American Hospital Association

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Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

Ref: CMS-1429-P; Section 623-Payment for Renal Dialysis Services

Dear Dr. McClellan:

The American Hospital Association (AHA), on behalf of our 4,700 member hospitals and health care systems and our 31,000 individual members, appreciates the opportunity to provide further comment on the Centers for Medicare & Medicaid Services' (CMS) Medicare physician fee schedule for calendar year (CY) 2005. We are focusing on the provisions that implement Section 623 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that mandated changes in Medicare payment for renal dialysis services.

Among other things, Section 623 of MMA requires reductions in payments for separately billed drugs and biologicals and an add-on to the end-stage renal disease (ESRD) composite rate equal to the difference between payments for separately billed drugs and biologicals under the old and new payment methodologies. This add-on is intended to produce the same, aggregate Medicare expenditures in 2005 that would have occurred absent the change in payment policy for separately billed drugs and biologicals. The MMA clearly designates that all ESRD providers receive the add-on payment, and CMS' proposal reflects this understanding. Additionally, the question of whether a different add-on should apply to hospital-based and independent dialysis facilities has been raised.

The AHA strongly supports CMS' proposal to apply the *same* add-on to the composite rates for all ESRD facilities, regardless of whether they are hospital-based or independent. We agree with CMS' observation that the drug add-on provision was intended to address concerns about the inadequacy of the composite payment rate and that these concerns apply

equally to hospital-based facilities and independent facilities. Also, since the Office of the Inspector General report used by CMS to establish the proposed payment methodology and rates did not differentiate between hospital-based and independent facilities in its estimates of acquisition costs, we agree that it would not be appropriate to use this report to create two separate adjustments.

Further, had CMS opted to provide different add-on amounts, freestanding dialysis facilities would have received a much higher add-on than hospital-based facilities. That would have resulted in, for the first time, a higher composite rate for independent facilities than for hospital-based ESRD facilities … a policy that would make no sense since hospital-based providers have higher costs due to higher patient acuity.

In addition, hospitals are already slated to experience reductions in ESRD-related payments due a change in Medicare inpatient policy. In the final FY 2005 inpatient rule, CMS revised its policies to reduce the number of hospitals with a high percentage of ESRD discharges that qualify for a Medicare payment adjustment. We strongly encourage CMS to implement this provision as proposed, through a single add-on for all ESRD facilities.

The AHA appreciates the opportunity to share our thoughts on this issue. If you have any questions, please contact me or Roslyne Schulman, senior associate director for policy, at (202) 626-2273.

Sincerely,

Rick Pollack
Executive Vice President