

CDC Report

Friday, August 20 ,2004

Los Angeles, California

Legislative Report and State Budget: Michael Arnold presented the following up-date from Sacramento.

We are currently in the final few weeks of the legislative session. We successfully lobbied for the defeat of proposed Medi-Cal reimbursement cuts and the budget has been signed into law. People in Sacramento are concerned about next year as the Governor was not as successful in improving the budget deficit as he planned and California will go into next year with a \$10 billion deficit. August 20 (today) is the deadline for amendments to bills. Michael Arnold will review these amendments on Monday.

The three major undertakings of interest are as follows.

1. Medi-Cal redesign. This has been slow getting a start but is planned for the Governor's January budget.
2. California Performance Review (CPR). The report from CPR will generate redesign and restructuring of state agencies. The intent is to reduce the number of agencies and the number of people in them. There are currently 14 agencies in the state government with many departments under them. The intent is to have 10 large departments.
3. The state is working with CMS to get a waiver for Medi-Cal operations. The Governor would like to move toward a block grant from the federal government for Medi-Cal.

Under each of the above undertakings, the Administration is pushing hard to expand managed care for the Aged, Blind & Disabled (ABD) program. CDC needs to assure that dialysis patients are carved out of the ABD group when this happens.

Michael Arnold distributed a summary sheet of bills of interest to CDC members. The following two are of particular interest.

AB 3029, a bill opposed by CDC, that would not allow Medi-Cal billing to contain a patient's social security number, did not move out of committee.

ACR 250. The CDC-sponsored California Chronic Kidney Disease Education Week is moving forward. The intent of the joint resolution is to increase awareness in the legislature regarding chronic kidney disease. Peter Crooks stated that he has seen similar resolutions from other states that include direction to providers to follow KDOQI guidelines. We may consider adding similar language to next year's resolution.

An American Hospital Association- sponsored proposition on the November ballot that would add a 3 cent tax on phones to fund Emergency Rooms is being hotly contested by the telecommunications business. There are a number of health care-related propositions on this year's ballot. Sue Vogel responded that the Kidney Care Partners (KCP), of which CDC is now a member, has someone who follows the Federal Register to track changes that might affect the renal community.

NRAA Report: Cindy LaMunyon delivered a report for the NRAA. A lot of time is being spent on the implications of the Medicare Modernization Act (MMA) that becomes effective in January 2005. Everyone is worried about operationalization of components that will be effective in a few months and that are not yet clear. Providers' cash flow may be delayed at the beginning of 2005 as a result of the first phases of MMA. Jan Anderson strongly suggested that CDC submit comments for the MMA process. A summary of the proposed physician fee schedule changes follows:

[2005 Physician Fee Proposal Includes ESRD/Drug Payments](#)

On July 27, the Centers for Medicare and Medicaid Services (CMS) released an advance copy of its proposed rule for the 2005 Physician Fee Schedule. In addition to setting next year's Medicare payment rates for nephrologists and other doctors, the proposal also describes how the agency intends to implement a number of provisions of the Medicare Prescription Drug, Improvement and Modernization Act (MMA), including how ESRD providers will be reimbursed for services and drugs. The regulation also allows nephrologists to provide telehealth services to ESRD patients under certain conditions.

The centerpiece of the proposal is a reduction in reimbursement rates for physician-administered drugs. CMS released a table for 32 widely used prescription drugs, showing the difference between the 2004 and 2005 reimbursement rates. Although some drugs would be reimbursed at a higher level, the majority would be cut in various degrees from 2 percent to 89 percent. The table included Aranesp, for which the current reimbursement rate of \$21.20 would be reduced by 15 percent to \$18.10. CMS Administrator Mark McClellan said the proposed drug reimbursement changes would save \$530 million in 2005.

Included in the proposed rule are:

- **Composite Rate Increase for Dialysis Facilities:** *A 1.6 percent increase in the composite rate for ESRD providers, as mandated in MMA. The proposal includes tables that reflect the updated hospital-based composite rate of \$132.40 and independent facility composite rate of \$128.35, adjusted by the current wage index. The increase would be effective on January 1, 2005.*

- **Composite Rate Adjustment to Account for Changes in the Pricing of Separately Billable ESRD Drugs:** CMS proposes to pay for separately billable ESRD drugs using average sales price (ASP) minus 3 percent as the basis for developing the drug add-on adjustment to the composite rate. The proposal states that the agency developed the add-on adjustment using, "historical total aggregate payments for separately billed ESRD drugs for half of 2000 and all of 2001 and 2002. For EPO, these payments were broken down according to type of ESRD facility (hospital-based versus independent). We also used the number of dialysis treatments performed by these two types of facilities over the same period." The proposal includes charts applying this formula to the 10 most frequently used dialysis drugs.
- **Per-Treatment Composite Rate Add-on:** The proposal includes a single add-on to the per-treatment composite rate of 11.3 percent. This provision would be effective on January 1, 2005.
The agency used the following calculations to arrive at that number: "For each of the ten drugs, we calculated the percent by which ASP minus 3 percent prices are projected to be less than reimbursement amounts under the current system for 2005. For Epogen, this amount is 10 percent. We applied this 10 percent figure to the total aggregate drug payments for Epogen in hospital-based facilities, resulting in a difference of \$18 million. We then calculated a weighted average of the percentages by which ASP minus 3 percent would be below current Medicare reimbursement prices for the top 10 ESRD drugs. We weighted these percentages by using the 2002 Medicare reimbursement values contained in the OIG report for the ten drugs. This procedure resulted in a weighted average of 19 percent. Since these ten drugs represented 98 percent of drugs payments, we applied the weighted average to 100 percent or all of aggregate drug spending projections for independent facilities, producing a projected difference of \$516 million. Combining the 2005 figures of \$18 million and \$516 million, for a total of \$534 million and then distributing this over a total projected 36.5 million treatments would result in a single add-on to the per treatment composite rate of 11.3 percent. By making this adjustment to the composite rate, we estimate that the aggregate payments to ESRD facilities would be budget neutral with respect to drug payments."
The agency is also seeking comment on an alternative approach that would provide separate payments for hospital-based and independent dialysis facilities but use the same methodology. "Under this option, we could distribute the \$18 million difference in EPO payments to hospital-based facilities based on data projecting 5.1 million treatments resulting in a hospital-based facility drug add-on adjustment of 2.7 percent. We would distribute the \$516 million difference in drug payments (including EPO) to independent facilities using projected treatments of 31.4 million, resulting in a drug add-on adjustment of 12.8 percent for independent facilities."
- **Case-Mix Adjustments:** The proposal notes that CMS is still researching and developing options for its MMA-mandated report on a fully bundled case-mix adjusted composite rate system, which is due to Congress in the fall of 2005. However, the document outlines case-mix adjustment factors for a limited number of patient characteristics. The proposed patient characteristic adjustments are: gender; age; and two comorbidities: AIDS and peripheral vascular disease (PVD). The three categories for age are: under 65; 65 to 79; and over 80. This adjustment would be effective on April 1, 2005 to allow time for the compilation of facility-specific data.
- **Geographic Index:** The proposal does not include any revisions to the current set of composite rate wage indices and the urban and rural definitions used to develop them and, according to CMS, they do not intend to seek any changes.
- **Budget Neutrality:** The proposal includes a "budget neutrality" adjustment to the composite rate of 0.8390 to account for the payment effect of the case-mix adjustment.
- **Use of Telemedicine for Nephrologists' Patient Management Visits:** The proposal includes a provision that would add monthly management of patients on dialysis (HCPCS codes G0308 through G0319) to the list of Medicare telehealth services. It states that a complete assessment must be performed face-to-face, but subsequent visits for a "maintenance dialysis beneficiary" could be performed using an interactive audio and visual telecommunications system. It notes that an allowable originating site is "a physician's or practitioner's office, hospital, critical access hospital, rural health clinic, or federally-qualified health center. ESRD facilities are not originating sites." New legislation would have to be enacted to include dialysis facilities as originating sites.
- **Increase for Nephrologist Visits and Changes to G-Codes:** Includes a 2 percent increase for nephrologist visits (Codes G0317 through G0319). Also includes a proposal to change to description of G codes for ESRD-related home services (G0324 through G0327) to allow for various scenarios by which a patient is only treated for part of a month. Further proposes the creation of a new G code for venous mapping for hemodialysis access placement.

The proposed rule will be published in the August 5 issue of the Federal Register, and comments are due to CMS by September 24. Comments may be submitted electronically to: <http://www.cms.hhs.gov/regulations/ecomments>; or by mail to: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1429-P, P.O. Box 8012, Baltimore, MD 21244-8012. The final rule is expected to be published on November 1.

A document containing only the ESRD-related language from the proposed rule is available in the MEMBERS ONLY section of the NRAA website (www.nraa.org), Report #511. The entire proposed regulation is available on-line at: <http://www.cms.hhs.gov/regulations/pfs/2005/1429p.asp>.

The NRAA annual meeting is next month in Denver, September 29 through October 2. Registration forms are available at www.nraa.org. This will be the first meeting held in conjunction with the Renal Support Network (RSN), Lori Hartwell's group.

Medicare/ Medi-Cal Report: Cindy LaMunyon also delivered the Medicare and Medi-Cal report.

1. There is an ESRD Open Door Meeting today.
2. The 90-day grace period for implementation of code changes (ICD-9-CM and HCPC) has been removed. Adherence to code changes will be required at the change effective date.
3. United Government Services (UGS) now has web-based training materials available for ESRD.
4. Jan Anderson reported on the geographic wage index. MMA is supposed to include a geographic wage adjustment factor. CMS has apparently said that they have the new wage index developed by OMB but they do not plan to use it. Jan believes this is because CMS has realized it will cost the program more if implemented. Jan urged that comments on MMA specifically address the wage index. Hospitals have lobbied to make adjustments that are advantageous to them and SNFs are receiving an across the board increase next year. The ESRD community continues to come up short. Despite the fact that KCP will be commenting on the proposed changes under MMA, Jan encouraged CDC to send comments that address California's specific needs. Jan presented summary data on a project she has undertaken regarding new facilities. A single summary statement might be, "We have fewer facilities with more patients, longer hours of operation."
5. Yvette Costa reported on the Epogen HMA program memorandum. Using data from Medicare, Yvette has determined that under the proposed changes, 9% of claims will be denied per month and 68% of these claims, using medical justification, would later be paid. This will result in an administrative burden for both the Fiscal Intermediary (FI) and the provider community. The new system under HMA will be a pre-payment review that will result in delayed claims. Yvette and Amgen are recommending that Medicare use the first hemoglobin of the month instead of the last and allow documentation on the claim form to demonstrate EPO adjustment. She will share the finalized form of the recommendations with the Board when they are available.
6. Dr. Farber is open to changing the Medi-Cal EPO reimbursement policy and CDC has worked with him and has developed a policy letter to him. We would like to move forward with this in as expedient a manner as possible. Cindy recommended change to the draft letter and then that it be mailed right away. She suggested including language regarding the natural variability of hemoglobin without a secondary diagnosis. Tom Paukert additionally recommended that the language preceding the list of secondary diagnoses be changed to read, "Per your request, the CDC Board has compiled a list of diagnoses that does medically justify targets greater than 13/39." Both language changes were approved by the Board with instructions to make the changes and send the letter to Dr. Farber.

Kidney Care Partners (KCP): Sue Vogel attended the July 7th Board meeting of KCP in Washington DC. She went to the Capitol for a reception around the roll-out of the ESRD Modernization Act. This would include an annual composite rate adjustment and Medicare coverage for pre-ESRD education. Sue brought up the geographic wage adjustment issue but members of the KCP stated that they do not believe it will happen this year. John De Palma, M.D. was very active in the discussion regarding the wage index adjustment and Sue requested that he write a letter on the topic. He stated that he would only draft such a letter if someone were able to provide him with wage/price index data since 1970. KCP dues are \$2,500 per year. The Board voted to pay this year's dues from the funds currently available. The value of membership in KCP for CDC will be evaluated annually before future funds are committed.

Grassroots Committee: Judith Filangeri reported that KCP recommends "dripping" information to legislators for the ESRD Modernization Act. This is defined as sending low key but regular communication to the legislators in support of the act and in anticipation of additional sponsorship. The bills are S. 2614 and H.R. 4927 and a memo to the KCP Board describing general guidelines for communication with legislators was distributed. Judith will send out additional information to assist in this effort.

Regulatory Report: Michael Arnold reported on California building standards. He stated that representatives from the Large Dialysis Organizations (LDOs) would need to devote time in developing a regulatory approach to revising the current requirement for I-1.2 occupancy standards. Seam Graham agreed to solicit information from DaVita with regard to the additional expense incurred by the I-1.2 standards and also whether or not that has negatively affected building for them.

Network Report: ESRD Network Report: Doug Marsh reported as follows:

Fistula First is in full swing. Mark McClellan, CMS Administrator is very interested in the project and will likely move to integrate other CMS offices (e.g., Beneficiary Services, Survey & Certification, Managed Care) into the member access initiative.

New G codes have been set aside for ESRD vascular access procedures but limit payment, due to regulatory language, solely to surgeons (as opposed to including interventional nephrologists, interventional radiologists, etc.). CMS is aware this needs to be changed but depends on comments to the rule to trigger changes. Doug will forward info to the CDC offices.

VISION training is slowly being rolled out. Information will be forthcoming from the Network to the dialysis community. Network 18 will be required to train 20% of the non-chain facilities by June 2005.

Conditions of Coverage: these have cleared CMS and moved to OMB, which has 90 days to review. Stay tuned.

Membership Report: Sandra Wilson delivered the membership report as follows. There are 182 Facility memberships with six facilities not renewing. There are 10 Corporate members with one new membership, Pam Labs. There are 13 Individual members and 15 Physician members

CDC Program Committee: No update. The meeting is scheduled for April 1-3, 2005. The 3rd Friday in November (11/19/04) is our educational session in Oakland. The new Conditions of Coverage may be the topic.

**Next Open Board Meeting:
September 17, 2004 Oakland**

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

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