimbursed. He would like CDC to request that vendor prices not exceed Medicare reimbursement for drugs. He stated that this is a request, we are not trying to price-fix. This would be aimed at manufacturers and wholesalers and would narrow the gap in pricing. There were several comments by the Board and other attendees and Tom will revise the draft resolution and circulate it to the Board. One vendor commented that an uncontrollable outcome of this resolution might be that a price reduction might result in reduced Medicare reimbursement for the drug. Tom stated that he believes sales agreements can be drafted in a way that protects small as well as large providers.

Next Open Board Meeting

January 19, 2005 (Wednesday) in Sacramento

For more information and a registration form, please visit our web site at:

http://www.caldialysis.org/next_meeting.htm