GAO

Briefing Report to the Chairman, Subcommittee on Health, Committee on Ways and Means
House of Representatives

July 1986

MEDICARE

Comments on HHS Proposal to Revise End Stage Renal Disease Facility Payment Rates

GAO/HRD-86-126BR

GAO

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July 22, 1986

The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

On June 16, 1986, you asked us to review the Department of Health and Human Services' (HHS') May 13, 1986, proposed revisions to Medicare's payment rates for facilities participating in the End Stage Renal Disease (ESRD) program. You also requested that we review a critique of this proposal which had been provided to you and a sample of other public comments submitted to HHS on the proposal. You requested our analysis of the main issues reflected by the HHS proposal and the public comments on it.

The critique and public comments primarily focused on the following issues:

--the age of the data used by HHS to compute the proposed rates,

--the use of audited cost data, which removed a substantial portion (about 17 percent) of the costs reported by independent ESRD facilities,

--a change in the method of weighing cost data from a per-facility basis to a number-of-treatments-provided basis, and

--the source of the data used to establish costs for patients who dialyze at home.

In our opinion, HHS has used the most recent data available to develop the proposed rates and has used the data appropriately.

A fifth issue on which the critique and public comments also focused was the adequacy of the data on the effects of the ESRD facility rates set in 1983 on access to and quality of care. The 1983 rates are the ones that would be revised by the HHS proposal. In our opinion, HHS is in a better position than we to judge the merits of this issue. When it proposed the rate revision, HHS stated that it believed that access and quality had not been adversely effected by the 1983 rates and that the proposed revisions to those rates would

not adversely effect access or quality. To support this belief, HHS cited data showing that the number of facilities had increased and that many facilities would be paid more than their costs.

Details on each of the five issues outlined above as well as on our objective, scope, and methodology are discussed in the briefing report. Briefly, we reviewed HHS' proposal and a judgmentally selected sample of public comments on it as well as the critique you furnished us. The public comments were selected to cover major provider and beneficiary groups. A list of those whose comments we reviewed is presented in appendix I.

As requested by your office, we did not obtain comments on this report. We are sending copies of this report to the Secretary of HHS and other interested congressional committees and parties and will make copies available to others on request.

Should you need additional information on the contents of this report, please call me on 275-6195.

Sincerely yours,

Thomas Dowdal

for Michael Zimmerman
Senior Associate Director

COMMENTS ON HHS PROPOSAL TO REVISE END STAGE RENAL DISEASE FACILITY PAYMENT RATES

BACKGROUND

In May 1983, HHS' Health Care Financing Administration (HCFA), which administers Medicare, published regulations that established a new prospective payment methodology for facility maintenance dialysis. Under the new methodology, facilities receive the same prospective composite payment rate per dialysis session regardless of whether a patient dialyzes at the facility or at home. The rates were based on audited 1978 and 1979 costs of facility dialysis--for both hospital-based and independent facilities--and the average costs of home dialysis. Because the rates were composite rates for both facility and home patients, the costs for each type of patient were weighted by the national ratio of home and facility patients for each type of facility--hospital-based and independent. The rate for hospital-based facilities was set at a higher level to account for their higher costs. It is generally agreed that hospital-based facilities have higher costs than independent facilities.

Based on this methodology, HHS established composite payment rates that averaged about $127 per treatment for independent facilities and about $131 for hospital-based facilities.[1] HHS also established minimum rates of $118 and $122 for independent and hospital-based facilities, respectively, and a maximum rate of $138 for both. Facilities with atypical costs may request an exception to the rates and be paid more.

HHS is proposing to reduce the composite payment rate to an average of about $115 per treatment for independent facilities and about $120 for hospital-based facilities. Two of the factors accounting for the reduction are the use of 1983 audited cost reports as the cost base and the change from weighing cost data based on the number of facilities to weighing it based on the number of treatments at the facility.

OBJECTIVE, SCOPE, AND METHODOLOGY

As requested by the Chairman of the Subcommittee on Health, House Committee on Ways and Means, our objective was to review HHS' proposed revision to the ESRD facility composite rates and public comments on that proposal to identify and evaluate the main issues raised.

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[1]Actual payment rates vary by geographic area because the rates are adjusted to reflect wage differences among areas.

We reviewed the HHS proposal and the critique of it that had been furnished to the Chairman. Because the issues raised in the critique were basically the same as those raised in the public comments we reviewed, in this report we will refer to both as public comments. We judgmentally selected comments from the public to include a mix of those from ESRD facilities, ESRD physicians, and ESRD patients. We included the comments sent to HHS by National Medical Care, Inc. (the largest chain of ESRD facilities), the American Hospital Association, and various other providers and provider groups. We also reviewed the comments of the Renal Physicians Association, the National Association of Patients on Hemodialysis and Transplantation, Inc., the American Nephrology Nurses' Association, and the National Kidney Foundation, Inc. A listing of the comments we reviewed is included as appendix I.

While these public comments included many points, the majority of them focused on five issues:

--the age of the data used by HHS to compute the proposed rates;

--the use of audited cost data, which removed a substantial portion (about 17 percent) of the costs reported by independent ESRD facilities;

--the change in the method of weighing cost data from a per-facility basis to a number-of-treatments-provided basis;

--the source of the data used to establish costs for patients who dialyze at home; and

--the lack of data on the effects of the 1983 revisions to the facility rates on access to and quality of care.

This report deals with our analysis of these major issues.

To evaluate the issues, we reviewed prior GAO reports and testimony related to ESRD facility rates and to the setting of prospective payment rates in general. We also discussed HHS' proposal with HCFA officials. Our analysis of the issues is based on our knowledge of the Medicare program in general and the ESRD program in particular.

As requested by the subcommittee's office, we did not obtain comments on this report.

OVERALL POSITION OF COMMENTS ON THE PROPOSED RATE REVISION

Almost all the public comments we reviewed opposed the proposed revision to the composite rates. In general, they favored freezing current rates, using more recent cost data for computing new rates, and studying the effects of the composite rate method on access to and quality of care.

One exception was the American Hospital Association, which generally supported the proposed revision but opposed using additional methodological factors to modify the proposal. HHS had asked for comments on certain additional methodology revisions that it was not proposing.

IS IT APPROPRIATE TO USE 1982 DATA TO REVISE THE RATES?

Many of the public comments we reviewed questioned the appropriateness of using 1982 cost data as the basis for revising the ESRD facility composite rates. The comments said that these data predated the change to the composite rates (which were effective in August 1983) and that many changes had occurred in ESRD treatment patterns since then.

HCFA's proposed rate revision is based on data from ESRD facility annual Medicare cost reports for accounting periods ended between July 31, 1982, and June 30, 1983. Thus, the cost data cover various periods from August 1, 1981, through June 30, 1983. The cost reports HCFA used are the most recent audited cost data available. Although cost reports for later periods have been submitted by ESRD facilities, they have not been audited. We have previously pointed out the importance of using audited cost data when computing prospective payment rates[2] because the audit process removes unallowable costs from facilities' reported costs.

Regarding the fact that the audited data HCFA used predates the 1983 change to composite rates, this change in payment methodology was designed to give ESRD facilities additional incentives to hold down their costs. Thus, use of more recent data could show lower costs and result in lower rates than those

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[2]See, for example, GAO's testimony before the Subcommittee on Health, Senate Committee on Finance, on "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," March 15, 1982, and Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (GAO/HRD-85-74, July 18, 1985).

currently proposed by HCFA. In fact, in a number of the comments, when arguing that HCFA should not try to force lower costs through a revision to the rates, it was alluded that costs had decreased since establishment of the composite rates.

Because the cost data HCFA used to develop its proposed revision to the composite rates is the most recent audited data available, we believe use of that data is appropriate.

IS THE USE OF AUDITED COST DATA APPROPRIATE?

A number of the comments questioned the use of the results of cost report audits to reduce reported costs, especially for independent facilities whose reported costs were reduced about 17 percent through the audit process. The comments said that the independent facilities had actually spent the funds for the disallowed costs and, therefore, unadjusted costs as reported by the facilities should be used.

Historically, Medicare payments to facilities have been based on allowable costs as has the determination of prospective payment rates. In fact, Medicare law and regulations provide for payments to facilities based on allowable costs. Medicare has an extensive set of rules for determining which costs are allowable. Basically, to be considered allowable, costs must be related to patient care and, for purchased goods or services, must result from arms-length transactions and not exceed what a prudent purchaser would pay. Medicare's cost principles for allowability are designed to assure that payments are not excessive. The types of costs that would not be allowable include such things as

- --administrator salaries that are substantially out of line with those paid by similar facilities;
- --intracompany profits that arise from transactions between the facility and entities related by common ownership or control;
- --costs associated with personal comfort items for patients; and
- --costs not related to patient care, such as federal income taxes.

Our March 15, 1982, testimony, cited in footnote 2, contains examples of unallowable costs that were reported by ESRD facilities in the cost reports used to compute the current composite rates. The audits that HCFA performed had excluded many of these unallowable costs from the cost data used to compute the rates, but we identified additional costs that should have been disallowed.

We discussed with HCFA officials the categories of reported costs on the cost reports used to compute the proposed rates that had been disallowed through the audit process. We were advised that the largest disallowance category related to compensation for facility administrators and medical directors that were substantially out of line with those for comparable facilities. The second largest category of disallowances was for intracompany profits from related-organization transactions. These categories of disallowed costs are the same as the major ones for previous ESRD facility cost reports audited for use in computing the composite rates in 1983.

We believe it is important for HCFA to use audited cost data to compute prospective payment rates to help assure that the rates are set at a reasonable level. Although, as the comments stated, facilities usually spend the funds reported in their cost reports, this does not mean that the Medicare program should subsidize inefficient operators or unreasonable costs. The cost report audit process is designed to remove such costs and we support the use of audited cost data to set the composite rates.

IS HCFA'S CHANGE IN THE METHOD OF WEIGHING COST DATA APPROPRIATE?

HCFA's 1983 computation of the current composite rates gave equal weight to the cost data of each facility in each sample stratum (strata were based on the number of dialysis stations); that is, HCFA "weighted" the cost data by facility. This resulted in every facility, regardless of number of treatments provided, contributing equally to the median treatment costs of its stratum. HCFA's proposed revision changes this weighing method to one where the number of treatments provided by a facility determines its contribution to the median costs of its stratum. Many comments questioned this change, stating that weighing data by facility was the appropriate method to use because large facilities with many patients would otherwise dominate the rate-setting process.

Weighing by facility measures the median cost per facility while weighing by treatments measures the median cost per treatment. The unit of service chosen for prospective payment for ESRD facilities is a dialysis treatment and we noted no comments opposing use of this unit for payment purposes. The composite rate is paid on a per-treatment basis; thus, we believe weighing by treatment is appropriate because this should result in a better estimate of median costs per treatment.

DID HCFA USE THE APPROPRIATE DATA BASE FOR HOME DIALYSIS COSTS?

A number of the comments said that it was inappropriate for HCFA to use data for home dialysis costs from facilities that participated in the "target rate" program under which, prior to the composite rate payment method, facilities were paid for their home dialysis patients an amount equal to 70 percent of their facility dialysis rate. Data on these facilities showed 1982 average costs of $84 per treatment. Some comments cited data in a 1983 GAO report,[3] which showed average per-treatment costs for home dialysis of about $108, to support their contention that the costs of the "target rate" facilities were too low for use in computing the composite rate.

One purpose of the GAO report cited in the comments was to show that Medicare costs for home patients who obtained dialysis equipment and supplies themselves could be reduced if HCFA were to negotiate equipment and supply contracts. Because such patients individually bought small quantities, they could not obtain volume discounts comparable to those received by large purchasers. About 70 percent of the 656 home patients in our sample were obtaining their own equipment and supplies. Our report discussed the substantial discounts available on supplies to volume purchasers. We also estimated that if these patients purchased their dialysis equipment instead of renting it, per treatment costs would be reduced by about $20.

We believe that the potential savings discussed in our 1983 report were and are available to facilities for their home patients because facilities would be purchasing items in larger quantities than individual patients. In effect, the home dialysis costs of target rate facilities would reflect such savings, while our sample of patients who primarily obtained their supplies and equipment on their own would not. We believe it is appropriate to use data from target rate facilities to compute the composite rates because these data should reflect costs that facilities incur supporting home patients rather than what patients incur when dealing with suppliers on their own.

WILL THE PROPOSED RATES AFFECT ACCESS TO AND QUALITY OF CARE?

Most of the comments expressed the belief that the proposed reductions in the composite rates would adversely affect access to and quality of care. Many also said that HCFA had not adequately studied the effects of the 1983 shift to the composite rate method on access and quality.

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[3] Opportunities to Reduce Medicare Costs Under the End Stage Renal Disease Program for Home Dialysis Patients (GAO/HRD-83-28, Jan. 21, 1983).

The comments generally expressed concern that reuse of dialysis supplies, such as dialyzers and bloodlines, has not been proven safe. Many comments said that another rate reduction would result in more facilities reusing dialysis supplies. However, some comments said that most facilities have been reusing dialyses supplies since the establishment of the composite rates. Also, for many years before establishment of the composite rates some facilities had reused dialysis supplies.

We believe that HHS is in a better position than we to address the access to and quality of care issues related to a revision to the composite rates. Regarding access to care, HHS asserts in its proposal that the proposed rate revisions will not adversely affect access. As support, the proposal shows that the number of dialysis facilities continued to increase after the 1983 shift to composite rates. A number of comments said that, although the number of facilities had increased, the percentage increase was not as great as the percentage increase in ESRD patients. The comments also stated that HHS had not addressed whether the number of dialysis stations had increased.

The number of dialysis facilities, stations, and patients for 1981, 1983, and 1985 and the percentage increase for each during this period are shown in table 1.

Table 1: Changes in Number of Dialysis Facilities, Dialysis Stations, and ESRD Patients (1981, 1983, and 1985)

	Facilities		Stations		Patients	
Year	Number	Cumulative percent change	Number	Cumulative percent change	Number	Cumulative percent change
1981	1,162		13,784		58,924	
1983	1,309	12.7	15,506	12.5	71,987	22.2
1985	1,463	25.9	17,845	29.5	85,086	44.4

Table 1 shows that the number of dialysis stations has generally increased faster than the number of facilities. The number of dialysis patients has increased somewhat faster than dialysis stations. As of December 31, 1985, however, about 19.6 percent of ESRD patients were dialyzing at home and usually did not need facility stations. Therefore, about 68,000 patients used facility stations. Another important factor to consider is the percent of treatment capacity actually used because the percent of unused capacity would influence the need to

increase the number of stations when the number of patient increases.[4] Unfortunately, we are not aware of any data available on this.

Regarding affects of the composite rate on quality of care, HHS in its notice of proposed rulemaking states in part that:

> "Our audits demonstrate that quality services are being furnished at a cost below the proposed rates at efficient and economical facilities. Hence, despite the estimated reductions in Medicare payments, we believe that quality of care will not be reduced. Further, if a facility demonstrates with convincing evidence that it will have an allowable cost per treatment higher than its prospective rate, and if these excess costs meet the criteria in section 405.439(g) [the regulations for a rate exception], a facility may receive an exception to that rate."

A number of the comments stated that HCFA's exception process is time-consuming, burdensome, and inadequate. Because we did not have time to assess the adequacy of HCFA's exception process, we cannot assess the validity of these comments. We believe that an appropriate exception process is important to assure that ESRD facilities which provide a needed service (for example, the only provider in an area) and whose costs exceed their composite rates for reasons beyond their control can receive payments sufficient to assure access to treatment for beneficiaries.

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[4]If average dialysis time is 5 hours, facilities operate two shifts per day, 6 days per week, and patients dialyze three times per week (these are all relatively standard numbers), available dialysis stations in 1985 could have handled about 71,000 patients. Of course, not all dialysis stations are in use at all times.

FACILITIES, INDIVIDUALS, AND ORGANIZATIONS WHOSE COMMENTS GAO REVIEWED

American Hospital Association
American Nephrology Nurses' Association
Artificial Kidney Foundation of California, Anaheim, CA
Blue Cross and Blue Shield Association, Chicago, IL
Boyle, Terence (Attorney), Red Bank, NJ
Cleveland Clinic Foundation, The, Cleveland, OH
Cleveland County Kidney Association, Lawndale, NC
Community Dialysis Centers
Community Dialysis Services
Compton, Philip M. (Dialysis Unit Administrator), Tampa, FL
Coughran, Jackson A. (ESRD Patient)
Dialysis Clinic, Inc., Nashville, TN
Dialysis Management Incorporated, Golden, CO
Dialysis Research Foundation, Ogden, UT
Dodge Munoz Agency, Oxnard, CA
Fadem, Stephen, M.D., P.A., Houston, TX
Federation of American Health Systems
Florida Renal Administrators Association
Geisinger Medical Center, Danville, PA
Haverford Dialysis Unit, Bryn Mawr, PA
Hemet Valley Hemodialysis Center, San Jacinto, CA
Hull, Alan R., M.D., Dallas, TX
Intercontinental Medical Services, Inc., Honolulu, HI
Internal Medicine and Nephrology Associates, P.C., Colorado Springs, CO
Louisiana State University Medical Center, Baton Rouge, LA
Maryland Renal Disease Network 31, Inc., Baltimore, MD
Medical Ambulatory Care, Inc., Tacoma, WA
National Association of Children's Hospitals and Related Institutions, Inc.
National Association of Patients on Hemodialysis and Transplantation, Inc.
National Dialysis Association
National Kidney Foundation, Inc.
National Kidney Foundation of Indiana, Inc.
National Kidney Patients Association
National Medical Care, Inc.
National Renal Administrators Association
North Beach Dialysis Center, Inc., North Miami Beach, FL
North Central Dialysis Centers, Ltd., Chicago, IL
North Mississippi Dialysis Services, Inc., Tupelo, MS
Queens Artificial Kidney Center, Jackson Heights, NY
Renal Physicians Association
Riverside-San Bernardino Hemodialysis Unit, Riverside, CA
Rochester General Hospital, Rochester, NY
Samaritan Health Service, Phoenix, AZ
Satellite Dialysis Centers, Inc., Redwood City, CA

Shreveport Regional Dialysis Center, Inc., Shreveport, LA
Southern New Mexico Regional Dialysis Center, Las Cruces, NM
University of Pennsylvania Out-Patient Dialysis Unit,
Philadelphia, PA
University of Pittsburgh School of Medicine, Pittsburgh, PA
Valley Nephrology Associates, Ltd., Roanoke, VA
West Virginia University, Morgantown, WV
Williams, Denise D. (Facility Administrator), Temple Hills, MD
Yale University School of Medicine, New Haven, CT

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