Questions For the Record
to Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission

March 17, 2009 Hearing on
MedPAC's March 2009 Report to the Congress

QUESTIONS FROM MR. STARK

<u>Including Oral Drugs in the Outpatient Dialysis Bundle</u>

Q1. In discussing the payment bundle for dialysis services, the March report states, "Part D drugs used to treat ESRD-related comorbidities may be another candidate for the expanded bundle. Their inclusion might help ensure that beneficiaries receive appropriate care and that providers do not substitute Part D drugs for drugs that are covered under the broader dialysis bundle." Can you explain further why including these drugs might ensure appropriate care? What are the implications if providers substitute Part D drugs for drugs covered under the bundle?

A1. The Commission has a longstanding recommendation for implementing a broader dialysis payment bundle that include services, products, and items needed and commonly used by dialysis patients. The Commission noted in its March 2009 Report to the Congress that including Part D drugs used to treat ESRD-related comorbidities (such as anemia and bone mineral disorders) may be another candidate for the expanded bundle. We also noted that their inclusion might help ensure that beneficiaries receive appropriate care and that providers do not substitute Part D drugs for drugs that are covered under the broader dialysis bundle.

Bundled payment approaches give providers an incentive to furnish the covered services as efficiently as possible, as they retain the difference if Medicare's payment exceeds the costs they incur to furnish the services. However, if Part D drugs are not included in the dialysis bundle, then providers might have an incentive to reduce their costs to furnish covered services by substituting (to the extent possible) Part D drugs for services covered under the bundle. A dialysis payment bundle that includes Part D drugs used to treat ESRD-related comorbidities would prevent providers from cost shifting by substituting Part D drugs for services covered under the payment bundle.

Including Part D drugs used to treat ESRD-related comorbidities in the dialysis payment bundle might help ensure that beneficiaries receive appropriate care. The decision making process would be based on what is best for the patient. Incentives to substitute a Part D drug for a service covered under the bundle, which might not result in the best care, would be eliminated. Patients' adherence to their drug regimen might be improved by receiving all of their drugs needed to treat ESRD-related comorbidities under Part B. For patients receiving in-center dialysis, providers could furnish all of the drugs that were necessary to treat ESRD-related comorbidities at the facility. Similarly, providers could

deliver the necessary drugs (along with other needed supplies and equipment) to home dialysis patients.

SNF PPS Revisions

Q2. Does MedPAC agree that prospectively revising the parity adjustment so that it reflects actual data, as proposed in the 2009 payment rule, is appropriate to improve payment accuracy?

A2. Yes. A revised estimate of the parity adjustment would improve payment accuracy. When CMS estimated the adjustment required to maintain budget neutrality with the adoption of the new case-mix system, using 2001 data it estimated that 19 percent of cases would be grouped into the new (highest payment) case-mix groups. However, using 2006 data, it found that more than 30 percent of cases were grouped into the new groups. With a larger than expected share of days grouped into the highest-payment case-mix groups, the new case mix system is not budget neutral. Instead, the new groupings generate higher payments for the same set of patients than the old case-mix system. A reduction in the parity adjustment is needed to maintain budget neutrality.

The industry may argue that by using more recent data, CMS does not address the changes in real case mix that have occurred. However, the parity adjustment is not intended to account for changes in case mix—it ensures that the same set of patients (and their days) would be paid the same amounts under different classification systems.

Q3. If that policy is combined with MedPAC's SNF payment recommendations from the June 2008 report, is that sufficient to both resolve MedPAC's earlier concerns that the recalibration policy exacerbates problems with NTA/therapy payments and also fix those payment issues moving forward?

A3. Yes. A separate payment component for NTA services will result in better targeting of payments for these services. Establishing therapy payments based on patient and stay characteristics will dampen the incentive to furnish therapy for financial, rather than clinical reasons. Payments will be higher for patients with high predicted therapy care needs and lower for patients who are predicted to require fewer therapy services.

Establishing the NTA pool based on estimates of the share of nursing costs attributable to NTA services will negate the need for an additional NTA adjustment. The distortions that would have resulted from the proposed revisions to the NTA adjustment would not occur because the NTA adjustment will be eliminated.

Physician Ownership of Ambulatory Surgical Centers

Q4. The March report points out that over 90 percent of ambulatory surgical centers have at least one physician owner. In the past, MedPAC has voiced concerns about physician ownership of hospitals and the effect on utilization of care. Do the same concerns apply to physician ownership of ASCs?