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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D C 20548

HUMAN RESOURCES
DIVISION

B-210417

JANUARY 21, 1983

The Honorable Richard S. Schweiker
The Secretary of Health and
Human Services

Dear Mr. Secretary:

Subject: Opportunities to Reduce Medicare Costs Under the End Stage Renal Disease Program for Home Dialysis Patients (GAO/HRD-83-28)

In March 1982, we presented testimony (see enc. I) in connection with hearings before the Subcommittee on Health of the Senate Committee on Finance and submitted a similar statement in April 1982 to the Subcommittee on Oversight of the House Committee on Ways and Means on the data used by the Health Care Financing Administration (HCFA) in preparing its February 12, 1982, proposal to establish a prospective reimbursement system for the end stage renal disease (ESRD) program. The proposed regulation was issued in response to section 2145 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) which required that a prospective system be in effect by October 1, 1981. Under this regulation, HCFA would establish a composite rate reflecting the costs of both home and facility dialysis treatment and pay facilities this rate regardless of where the patient dialyzes. As of December 1982, the regulation had not been finalized.

Because the thrust of our testimony dealt with developing the composite rate, we did not address issues pertaining to home patients who would continue to obtain their dialysis equipment and/or supplies on their own rather than through a facility under the proposed composite rates. Home patients currently have, and will continue to have under the proposed payment system, the option of (1) getting their equipment and supplies through a supporting facility or directly from the suppliers and (2) buying or renting needed equipment.

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About 70 percent of our sample of home patients were obtaining their equipment and supplies directly from suppliers. The cost of direct purchase of supplies and rental or purchase of equipment was usually lower for those patients than the proposed facility prospective reimbursement rates. Therefore, it would be economically advantageous for most home patients to continue dealing directly with suppliers considering the difference in Medicare's 20-percent coinsurance amounts they may have to pay.

Using the average costs of home dialysis treatments and average number of treatments for our sample of home patients, we estimated the calendar year 1980 costs of obtaining dialysis supplies and equipment for the direct-dealing patients in the areas covered by our sample to be about $6.1 million, of which Medicare paid about 80 percent. There were a total of about 7,660 home patients in 1980. If there are the same proportion of direct-dealing patients in this group and their cost experience is similar to that of our sample, the total cost of obtaining dialysis supplies and equipment for all direct-dealing home patients during calendar year 1980 would have been about $75 million.

The purpose of this letter is to present our views about how Medicare equipment and supply costs could be reduced for home patients who deal directly with suppliers. In summary, the amounts Medicare allowed for equipment rentals varied widely and rental charges were substantially more costly over the estimated useful lives of the equipment than outright purchase. Requiring the purchase of equipment would substantially lower costs (on the order of $20 per treatment less than rental) for patients who will be dialyzing for prolonged periods. In those cases, which should be relatively few, where the period of need for the equipment is not sufficient to justify purchase or the need period is unknown, entering into lease/purchase arrangements with equipment suppliers similar to those negotiated by State-sponsored kidney programs would reduce Medicare costs.

Also, significant differences exist in the amounts allowed by Medicare for selected supply items and the amounts allowed have exceeded the lowest available prices for such items. HCFA--as the major source of funds for the purchase of these items--should negotiate with the suppliers to obtain prices at least as favorable as other purchasers. Additional information on our findings pertaining to each of these issues follows.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our review covered a random sample of 656 ESRD patients from 13 States in four HCFA regions who were on home dialysis as of December 31, 1980. To determine the cost of home dialysis treatments for these patients, we obtained calendar year 1980 cost data for dialysis equipment, supplies, and related support service from Medicare carriers and intermediaries. The cost data obtained are representative of the home patients within the 13 States covered by our review but cannot be projected to the Nation. However, we believe the data to be representative of national costs because ESRD patients tend to use the same companies for their dialysis supplies.

In developing our cost estimates we used the data as provided by the carriers and intermediaries. We did not review the reasonableness of the amounts charged or allowed, nor did we question the medical necessity of the services provided.

To compare the cost of leasing and purchasing dialysis machines, we obtained cost information for eight dialysis machines, used by home patients, from four major equipment manufacturers. The information covered purchase prices, maintenance contracts, and monthly rentals in effect during calendar year 1981. We also obtained information on lease/purchase arrangements for dialysis equipment from the Maryland kidney disease programs.

We visited selected dialysis facilities in the four regions covered by our review to obtain information on the prices paid in fiscal year 1981 for selected supply items to determine if different amounts were being paid for the same item. For this comparison we also used 1981 price lists for two Veterans Administration (VA) home dialysis supply contracts and a price list used by the Medicare carrier in Texas to determine the reasonableness of the amounts charged by a major supplier of dialysis supplies in Texas.

We discussed our findings with HCFA officials and considered their views in finalizing our report.

Our review was performed in accordance with generally accepted Government auditing standards.

HOME DIALYSIS COSTS

Of our 656 sample patients, 308 were hemodialysis patients and the remaining 348 used one of three variations of peritoneal dialysis (275 were using continuous ambulatory (CAPD), 62 intermittent (IPD), and 11 continuous cycling (CCPD)). About 70 percent of these were dealing directly with suppliers for their dialysis equipment and/or supplies. The remainder obtained their supplies, equipment, and related support services through a dialysis facility. As discussed in the testimony (see enc. I), we estimated that the average cost of home dialysis treatment for hemodialysis, CAPD, and IPD patients was about $103, $110, and $134, respectively. For CCPD patients the average cost was $201 per treatment. Under the current Medicare coinsurance requirement, the patient is responsible for 20 percent of these amounts.

HCFA's proposed composite rates will establish a facility reimbursement rate of about $128 for independent facilities and $132 for hospitals. The composite rates will cover all modes of treatment. The rates also cover patients who dialyze in facilities as well as those who dialyze at home and obtain all their supplies, equipment, and related support services through a facility. The cost of home dialysis treatment for 423 (or about 65 percent) of our sample patients was below the proposed facility rate of $128 per treatment. Because of the higher proposed rates, the coinsurance amount for patients dialyzing through a facility would be higher than for direct-dealing patients, providing an economic incentive for direct-dealing patients to continue obtaining supplies and equipment on their own.

SAVINGS POSSIBLE THROUGH PURCHASE OF EQUIPMENT

About 65 percent of the sample patients who rented equipment were obtaining their machines directly from the suppliers. The remainder were renting through a dialysis facility. As discussed in the testimony, the monthly rental charges allowed for these machines ranged from $34 to $648. Among the factors pointed out as possible reasons for the wide differences in rental charges were:

--Whether or not the monthly charges cover maintenance and repairs.

--What types of optional or auxiliary equipment were included in the agreement.

--Whether or not provider facilities added a surcharge to the suppliers' equipment charge and the amount of the surcharge.

To determine if rental costs exceeded purchasing costs, we compared purchase, maintenance, and rental cost data from four major dialysis machine manufacturers for eight different machines used by home patients. The results were as follows.

Dialysis machine model	Purchase price	Annual maintenance contract	Rental cost including maintenance Monthly	Rental cost including maintenance Yearly	Purchase cheaper than rental after
Cordis Dow 250-100	$6,650	$750	$370	$4,440	20 months
Cobe 18-700	7,240	645	380	4,560	21 months
Cobe 18-701	7,540	645	380	4,560	22 months
Extracorporeal DM-350	7,250	850	395	4,740	21 months
Drake Willock 4215	7,930	720	465	5,580	19 months
Drake Willock 4216	8,650	720	500	6,000	19 months
Drake Willock 7200	9,530	720	585	7,020	18 months
Drake Willock 7200BC	10,030	720	585	7,020	19 months

Using these data we computed the difference between purchase and rental costs for a 5-year period, the manufacturers' estimated useful life for these machines. Our computations

showed that rental costs over a 5-year period exceeded the purchase cost by amounts ranging from about $11,800 to $21,900.[1] The average cost of purchasing was about $15,800 or $3,200 a year less than renting. This average yearly savings is equal to a difference of about $20 per treatment for a patient who requires dialysis three times a week. Applying this potential savings to the direct-dealing hemodialysis patients in our sample would have resulted in annual savings of about $3.7 million. Home patients can continue to rent equipment indefinitely, and any use of a purchased machine beyond the 5-year period would result in significant additional savings.[2] Also, as shown in the table, purchase of the machines is cheaper than rental as soon as the patient uses them for periods ranging from 18 to 22 months. This is a relatively short period of time for dialysis and is less than half the manufacturers' estimated useful life of the machine.

Lease/purchase as an alternative to purchase

Use of lease/purchase arrangements for durable medical equipment continues to be a controversial issue as pointed out in our report to the Congress on Medicare payments for durable medical equipment.[3] However, we concluded that such arrangements might be cost effective for high-cost items where the risk

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[1]These computations do not take into account the differences in interest costs to the Government between a large lump-sum payment versus a lower monthly payment. However, taking interest costs into account has relatively little impact on the numbers because it only changes the breakeven point by a few months and changes the 5-year savings from purchasing to some extent. For example, using a 10-percent annual interest rate compounded monthly, for the Cordis Dow 250-100 machine the breakeven point is increased from 20 to 24 months and the 5-year savings from purchasing increase from $11,800 to $12,980. For the Drake Willock 7200BC, the breakeven point increases from 19 to 20 months and the savings increase from $21,470 to $24,485.

[2]We noted several cases during our review where home patients used their machines for substantially more than 5 years and obtained information from a VA official which indicated that machines used by VA home patients lasted longer than 5 years.

[3]Medicare Payments for Durable Medical Equipment Are Higher Than Necessary (GAO/HRD-82-61, July 23, 1982).

of incurring excess costs through outright purchase is not justified because the rental period is uncertain but could extend over a long period of time. Because of the permanent nature of end stage renal disease and the high cost of dialysis equipment, we believe that in instances where outright purchase would not be feasible because of the financial burden on the beneficiary, a lease/purchase arrangement would be appropriate.

One State-sponsored kidney program, Maryland, has been successful in negotiating such arrangements. For example, under one of the Maryland arrangements dialysis machines can be purchased over a 5-year period with declining monthly payments. For the first 36 months the negotiated monthly rental charge is paid in full. For the next 24 months the State pays half the monthly rental charge. The State then owns the machine and pays only for maintenance and repairs. A second arrangement provides for purchasing the machine at a reduced price after it has been rented for a specified period. Under this arrangement the Maryland program can purchase a dialysis machine at the following price reductions:

--20 percent after 12 months.

--40 percent after 24 months.

--60 percent after 36 months.

--80 percent after 48 months and thereafter.

To compare the cost of these arrangements with the cost of outright purchase and rental, we used cost data obtained from equipment manufacturers in August 1981. At that time an Extracorporeal model DM-350 machine sold for about $7,250 and a 1-year maintenance contract cost $850. The machine rented for $395 a month including maintenance. The manufacturer's estimated useful life for this machine was 5 years. Our comparison showed that lease/purchase arrangements can be considerably less costly than straight rentals even though outright purchase offers the best potential for savings. The purchase and/or rental cost of the DM-350 machine, assuming the purchase option would be exercised as early as possible, for 5 years would be as follows:

Cost to Medicare and the Patient of Various Ways of Obtaining Equipment

Years	Purchase and maintenance		Rent with purchase after first year		Full rent, half rent, then owned		Rental only	
	Medicare	Patient	Medicare	Patient	Medicare	Patient	Medicare	Patient
1	$6,480	$1,610	$ 3,792	$ 948	$ 3,792	$ 948	$ 3,792	$ 948
2	680	170	5,320	1,330	3,792	948	3,792	948
3	680	170	680	170	3,792	948	3,792	948
4	680	170	680	170	1,896	474	3,792	948
5	680	170	680	170	1,896	474	3,792	948
Total	$9,200	$2,300	a/$11,152	a/$2,788	$15,168	$3,792	$18,960	$4,740

a/If purchased after 2 years, Medicare cost would be $13,104 and the patient's share, $3,276. After 3 years, Medicare's cost would be $15,056 and the patient's would be $3,764.

The Maryland program also has lease/purchase arrangements for water treatment equipment whereby ownership of the equipment passes to the State program after being rented for 2 years.

In summary, for persons who will be dialyzing at home for 2 years or longer, the lowest cost available for the Medicare program and for the patient as shown by our comparison is outright purchase of the machine. This is also true for the other seven machines on which we obtained data (see p. 5) and should generally be true across the board. The main problem with purchase for the patient would be the lump-sum coinsurance payment at the time of purchase, but considering that this amount is less than the total coinsurance for the first 2 years, and substantially less over 5 years, than under the other options, it should not be an insurmountable problem.

The main risk for Medicare would be that if the patient no longer needed the machine (because of a successful transplant, inability to continue dialyzing at home, or death) before the breakeven point (21 months in the example), Medicare would pay out more than it would have under other options. However, the average length of time a patient stays on dialysis is about 54 months, and any losses associated with this risk should be more than offset by the resulting long-term savings.

SUPPLY COSTS COULD BE REDUCED

Disposable supplies accounted for most (about 70 to 90 percent depending on the mode of treatment used) of the dialysis treatment costs incurred by our sample home patients. A comparison of the amounts allowed for selected items showed significant differences in cost for the same item compared to what others were paying for it. For example, the differences between what Medicare was allowing and what VA paid for the 14 items compared averaged to about $12.70 more per treatment for Medicare, assuming the dialyzers were not reused. Applying this difference to the average number of treatments received by the direct-dealing hemodialysis home patients in our sample would have resulted in annual savings of about $2.5 million.

To determine whether Medicare was reimbursing for dialysis supplies at the lowest available prices, we obtained and compared information from a Medicare carrier and from selected ESRD facilities on the amounts allowed or paid for selected dialyzers and bloodlines, two of the more costly supply items used by home dialysis patients. We also obtained home patient cost data from VA for these two items to determine what another Federal program was paying for the same items delivered to the patient's home.

Our comparison showed that for three of the items Medicare was allowing almost twice as much as what was paid by some facilities. For every item compared Medicare was allowing more than the price at which VA could purchase the item. Information on the items compared and the various amounts allowed or paid follows.

Supply item	Amounts allowed by Medicare (note a)	Amount paid by VA	Amount paid by Texas facilities Low	Amount paid by Texas facilities High
Dialyzers				
Cordis Dow C-DAK 1.3	$31.19	$26.95	$21.95	$22.95
Cordis Dow C-DAK 1.8	39.93	31.95	26.95	27.95
Cordis Dow C-DAK 2.5	56.43	45.50	37.50	45.50
Extracorporeal TRIEX-1	32.14	31.35	22.50	-
Travenol 5M 1767	28.13	19.95	-	-
Travenol 5M 1782	42.78	25.95	-	-
Travenol 5M 1786	53.69	33.95	26.95	-
Bloodlines				
Cordis Dow 205.211	6.79	5.55	3.65	-
Cordis Dow 205-410	5.57	4.50	2.85	-
Extracorporeal TS-110	8.50	7.90	-	-
Gambro V 410-A-X	9.90	3.30	-	-
Gambro A 400-A-8	11.75	4.20	-	-
Travenol 5M 1640	5.36	3.75	-	-
Travenol 5M 1641	4.86	3.40	-	-

a/Represents the amounts allowed by the Medicare carrier in Texas.

The VA contract prices shown include delivery to the patient's home and are available for VA patients nationwide. Generally, the VA facility supporting the patient orders and pays for the supplies.

We see no reason why Medicare patients should have to pay more for supplies delivered to their home than VA pays for the same supplies delivered to its patients' homes. In addition, Medicare covers about 90 percent of all ESRD patients which should put it in a good position to negotiate prices at least as low as those VA negotiates. This should benefit Medicare and its beneficiaries because both would be paying less.

Medicare could negotiate with the major suppliers to establish what it will recognize as a reasonable charge for supplies, obtain the suppliers' agreement to charge beneficiaries no more than that price, and inform the beneficiaries of these arrangements. The suppliers would bill Medicare for its share of the costs and the beneficiary for the applicable coinsurance and deductible.

CONCLUSIONS

The information we obtained on our sample of home patients shows that most of those who obtained equipment and supplies directly from suppliers would incur lower costs if they continue to do so rather than obtaining them through a facility under HCFA's proposed ESRD reimbursement system. Thus, it is economically advantageous for these patients not to use HCFA's proposed system, and we believe that many of them will continue to deal directly with suppliers. Therefore, it would be advantageous for the Medicare program to take actions to ensure that its costs for home patients who deal directly with suppliers are as low as possible.

The amounts Medicare has allowed for dialysis equipment have been substantially more than the cost to purchase and maintain it and the amounts Medicare allowed for dialysis supplies have exceeded the lowest available prices for such items. HCFA, as the major source of funds for payment for these items, should be able to negotiate prices at least as low as those obtained by other purchasers.

Because it will continue to be economically advantageous to ESRD patients who dialyze at home to obtain their supplies and equipment directly from suppliers and because of the savings available to Medicare, we believe HHS should, to the maximum extent possible, require the purchase of dialysis equipment. As an alternative in what should be a relatively few cases where purchase is not justified, Medicare could enter into lease/purchase arrangements with equipment suppliers similar to those entered into by State-sponsored kidney disease programs.

RECOMMENDATIONS

We recommend that you direct the Administrator of HCFA to:

--Require the purchase of dialysis equipment by home patients dealing directly with suppliers except in cases where to do so would place an undue hardship on the patient or where purchase can be shown to be more costly.

--In those cases where purchase of equipment is not required, enter into lease/purchase agreements with equipment suppliers similar to those entered into by State-sponsored kidney programs.

--Negotiate dialysis supply contracts with the major suppliers to obtain prices which are as favorable as those negotiated by other purchasers.

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As you know, 31 U.S.C. 720 requires the head of a Federal agency to submit a written statement on action taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of this report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the Chairmen of interested Committees and Subcommittees; to various Members of Congress who expressed an interest in our review; to the Director, Office of Management and Budget; the Inspector General of HHS; and the Administrator of HCFA.

Sincerely yours,

Edward A Glensmore

for Philip A. Bernstein
Director

Enclosure

 ENCLOSURE I

United States General Accounting Office

Washington, D.C. 20548

FOR RELEASE ON DELIVERY
Expected at 9:00 a.m. EST
Monday, March 15, 1982

Statement of Michael Zimmerman

Associate Director, Human Resources Division

Before the

Subcommittee on Health

Senate Committee on Finance

On the Data Used by the Health Care Financing Administration in Preparing Its Proposal to Establish a Prospective Reimbursement System for the End Stage Renal Disease Program

Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss our ongoing review of reimbursement issues in Medicare's end stage renal disease (ESRD) program. As requested, our discussion will focus on the data used by the Health Care Financing Administration (HCFA) in preparing its recent proposal to establish a prospective reimbursement system for paying for home and outpatient dialysis treatments under the ESRD program. We will also provide some information on physician compensation in the ESRD program where the related costs are generally reflected in the prospective payment rates and briefly discuss the role of ESRD networks in administering the program. We will be issuing a report on our overall review.

In summary, we believe that the data HCFA used, and the resulting proposed ESRD payment rates, probably overstate what it would cost an efficient and economical provider to deliver needed services. In particular, we question the accuracy of the cost data obtained on independent ESRD facilities because of the incomplete audits on which the data is based.

Specifically:

--The 13 facilities we reviewed reported $15.4 million in costs, including about $6 million in related organization transactions that had not been adequately examined to eliminate inter-company profits and other unallowable costs.

--Physician-owner compensation for administrative services and profit sharing arrangements were included in the audited costs without assessing their reasonableness. These annual payments we were able to identify ranged as high as $360,000 per facility in addition to whatever the the doctors received from Medicare for providing ESRD medical services.

Background

The Social Security Amendments of 1972 (Public Law 92-603) provided Medicare coverage to persons suffering from kidney (renal) failure who are either currently or fully insured under the Social Security Act or are dependents of a person currently or fully insured. The program that resulted from this provision is known as the ESRD program. The program is generally considered effective in protecting beneficiaries from the catastrophic costs

associated with caring for a person with renal failure. However, the large and rapidly rising costs of the program--from about $230 million in 1974 to an estimated $1.8 billion in F.Y. 1982--have caused great concern about the future of the program.

In 1978, the Congress passed amendments to the ESRD program (Public Law 95-292) designed to encourage patients to dialyze at home which was believed to be less costly. These included (1) a prospective reimbursement system for home dialysis based on paying facilities a target rate and (2) 100 percent reimbursement to facilities for equipment to be used and maintained for home patients. The original objectives of our work were to evaluate the reasonableness of the target rates that had been established and the effectiveness of the new provisions in encouraging patients to dialyze at home. However, when the Congress provided, in the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) for establishing new methods of paying for ESRD services, we began reanalyzing the data gathered in light of these revisions.

We reviewed the audits conducted by Medicare intermediaries for 13 independent facilities and HCFA's adjustments to these audits to determine the reliability of the resulting data. Our analysis of the audits consisted primarily of a review of the audit reports for the cost reporting years ended in 1978 or 1979 and supporting working papers prepared by the auditors. We also reviewed the adjustments made by HCFA and the supporting documentation for the adjustments. In addition, we talked or met with the intermediary auditors and HCFA officials to obtain

additional information on the work performed. Our proposed adjustments were discussed with the intermediary auditors.

Our cost data for home dialysis is based on the costs incurred in 1980 for a sample of 656 beneficiaries dialyzing at home as of December 31, 1980. Our sample was drawn from all the home patients residing in 13 States and while the data is representative of these States it cannot be projected to the Nation. We obtained data from all the Medicare claims processing contractors that we could identify as having paid for services provided to our sample beneficiaries. This involved obtaining data from 27 carriers that pay for Medicare part B services such as physicians' services and dialysis equipment and supplies and 21 intermediaries which pay facility based suppliers such as hospitals and independent renal dialysis facilities.

There are two general types of dialysis treatment modes, hemodialysis and peritoneal dialysis, both of which can be performed at home. For hemodialysis, the most widely used mode, blood is taken from the patient's body and passed through a dialysis machine, which filters out body waste before returning the blood to the patient. Under peritoneal dialysis the blood is filtered within the patient's abdominal cavity without leaving the body. There are three variations of peritoneal dialysis--continuous ambulatory (CAPD), intermittent (IPD), or continuous cycling (CCPD). Of the three variations, CAPD has gained popularity. Our review covered patients using each mode of treatment.

HCFA data shows that overall about 17 percent of ESRD beneficiaries dialyze at home. Of those beneficiaries associated with

independent facilities about 10 percent dialyze at home and of those associated with hospitals about 23 percent dialyze at home.

HCFA'S PROPOSED REIMBURSEMENT SYSTEM

On February 12, 1982, HCFA published a proposed rule to change the way Medicare pays for outpatient dialysis and related physician and laboratory services. Under this rule, HCFA proposes to establish a composite rate designed to cover the costs of both home and in facility dialysis treatments. A simplified explanation of the composite rate is that it is made up of HCFA's estimated home dialysis costs times the percentage of all ERSD beneficiaries who dialysis at home plus HCFA's estimate of in facility dialysis costs times the percentage of beneficiaries dialyzing in facilities. Each facility will receive a certain payment rate per treatment, adjusted for geographic differences in the cost of labor. According to the proposal the average payment for independent facilities would be $128 per treatment and $132 per treatment for hospital-based facilities. These amounts will be paid regardless of whether the treatment is furnished in the facility or in the patient's home. The proposal would do away with the home target rates and the 100 percent equipment reimbursement payment methods established pursuant to the 1978 amendments. The methods currently used to reimburse physicians for routine support services would also be changed in a manner which HCFA believes will eliminate some of the economic incentives for physicians to treat dialysis patients in the facilities rather than at home.

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INDEPENDENT FACILITY AUDITS WERE POORLY DONE

HCFA has proposed the establishment of a prospective reimbursement system to pay for dialysis services in the patient's home and in facilities. We believe that prospective payment systems should be based on the costs which would be incurred by an efficient and economical provider to deliver needed services. In fact, the Congress has required the States to have Medicaid reimbursement systems for hospitals and nursing homes which meet a similar criteria.

In order to determine the level at which efficient and economical providers can deliver needed services, we believe it is necessary to obtain through audit, data on actual reasonable and allowable costs incurred by a statistically valid sample of providers. To see if HCFA had this data, we reviewed 13 of the 38 audits of independent facility costs which the intermediaries had performed and HCFA used in establishing its proposed rates. We do not believe the audits provide HCFA with the data necessary to adequately establish a prospective reimbursement system because the audits did not result in the elimination from the costs reported by the facilities substantial amounts of unreasonable and unallowable costs.

The total costs reported by the 13 facilities were about $15.4 million. Work done by the fiscal intermediaries and HCFA resulted in reductions of about $2 million to the reported costs. Based on our limited review, we estimated that there should have been

additional reductions of about $700,000. The adjustments we made would reduce the average cost per treatment for the 13 facilities reviewed by about $5.50. In addition, we believe there are significant amounts of unallowable or unreasonable costs of related organization transactions which should have been eliminated from the facilities' reported costs. However, due to the limited review work done on related organization transactions by the intermediary auditors, we could not determine from the data reviewed how much these adjustments should have been. A more complete audit could have resulted in additional reductions.

Attachment I summarizes the costs and number of treatments for the 13 facilities as reported by them and the adjustments made by the intermediary auditors, HCFA, and GAO. Most of the reductions we made related to

--incorrect allocations of parent company home office and/or regional office expenses,

--insufficient documentation to support management fees charged by related organizations,

--the cost of dialysis treatments provided for patients of other facilities for which those facilities were responsible,

--nonrecurring and/or undocumented legal expenses, and

--profits on transactions between related organizations.

We made reductions on all of the audits reviewed. Some examples of unreasonable and unallowable costs we identified which neither the intermediary nor HCFA had identified are:

--A facility paid its parent company $28,212 for management services but we saw no evidence that any services had been provided.

--One facility included $29,065 in costs for services provided to hospitalized patients. The hospitals were billed for these services and the hospital can include these charges in its costs for Medicare reimbursement purposes. Permitting the facility to include these costs would amount to duplicate payment--once to the facility and once to the hospital. Several other facilities also included the same type of costs.

--A facility owner was paid $11,856 in excess salary.

--A facility paid a related organization $5,430 more to sublease a building than the related organization paid to lease it.

Some of the intermediary auditors were more successful than others in identifying unallowable costs, however, we generally found similar deficiencies in the audits performed by each of the five intermediaries whose audits we reviewed. These five intermediaries performed 24 of the 38 independent facility audits.

Perhaps of more interest than the unallowable costs we were able to identify by reviewing the intermediaries' workpapers were the questionable costs where the documentation in the workpapers was insufficient for us to determine how much cost should be eliminated. Most of these costs related to transactions between 12 of the facilities and organizations which we considered related

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to the facility by common ownership or control. Medicare cost reimbursement principles permit reimbursement for such transactions at the lower of (1) the cost incurred by the related organization in furnishing the supplies or services or (2) the costs at which the supplies or services could be obtained elsewhere (see 42 CFR 405.427). About 60 percent of the related organization transactions were for purchases of supplies, and the remainder were primarily for management and administrative services. The costs of these supplies and services in most cases amounted to more than 40 percent of the facilities' total reported costs. Attachment II summarizes the total costs reported by the facilities and shows our estimate of the portion of the costs represented by related organization transactions. Examples of these related organization transactions are:

--A facility purchased $413,539 worth of supplies from a related organization. The related organization was not audited and no adjustments were made to eliminate any profits or unallowable costs.

--Another facility purchased $1.6 million worth of supplies and services from a related organization. This facility routinely marked-up supplies provided to home patients. In 1978, the mark-up was 10 percent (increased to 35 percent in 1981). Any intercompany profits or unallowable costs were not eliminated because the related organization was not audited.

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--A facility was allocated $101,790 for services provided by the regional office of the parent company, a chain organization. The auditors eliminated $4,322 of this amount based on an error in the amount allocated. The remaining $97,468 was unaudited.

The data reviewed did not provide enough information to enable us to determine how much of the related organization costs were audited by the fiscal intermediaries. However, none of the audits determined the actual costs to the related organizations selling dialysis supplies or the costs at which the supplies could be obtained from nonrelated organizations. Also, in many instances, home office and regional office costs reported by chain facilities were not audited. Therefore, substantial portions of costs were included in the cost reports HCFA used without adequate assurance of compliance with Medicare regulations concerning related organization costs.

We did obtain some information which indicates the extent of unallowable or unreasonable costs included in some related organization transactions. One facility covered by our review which belonged to a large national chain had related organization costs of about $540,600, including home office expenses of about $124,400. This amount was part of about $10.3 million in home office expenses the parent company allocated to its ESRD facilities for the year. HCFA designated a separate intermediary to audit the parent company home office costs. As part of our analysis,

we reviewed the report and related working papers for this audit and found the audit to be insufficient.

We discussed this audit with intermediary officials. One of the officials advised us that no effort had been made to determine if the home office costs were reasonable or if the costs were related to patient care. He advised us also that HCFA had not authorized enough time to conduct an adequate audit and they only eliminated the obvious costs which were specifically unallowable under Medicare regulations. For most of the $10 million home office expenses the auditors simply verified that the amounts reported agreed with the amounts shown in the parent company's general ledger. We believe that this home office expense audit cannot reasonably be used to determine the cost of dialysis treatments. Five of the 13 facilities whose audits we reviewed were part of this chain. All had essentially the same arrangements with related organizations.

The Inspector General's Office for the Department of Health and Human Services recently completed a review of the 1977 and 1978 costs reported by one of the facilities in this chain. Their review showed that

--this facility had paid about $309,000 or 149 percent more for property and equipment leased from a related organization than it would have cost to own the same property and equipment,

--the facility was charged 22 percent more by a related supply company for certain routine dialysis supplies than the related organization had charged three unrelated facilities in the same geographical area, and,

--in some instances, the facility paid up to 56 percent more for supplies purchased from the related organization than would have been paid had the supplies been purchased from unrelated vendors.

Another facility which is part of another chain paid a related organization about $199,300 for dialysis supplies which amounted to about 39 percent of the facility's total operating costs. Unlike most of the audits we reviewed, the intermediary auditors for the facility tried to eliminate the related organization profits for these transactions based on a profit percentage computed from the related organization's unaudited financial statements. Intermediary officials told us that their $32,735 adjustment did not eliminate all profits involved, but it was the best adjustment they could do since the related organizations would not allow them to review pertinent invoices.

The related organization that provided the dialysis supplies to the facility reviewed, held the master lease on the facility, and owned the facility's dialysis machines. We believe that a full audit of this organization's costs probably would have disclosed significant amounts that were unreasonable or not related to patient care. For example, we noted that in 1979,

the organization spent $163,000 for five Mercedes Benz sports cars--one for use by each of the five physician owners.

In addition, this related organization was managed and operated by employees of four of the ESRD facilities controlled by the owners of the related organizations which had no employees of its own. The organization paid the facilities $36,000 for the services of these employees. The intermediary auditors eliminated $36,000 from the facility's cost report based on the amount of time that the facility employees stated was devoted to operating the related organization. The intermediary auditors told us that they believed the adjustment was reasonable since it equaled the amount paid. We believe that the true cost of operating the supply and leasing business could have been significantly more than the $36,000 eliminated and should have been audited. There was not enough information available for us to determine the actual expenses incurred by the facilities to operate the related organizations.

We are presenting this information to provide a general idea of the extent of related organization transactions. The HCFA audits generally did not eliminate related organizations' profits or unallowable costs. Intermediary officials told us that they were not provided enough time or financial resources to audit the cost of related organizations. We believe that the audits should have been expanded to include reviews of related organizations' activities so that unallowable profits and costs not related to patient care could have been identified and eliminated.

The audits should also have included some market surveys to determine the costs that the goods and services could have been obtained from unrelated organizations. Since such review procedures were not followed we question whether the audit results should be used as the primary basis for establishing prospective reimbursement rates.

PHYSICIAN COMPENSATION

As part of our analysis of the 13 facility audits we obtained some information on the amount of compensation and other benefits several physicians receive through the ESRD program. Medicare regulations allow physicians to select one of two reimbursement methods for their ESRD services, the initial and the alternative methods. Under the initial method, reimbursement for physicians' routine supervisory patient care is made to the facility as part of the facility's reimbursement rate. The facility then reimburses the physician for his/her services. Non-supervisory services are billed separately and paid on a fee-for-service basis. Physician services provided to home patients are billed on a fee-for-service basis. Under the alternative reimbursement method, the physicians are paid a comprehensive monthly fee by Medicare for supervisory services provided to both in facility and home patients. HCFA has set a maximum reimbursement rate for services provided to in facility patients at $260 per month and $182 per month for home patients. Each carrier establishes monthly reimbursement rates for the physician in its service area subject to the limits set by HCFA. Under HCFA's

proposal, all physicians would be paid under the alternate method and would be paid the same amount for infacility and home patients--an average of about $184 per month per patient.

Although there are some limits on the amount Medicare will reimburse for some ESRD services, there is no overall limit on the amount of compensation, benefits, or profits that physicians can receive under the ESRD program. Some of the information we were able to obtain on physicians' compensation and other benefits shows that some physicians received significant amounts of compensation or monetary benefits through the ESRD program. Generally, payments to physicians for administrative services and profits would be included in the facility cost reports. Some examples follow.

The physician owner of a relatively small ESRD facility received about $96,000 in a 1-year period from the facility for administrative services, even though the facility had a non-physician administrator, an assistant administrator, and a chief of nursing services. During the same period, the physician received about $57,400 from the Medicare program under the alternative reimbursement method. The physician also sub-leased the building to the facility and received dividends as its majority stockholder. In addition, the physician maintained a full-time medical practice from which he received Medicare payments of about $44,500 for non-ESRD services.

Two owner physicians of another facility received during a 1-year period combined compensation of

--$192,000 from the facility for administrative services;

--$132,000 from Medicare under the initial method of reimbursement for supervisory services; and

--$186,000 from the facility in profit sharing dividends.

A physician employee of anotner facility received during a 1-year period

--$56,000 for administrative services;

--$121,900 from the Medicare carrier for supervisory services;

--free hospitalization and professional liability insurance;

--the use of 1,000 square feet of space at $10 a month for his private medical practice; and

--about $25,000 from Medicare for non-ESRD related services.

The nation's largest ESRD chain organization paid more than $5.3 million in 1978 to some of the physicians or groups of physicians who operated its facilities. The payments were made for administration of the facility and/or under profit sharing agreements and were generally based on the facilities' profits. The payments were made by the home office and charged back to the facilities through the allocations of home office expenses. The average payment was about $69,000 and ranged from less than $100 to $360,000.

The intermediary auditors did not determine the reasonableness of these payments. The payments were included as part of the facilities' total operating costs which were used to establish the proposed new reimbursement rates. Ten of the 38 independent facilities audited were part of this chain.

MEDICARE HOME DIALYSIS COSTS

HCFA estimated nationwide the weighted median home dialysis per treatment costs for hemodialysis to be $87; $114 for CAPD; and $111 for IPD. We estimated that for the 13 States covered by our review the weighted mean home dialysis per treatment costs to be $103, $110, and $134, respectively. The methodologies used by HCFA and GAO to estimate home dialysis costs differ significantly and would be expected to result in somewhat different cost estimates.

HCFA reviewed home costs for 2,232 patients who obtained their supplies and equipment primarily through one of 23 selected facilities or two State kidney programs. We reviewed home costs for 656 patients randomly selected from the universe of patients in 13 States regardless of their source of supplies and equipment. The majority (70 percent) of our sample patients obtained their supplies and equipment on their own. Theoretically, we would expect that patients obtaining supplies through a facility, as HCFA's sample patients did, should obtain them at a lower cost because of the advantages of volume purchasing by facilities and hospitals. This could help explain part of the differences between the HCFA and GAO estimates. Because HCFA proposes to use a combination rate covering both home and in facility patients, it probably is more appropriate to use a sample like HCFA's because under the proposed rates most home patients are expected to obtain their supplies through the facility.

HCFA made certain assumptions in developing its estimate of home dialysis costs at the 25 selected locations. While we did not have an opportunity to review all the assumptions HCFA made, we did look at those for the Maryland Kidney Disease Program because the supply costs HCFA found were only about half of what we found. Of HCFA's sample, 107 patients were from the Maryland Kidney Disease Program. To determine the number of home patients in the Maryland program and the number of home treatments they received, HCFA apparently assumed that the

--number of home patients in the program at year-end represented the average number of home patients for the year,

--home patients had dialyzed at home all year without any in facility treatments during the year, and

--home patients obtained all their supplies and equipment through the Maryland program.

The data we obtained from the Maryland program for 1980 show that this was generally not the case. Several of the Maryland program home patients were not getting all their supplies and equipment through the program. Some were getting only drugs and water treatment services. Others were getting only part of their supplies and/or equipment from the program. Our data indicate also that some of the patients were hospitalized or otherwise received in facility treatments during the year. By assuming that the patients got all their services from the program, HCFA's total cost data for patients using

the Maryland home program would be understated and by not adjusting for actual time on dialysis or for in facility treatments the number of treatments used to compute average per treatment costs would be overstated. Both of these would result in an understated average cost per treatment.

As HCFA pointed out in the notice of proposed rulemaking, it is not sure that only reasonable and allowable costs were included in its estimate. Although our estimate includes only costs determined allowable by the Medicare contractors, except for the 122 patients obtaining supplies through hospitals where retroactive adjustments could be made, we are not 100 percent sure that we captured all costs.

We would like to make several observations related to the data we obtained. First, we noted wide ranges in the cost per treatment among patients and among the eight ESRD networks covered by our review. Among the networks average cost per treatment ranged from a low of $81 to a high of $124 for hemodialysis, from $96 to $126 for CAPD, and from $92 to $186 for IPD. Among individual patients the ranges were even greater--from $55 to $693 per treatment for hemodialysis, from $46 to $639 for CAPD, and from $56 to $328 for IPD.

A number of factors contribute to the wide ranges including:

--The length of time a patient has been on home dialysis. Patients just beginning generally incur substantial start up costs and, thus, new patients have higher average costs. Conversely, patients who have been dialyzing at

home for a long period may have purchased their equipment in previous years and would show no equipment costs.

--Whether patients need special or additional supplies or equipment such as water treatment equipment in areas with hard water or because of complicating medical conditions.

--Whether equipment is owned by the patient or is rented.

--The source used for obtaining supplies and equipment.

HOME DIALYSIS COSTS COULD PROBABLY BE SUBSTANTIALLY LOWERED

Although our cost data for home dialysis treatments is reflective of what Medicare was paying for such services in 1980, we do not believe that it is necessarily representative of the costs that an efficient and economical provider would incur to deliver such services. As discussed below, our data indicate that significant opportunities exist for lowering home dialysis costs.

Comparison of Equipment Rental and Purchase Costs

About 70 percent of our sample patients obtained dialysis machines through rental agreements with suppliers or the patients' supporting facility. To determine if savings could be realized by purchasing these machines we compared data from four major equipment manufacturers on purchasing, maintaining, and renting their equipment. The data provided covered eight different machines used by home patients. The prices quoted ranged from $6,650 to about $10,030 per machine. Monthly rental charges

which generally included maintenance ranged from $370 to about $525. Maintenance contracts ranged in price from $645 per year to about $1,100.

Using this data we computed the difference between purchase and rental costs for a five-year period, the estimated useful life for the machines. Our computations for these eight machines showed that the average costs of purchasing would be about $15,800, or about $3,200 a year less than renting it. This equates to a difference of about $20 a treatment. Savings ranged from $11,800 to $21,900.

We visited three VA hospitals to get information on their methods of providing dialysis equipment to home patients. The three hospitals purchased the dialysis machines used by their home patients as a cost saving measure. An official at one hospital advised us that this method enabled VA to reissue available equipment to new patients or to transfer it to or from in facility use as the needs demanded. The official said that by owning and properly maintaining their equipment it had lasted well beyond the useful life stated by the manufacturers. He advised us also that there was little administrative burden associated with the management of the equipment once it entered their inventory.

Reasonable Charge and Reasonable Cost Determinations

Suppliers that provide dialysis equipment and supplies for ESRD home patients are generally reimbursed by Medicare carriers

on the basis of the reasonable charge for such services. ESRD facilities that choose to provide such services for their home patients are usually reimbursed through an intermediary on the basis of reasonable costs. For those home patients for whom we had both the billed and allowed amounts for dialysis equipment and supplies we determined the reduction made to the amounts billed. The data showed a total of about $6 million billed for supplies and about $1.3 million for equipment. These amounts were reduced by the carriers and intermediaries to about $5.8 million for supplies and $1.2 million for equipment for an average reduction of about 3 percent for supplies and 10 percent for equipment. Data published by HCFA on reasonable charge reductions shows that the average reasonable charge reduction for calendar year 1980 for all part B claims was about 22 percent.

Although our costs reflect virtually no reasonable charge reductions for supply charges, we noted large differences in the amounts charged per treatment by different suppliers. For example, for hemodialysis patients, average supply costs ranged from a low of $72 for one supplier to a high of $114 for another. Similar ranges were from $99 to $163 for CAPD and from $67 to $180 for IPD.

About 120 of our sample home patients were getting their supplies through hospitals. Hospital costs are subject to retroactive adjustments based on annual audits. Our computation of the reasonable cost reductions for the hospitals servicing these

patients could be over or understated to the extent that retroactive adjustments are made.

Variation In Machine Rental

As previously stated, about 70 percent of our sample patients were using rented dialysis machines obtained either through their support facility or directly from a supplier. The data analyzed to date show monthly allowed amounts for machines used by hemodialysis patients ranged from $34 to $648. Those allowed for machines used by IPD patients ranged from $125 to $440 per month. The range of machine rental charges allowed for the major sources used were as follows:

Source of Machines	Range of Monthly Rentals Allowed
Hemodialysis patients	
Independent facilities	$100 - $615
Hospitals	34 - 439
Cobe	205 - 364
Extracorporeal	192 - 388
Cascade-Drake	165 - 409
Cordis Dow	330
Baxter Travenol	156 - 400
Organon Teknika	181 - 439
Dialysis Inc.	400 - 648
IPD Patients	
Amer. Med. Prod.	125 and 160 (note a)
Hospital	200
Erika	125 and 160 (note a)
Cascade-Drake	322 - 346
Physio Control	407 and 440 (note a)

a/The higher allowed amounts resulted primarily from a price increase made during the year.

The data available in most instances did not contain information on the rental agreements between the equipment suppliers and the ESRD facilities or patients or specific information on the types and capabilities of rental machines. Therefore, we could not determine to what extent cost differences could be due to the different prices paid for similar machines. Several other factors could account for some or all of the differences. For example, rental rates would vary depending on

--whether or not the monthly charges cover maintenance and repairs,

--whether or not the different machines have the same capabilities,

--the types of optional or auxiliary equipment included in the agreement, and

--whether or not provider facilities add a surcharge to the suppliers' equipment charge and the amount of the surcharge.

Surcharges

Several of the independent facilities and hospitals providing equipment and/or supplies for their home patients added a surcharge for their services to the costs at which they obtained the items. The data analyzed to date show that 9 of 12 providers were marking up equipment and/or supply bills by amounts from 10 to 45 percent of their costs. One facility added a flat $25 charge per supply order. Another facility added the lower of $55 or 55 percent to each order, usually $55. Other facilities which provided this service did not charge for it.

Two of the hospitals that added a surcharge for supplies received the bulk supplies and redistributed them to their home patients. Three others merely ordered the supplies and processed the claims. The supplies were shipped directly to the home patients. We do not have enough information to determine the arrangements used by the remaining providers.

ESRD NETWORKS

The 1978 Amendments provided for the establishment of renal disease network organizations as a means of assuring effective and efficient administration of ESRD Medicare benefits. A total of 32 network organizations were established to cover all geographic areas of the country. Membership in these organizations is generally made up of representatives from each of the ESRD facilities within the networks area and consumer representatives. Responsibilities given to the networks included

--encouraging the use of the most effective treatment settings,

--developing criteria and standards for quality and appropriate patient care,

--setting network goals for placing patients in self-care settings and for kidney transplants,

--working with facilities to meet network goals,

--evaluating procedures used by facilities and providers to assess the appropriateness of patients for treatment modes, and

--submitting periodic reports to HHS on goals, performance, and projected service needs.

We made a limited evaluation of the effectiveness of the networks in carrying out these responsibilities. Our evaluation covered 8 of the 32 networks and consisted primarily of

--reviewing the organizational structure of the networks, annual reports, network policies and procedures relating to goals and objectives, and the criteria and procedures used for their certification of need reviews,

--discussing network responsibilities and performance with network officials, and

--obtaining the views of selected facility officials on the effectiveness of the networks.

Our review indicates that most of the networks covered by our review had not met all the requirements of the 1978 amendments. Some appeared to be operating more as data gatherers and reporters than as active participants in the planning and directing of renal disease services within their respective areas. In this respect, the networks were able to provide us much home patient data. The data provided in most instances was not readily available from HCFA.

The organizational structures of the networks reviewed generally conformed with statutory requirements. All had established goals to increase the number of home patients and kidney transplants. Although these goals were met in many instances, many of the goals reviewed were more in the nature of projections based on prior years experiences than attainable objectives the facilities should strive to achieve to increase the use of these two methods of treatments. At the time of our review, most of the eight networks had not developed criteria or standards for quality and appropriateness of care. About half

had made efforts to evaluate the patient care provided by the facilities in their area.

All the networks had some procedures for reviewing and evaluating applications for the establishment of new facilities or the expansion of existing ones. The procedures and criteria followed and the extent of coordination with other health organizations varied from network to network. The dispositions made of the applications processed during the period of our review would indicate that the networks' recommendations probably did not have much impact on the final decisions made by HCFA because about 50 percent of the applications disapproved by the networks were approved by HCFA.

We visited 18 facilities in 4 of the 8 networks to obtain the views of facility officials on the effectiveness and usefulness of their networks. The officials from eight facilities in two of the networks were of the opinion that the networks were performing useful functions. However, officials at two of these facilities stated they could get by without the networks. Officials from one of the two other facilities visited in these two networks were of the opinion that the network should not have been established initially because of the conflict of interests involved. Officials at the second facility had no opinions to give since they had had few contacts with the network. The views of the officials from the eight facilities visited in the other two networks were all negative. Officials at four of these facilities thought the networks should be discontinued.

In conclusion, based on the limited work we performed, the networks reviewed do not appear to be very effective in carrying out the objectives of the 1978 amendments. Our conclusion is similar to the views expressed by HCFA officials in testimony before this Subcommittee last September. At that time, it was stated that HCFA had little evidence that the networks had successfully accomplished any of their major functions. In addition, it was stated that few of the networks had had any impact on the quality of care provided. It was stated also that HCFA was not satisfied with the networks' planning activities and that HCFA proposed to eliminate the networks.

ENCLOSURE I

COSTS AND NUMBER OF TREATMENTS AS REPORTED BY THE FACILITIES AND AS ADJUSTED AS OF SEPTEMBER 1981 BY THE FISCAL INTERMEDIARY, HCFA, AND GAO FOR THE 13 INDEPENDENT FACILITIES

Facility		Costs	Number of treatments	Average costs per treatment	Per treatment adjustment to reported costs (decrease (increase)) (note a)
Kidneycare of Florida, Clearwater Unit, Clearwater, Fla.	Reported	$ 516,058	4,248	$121.48	
	Intermediary	453,793	4,247	106.85	$14.63
	HCFA	453,793	4,247	106.85	0
	GAO	430,603	4,247	101.39	5.46
Kidneycare of Florida Lakeland Unit, Lakeland, Fla.	Reported	711,662	5,858	121.49	
	Intermediary	565,764	5,671	99.76	21.73
	HCFA	565,764	5,671	99.76	0
	GAO	551,924	5,671	97.32	2.44
Sarasota Artificial Kidney Center, Sarasota, Fla.	Reported	899,502	7,005	128.41	
	Intermediary	821,649	7,005	117.29	11.12
	HCFA	806,085	7,005	115.07	2.22
	GAO	773,006	7,005	110.35	4.72
St. Petersburg Artificial Kidney Center, St. Petersburg, Fla.	Reported	1,155,984	9,499	121.70	
	Intermediary	1,082,859	9,499	114.00	7.70
	HCFA	1,057,984	9,499	111.38	2.62
	GAO	1,018,603	9,499	107.23	4.15
Community Dialysis Services of Northwest Georgia, Rome, Ga.	Reported	574,158	4,972	115.48	
	Intermediary	538,867	4,866	110.74	4.74
	HCFA	538,867	4,866	110.74	0
	GAO	499,210	4,866	102.59	8.15

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Facility		Costs	Number of treatments	Average costs per treatment	Per treatment adjustment to reported costs (decrease (increase)) (note a)
Community Dialysis Services of Southwest Georgia, Valdosta, Ga.	Reported	$ 710,837	6,699	$106.11	
	Intermediary	687,013	6,422	106.98	$ (.87)
	HCFA	687,013	6,422	106.98	0
	GAO	619,570	6,422	96.48	10.50
Anderson Dialysis Clinic, Inc., Anderson, S.C.	Reported	662,858	4,341	152.70	
	Intermediary	508,683	4,145	122.72	29.98
	HCFA	458,943	4,145	110.72	12.00
	GAO	435,724	4,145	105.12	5.60
Florence Dialysis Center, Inc., Florence, S.C.	Reported	1,096,007	11,189	97.95	
	Intermediary	939,909	10,623	88.48	9.47
	HCFA	892,464	10,623	84.01	4.47
	GAO	843,240	10,623	79.38	4.63
Florida Parish Artificial Kidney Center, Hammond, La.	Reported	683,690	4,271	160.08	
	Intermediary	588,915	4,271	137.89	22.19
	HCFA	528,607	4,271	123.77	14.12
	GAO	483,532	4,271	113.21	10.56
Cape Code Artificial Kideny Center, Yarmouth, Mass.	Reported	516,752	4,513	114.50	
	Intermediary	505,214	4,513	111.95	2.55
	HCFA	505,214	4,513	111.95	0
	GAO	472,847	4,513	104.77	7.18
Dialysis Services of New Hampshire, Inc., Concord, N.H.	Reported	1,088,134	7,075	153.80	
	Intermediary	980,941	7,188	136.47	17.33
	HCFA	866,152	7,188	120.50	15.97
	GAO	854,261	7,188	118.85	1.65

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Facility		Costs	Number of treatments	Average costs per treatment	Per treatment adjustment to reported costs (decrease (increase)) (note a)
Southern Connecticut Out of Hospital Dialysis Unit, Inc., Bridgeport, Conn.	Reported	$1,576,609	11,006	$143.25	
	Intermediary	1,492,696	10,966	136.12	$ 7.13
	HCFA	1,232,666	10,966	112.41	23.71
	GAO	1,230,693	10,966	112.23	.18
The Kidney Center, Boston, Mass.	Reported	5,165,798	46,886	110.18	
	Intermediary	4,786,213	46,515	102.90	7.28
	HCFA	4,768,381	46,515	102.51	.39
	GAO	4,456,291	46,515	95.80	6.71

a/Represents the extent of adjustments beyond those made by the immediately preceding organizations.

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TOTAL COST REPORTED AND GAO'S ESTIMATE OF TRANSACTIONS WITH RELATED ORGANIZATIONS FOR THE 13 INDEPENDENT FACILITIES

Facility	Total reported costs	Related organization transactions	
		GAO estimated costs	Percentage of total reported costs
Kidneycare of Florida, Clearwater Unit, Clearwater, Fla.	$ 516,058	$ 286,825	56
Kidneycare of Florida, Lakeland Unit, Lakeland, Fla.	711,662	352,471	50
Sarasota Artificial Kidney Center, Sarasota, Fla.	999,502	415,551	46
St. Petersburg Artificial Kidney Center St. Petersburg, Fla.	1,155,984	540,624	47
Community Dialysis Services of Northwest Georgia, Rome, Ga.	574,158	155,619	27
Community Dialysis Services of Southwest Georgia, Valdosta, Ga.	710,837	212,503	30
Anderson Dialysis Clinic, Inc., Anderson, S.C.	662,858	291,891	44
Florence Dialysis Center, Inc., Florence, S.C.	1,096,007	514,083	47
Florida Parish Artificial Kidney Center, Hammond, La.	683,690	302,166	44
Cape Cod Artificial Kidney Center, Yarmouth, Mass.	516,752	225,956	44
Dialysis Services of New Hampshire, Inc., Concord, N.H.	1,088,134	105,110	10
Southern Connecticut Out of Hospital Dialysis Unit, Bridgeport, Conn.	1,576,609	0	0
The Kidney Center, Boston, Mass.	5,165,798	2,577,169	50

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