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Report to Congressional Committees

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MEDICARE

Renal Facility Cost Reports Probably Overstate Costs of Patient Care

GAO/HRD-93-70

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

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May 18, 1993

The Honorable Daniel Patrick Moynihan
Chairman, Committee on Finance
United States Senate

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

Medicare assists renal failure patients in meeting the costs of dialysis treatments by paying dialysis facilities a predetermined amount per outpatient treatment. A full year of dialysis treatments at Medicare's average payment rates costs more than $19,000, of which the program pays 80 percent and the patient 20 percent. The dialysis industry believes that Medicare dialysis payment rates should be raised, but the Health Care Financing Administration (HCFA), which administers Medicare, has proposed reducing the rates.

The former Chairman, Senate Committee on Finance, and the Chairman, Subcommittee on Health, House Committee on Ways and Means, asked us to address the following questions about this controversy:

- Are the definitions Medicare uses to define costs for payment rate-setting purposes appropriate?
- What is the quality of the most recent audited cost data for rate-setting purposes?
- Do costs incurred by integrated[1] and nonintegrated firms differ?

To conduct our review, we discussed issues related to cost finding principles with representatives of HCFA and the end stage renal disease (ESRD) industry and reviewed previous GAO work and administrative and court decisions on this issue. To obtain overall data on HCFA's most recent audit of 124 dialysis treatment facilities and to compare cost differences among integrated and nonintegrated facilities, we used computerized files supplied by the agency. To evaluate the adequacy of the audits of these sample facilities, we obtained and reviewed the auditor workpapers of 11 facilities (a 9-percent subsample) and discussed our findings with the

[1]Firms can be horizontally integrated, vertically integrated, or both. A horizontally integrated firm, commonly referred to as a chain, operates two or more dialysis facilities through a home office. A vertically integrated ESRD company owns related businesses, such as a laboratory or supply company, to support its dialysis facilities.

auditors responsible for each audit. Details on our objectives, scope, and methodology are included in appendix I.

Results in Brief

Medicare has an extensive set of rules, referred to as Medicare cost principles, that the program uses to determine costs for rate-setting purposes. These rules are designed to ensure that unreasonable costs, such as those resulting from nonarms-length transactions and amounts paid for goods and services above what a prudent buyer would incur, are excluded. On the other hand, the dialysis industry maintains that generally accepted accounting principles (GAAP)[2] should be used for rate setting. GAAP are designed to ensure consistent financial reporting so that creditors and investors can assess and compare company performance and financial position. GAAP are not designed to determine what a buyer should pay for a product or service while Medicare cost principles are designed to ensure that payment rates are set at reasonable levels.

In 1990, HCFA selected a sample of 124 dialysis facility cost reports to audit. Medicare's rate-setting methodology bases payments on the median cost per treatment, and the median cost reported by the facilities, if used to set rates, would result in a lower payment rate. Medicare's audits of these cost reports removed some unallowable costs, and the audited median cost would result in even lower payment rates if used to set rates. We reviewed a subsample of Medicare's audits to assess their adequacy and found that the audits were incomplete and poorly done. If the audits had been adequately performed, additional unallowable costs would probably have been uncovered and removed from the cost reports. This would have resulted in a further reduction of the median cost per treatment.

Finally, we compared the costs reported by integrated facilities to those of nonintegrated ones. The cost report data show that integrated facilities provided dialysis treatments at a substantially lower cost than nonintegrated firms.

Background

ESRD is the stage of kidney impairment considered irreversible and requiring either a kidney transplant or recurring dialysis treatments to sustain life. Dialysis, the process of cleansing excess fluid and toxins from the blood, accounts for the majority of patients and program expenditures. Dialysis can be provided on an outpatient basis at a dialysis facility or in

[2]In the private sector, generally accepted accounting principles consist primarily of rules and procedures established by the Financial Accounting Standards Board for financial accounting and reporting.

patients' homes. In addition, dialysis is provided on a temporary inpatient basis when medically necessary.

Almost all people with ESRD are eligible for Medicare and, in 1991, the most recent year for which data are available, Medicare paid about $5.8 billion for medical services for patients with ESRD. These services included inpatient hospital care, outpatient care, and physician services. Payments for outpatient dialysis treatments totaled about $1.6 billion.

In 1978, the Congress gave incentives to dialysis providers to furnish services efficiently by requiring HCFA to establish a prospective payment method for dialysis services (section 1881(b)(7) of the Social Security Act). In response, Medicare established a method that pays facilities for outpatient dialysis services using a prospectively determined payment rate known as the composite rate. The composite rate covers required equipment and supplies as well as routinely needed drugs, tests, and services and is based on the national median cost of furnishing dialysis treatments.[3] Median costs are used so that facilities have financial incentives to operate efficiently and hold down costs. If a facility keeps its costs below the payment rate, it profits; otherwise, it suffers a loss. The current nationwide average composite rate is $126 per treatment for independent facilities and $130 for hospital-based facilities. Facilities receive the same payment rate per treatment whether their patients dialyze at home or in the facility.

In addition, Medicare pays for certain dialysis-related items and services separately from the composite rate. For example, physicians who manage the care provided to dialysis patients receive a monthly capitation payment for these services, $173 per month on average. This payment covers all physician services related to maintenance dialysis. Also, the costs related to drugs, supplies, and laboratory tests that are atypical of routine dialysis treatments as well as the costs of support services a facility provides to certain home patients[4] are paid outside of the composite rate. In addition, if the facility provides dialysis services to another institution, commonly referred to as "under-arrangement" services, it obtains payment for the services from that institution.

[3]Payment rates vary by geographic area because rates are adjusted to reflect differences in labor costs among areas. In addition, hospital-based providers receive a somewhat higher payment rate because they are paid an additional amount to account for their higher administrative costs.

[4]Some home patients obtain dialysis equipment and supplies directly from suppliers rather than a dialysis facility. A hospital-based dialysis facility is paid the reasonable costs, and an independent dialysis facility is paid the reasonable charges for any home dialysis support services they furnish.

The composite rate is based on Medicare cost principles, an extensive set of rules for determining the amount of costs that Medicare will recognize as allowable. Generally speaking, costs are allowable if they are reasonable and related to patient care. The dialysis industry maintains that the use of Medicare cost principles is inappropriate. The industry believes that GAAP should be used instead of Medicare cost principles to set dialysis payment rates.

To determine if the composite rate should be changed, HCFA periodically audits a sample of facilities' cost reports. As part of the ESRD audit, HCFA also requires audits of home or regional offices for any chain facilities in the sample because the facilities are allocated costs from these related organizations. The most recent audit, conducted in 1990, covered cost reporting periods ended between August 31, 1988, and July 31, 1989, for 124 hospital-based and independent facilities.

Most audits are performed by intermediaries—insurance companies under contract to HCFA—or their subcontractors—certified public accounting (CPA) firms. The Department of Health and Human Services' (HHS) Office of Inspector General (OIG) audits the home office of National Medical Care, Inc. (NMC), the nation's largest independent dialysis chain.

To help ensure consistency in the scope and quality of the audits, HCFA provides the auditors with written instructions for performing the work and reporting the results. In addition, the auditors are required to conduct the work in accordance with government auditing standards, which provide general audit criteria as well as specific fieldwork and reporting requirements.

Medicare Cost Principles Are Appropriate for Prospective Rate Setting

HCFA and the dialysis industry disagree about the cost-finding principles that should be applied in gathering the data used to set the composite rate. HCFA uses Medicare cost principles while the industry believes that GAAP should be used. We agree with HCFA that Medicare cost principles are more appropriate for rate-setting purposes.

Medicare cost principles are designed to ensure that Medicare only pays reasonable expenses related to patient care. These principles were originally developed to determine reasonable costs when providers were primarily paid under a cost-based reimbursement system. However, the use of these principles continues to be necessary under a prospective

reimbursement system, such as the composite rate, if such a system is to have assurance that reasonable payments are made.

In contrast, GAAP are rules and procedures used to prepare financial statements and are designed to assure consistent financial reporting so that investors and creditors can assess company performance and financial position. Although GAAP normally represent the appropriate principles for business financial statement purposes, they do not necessarily reflect the reasonable costs of patient care, which is the purpose of Medicare's cost principles.

In general, GAAP result in reporting higher costs than Medicare cost principles do because GAAP are not designed to test the reasonableness of costs. For example, if a dialysis facility administrator received a salary of $250,000, GAAP would include the full amount as a facility cost. Medicare cost principles require that the salary be tested for reasonableness by comparing it to the amount paid to administrators by similar health facilities and disallowing any excess amount.[5]

The industry maintains that all amounts included in its cost reports should be recognized as allowable because those are the amounts spent. Although facilities may have incurred the expenses reported on their cost reports, this does not mean that Medicare should subsidize inefficient providers or unreasonable costs. We have previously pointed out the importance of using Medicare cost principles as a basis for computing payment rates to ensure that rates are not excessive.[6]

Most Independent Dialysis Providers Report Costs Below Their Medicare Payment Rate

The composite rate has remained essentially the same since it was instituted in 1983. Nevertheless, the number of outpatient dialysis providers has grown from 1,247 in 1983 to 2,084 in 1991, an increase of more than 67 percent. The number of independent providers (those not part of a hospital) more than doubled during the period and in 1991 accounted for 66 percent of the facilities and more than 70 percent of the treatments.

[5]Normally the salary limit is $50,000, but it can be higher if justified by the size of the dialysis facility.

[6]Information on Prospective Reimbursement Systems (GAO/HRD-82-73, May 10, 1982), Hospital Merger Increased Medicare and Medicaid Payments for Capital Costs (GAO/HRD-84-10, Dec. 22, 1983), and Comments on HHS Proposal to Revise End Stage Renal Disease Facility Payment Rates (GAO/HRD-86-126BR, July 22, 1986).

The increase in the number of independent facilities suggests that providers have been able to control costs and maintain profitability despite the static payment level. HCFA's audit sample supports this view. For example, 46 of the 62 independent facilities in HCFA's sample reported per treatment costs below their composite rate, with the differences ranging from $3.43 to $54.70. The 62 independent facilities had median reported costs per treatment of $108.91, compared to a median composite rate of $124.75.

Similarly, 40 percent of the hospital-based dialysis facilities reported costs below their payment rates. However, the median reported cost per treatment for hospital-based facilities exceeded their median composite rate by $6.07.

Audits Necessary to Assure Accurate Cost Data for Rate Setting

Historically, unaudited cost reports have included significant amounts of costs that Medicare does not allow. Consequently, ESRD audits are necessary if there is to be assurance that the cost data used for rate setting are accurate and reliable and that they conform with Medicare cost principles.

Because the audited cost data from a sample of facilities could affect the amounts Medicare pays to all ESRD facilities, it is important that these audits be thorough and complete. Auditors should determine that costs shown on the cost report are supported by the facilities' accounting records. Auditors also should ensure that costs are reasonable and related to patient care. Because certain items and services are paid separately from the composite rate, auditors must verify that the costs related to these items and services are not included in a facility's routine dialysis costs. Moreover, the auditors must determine the appropriateness of transactions with affiliated entities—called related organizations—that are under common ownership or control. ESRD facilities can inflate their costs by dealing in nonarms-length transactions with such organizations.

As a result of the ESRD audits, the reported costs of 62 independent facilities were reduced by almost 15 percent—from a median of $108.91 to $93.10 per treatment. Median per-treatment costs for the 62 hospital-based facilities increased slightly, from $134.24 to $134.72. In 9 of the 11 cost reports we reviewed (including that of 1 of the 3 hospitals), the audits resulted in reductions in the facilities' dialysis costs per treatment.

Following are some examples of unreasonable and unallowable costs removed by the auditors:

- One facility claimed $1,163,000 in management fee expenses in excess of what it had cost the facility's home office to provide the services.
- Another facility paid its home office $86,267 more to sublease a building than the home office paid to lease it.
- A third facility claimed $100,697 in compensation for a medical director. But, based on the amount of time the physician actually spent at the facility, it was only entitled to $9,180.
- A regional office claimed $865 for season tickets to a professional sports team's events.

Allowing costs such as these for rate-setting purposes could result in higher Medicare payments to all dialysis providers.

Quality of Most Recent ESRD Audits Is Questionable

Based on our review of the audit workpapers, we concluded that the audits performed by intermediaries and their subcontractors were incomplete and poorly done. On the other hand, we concluded that the OIG's audit of NMC's home office cost report was thorough and complete.

Government auditing standards, among other things, require auditors to obtain sufficient and competent evidential matter to afford a reasonable basis for their findings and conclusions.[7] Further, the standards require that auditors retain a written record of their audit evidence in workpapers. The information contained in the workpapers constitutes the principal record of the work that auditors have performed and the conclusions reached.

The ESRD audits we reviewed resulted in net reductions of about $1.9 million to the $20.6 million reported by the 11 facilities. More than 60 percent of this reduction resulted from the disallowances identified by the OIG during its audit of the NMC home office.

Our review found many weaknesses in the intermediary and subcontract audits. In some cases, required testing was not performed, while in many others, the testing was inadequate or the workpapers lacked sufficient evidence to support the auditors' findings and conclusions. For example, we concluded that the auditors did not adequately examine as required

[7]Sufficiency of evidence is the presence of enough factual and convincing evidence to support the auditors' findings, conclusions, and any recommendations. Competent evidence is evidence that is valid and reliable.

almost $7.7 million, or about 37 percent, of the facilities' reported costs to ensure that the costs were accurate and allowable. Further, the auditors did not always ensure that costs of items and services paid separately from the composite rate were excluded from the facilities' cost per treatment figure. Thus, the costs of providing dialysis services as stated in the audited cost reports are probably overstated because substantial costs were included without adequate assurance of their propriety.

Based on our evaluation of these audits, more thorough and complete audits would have resulted in additional reductions. The following examples illustrate the problems we found:

- Auditors overstated one facility's cost of providing dialysis treatment because they added in costs that the facility had excluded. The auditors' workpapers indicated that these costs were for items paid by Medicare outside the composite rate. Consequently, as much as $887,000, nearly 26 percent of the total costs shown on the cost report, was for dialysis services and supplies furnished to home patients not covered by the composite rate.
- A home office for a dialysis chain allocated over $4.4 million in costs to its facilities, and that amount was included in the facilities' cost reports. However, the home office cost report that was audited included only $3 million. As a result, over $1.4 million included as home office costs on the facility cost reports was not reviewed by the auditors at the home office or the facilities. Moreover, a significant amount of the costs included on the home office cost report were not adequately examined. For example, the workpapers showed little evidence that auditors assessed the reasonableness of $866,000 in compensation to corporate officers, including $200,000 in severance pay to a physician. In addition, although the auditors noted that the home office paid more than $245,000 in rent expenses to a partnership that included shareholders of the dialysis chain, they did not follow up to ensure that the expenses claimed excluded unallowable related-party profits. Approximately $558,000 of these inadequately audited home office costs were allocated to the independent facility in our sample, accounting for almost 21 percent of the facility's reported expenses.
- An intermediary instructed its CPA subcontractor to audit the wrong facility cost report, 1989's instead of 1988's. The intermediary then used the findings from a 1988 audit of the facility's home office to adjust the 1989 facility cost report. Thus, data from two time periods were mixed, and the facility's cost report did not accurately reflect true costs. Further,

the intermediary told us that this same situation occurred for two other facilities in HCFA's audit sample.

- Several audits did not include, or inadequately performed, required comparisons of cost data between the year audited and prior years. Such comparisons are important because significant changes may indicate errors or problems with the data and, thus, the need to more intensively review the applicable area. At one hospital-based facility, for example, the auditors' comparison of various renal department costs for the current and prior year showed increases ranging from approximately 23 to 122 percent. The auditors did not investigate these increases because they used an inappropriate measure of cost growth based on total hospital costs rather than ESRD department costs. Use of this measure precluded scrutiny of virtually any level of cost growth in the ESRD department.
- Auditors concluded that $942,000 in supply-related expenses claimed by one facility were accurate and allowable. However, the workpapers showed that the auditors had simply verified that the total supply expenses reported on the cost report agreed with the total shown in the facility's accounting records. Similarly, another audit only examined $114 of more than $83,000 claimed by the facility for depreciation expenses.
- An audit of a regional office that allocated costs to two of the facilities in our sample showed inadequate evidence that these expenses had been examined to eliminate unallowable costs. For instance, the auditor's workpapers showed no evidence that approximately two-thirds of the $1.5 million in expenses reported by that office were tested.
- The workpapers for an independent facility audit noted that the facility was providing dialysis services for other providers who paid the facility directly. The costs for these services were separately identified on the cost report, but the workpapers showed no evidence that the auditors sought to verify that the amounts reported accurately represented the services' costs. Thus, assurance was lacking that all costs paid by others outside the composite rate were excluded from the facility's cost of providing routine dialysis.
- For another audit, the workpapers contained a number of errors and discrepancies that made the accuracy of the auditors' work on 51 percent of the facility's reported costs questionable. For instance, the auditors accepted expenses as allowable even though they had been incurred in a prior year and should have been reported on that year's cost report. In addition, the workpapers showed that an account total matched a detailed list of invoices. However, we added the invoice amounts and found that the account balance understated costs by about $7,000. Similarly, as part of a verification of an insurance expense account, the auditors included

amounts that did not apply to the facility and amounts equal to the face value of the insurance policy rather than the amount of premium paid.

- An independent facility did not report any costs for drugs paid outside the composite rate on its cost report. The auditors concluded that $13,827 reported as routine dialysis supply costs on the cost report actually represented the cost of drugs paid outside the composite rate, and they removed this amount from reported costs. However, the workpapers showed that Medicare had paid the facility more than seven times that amount for nonroutine drugs, indicating that the facility's dialysis costs were still overstated. The auditors also overlooked evidence that other separately reimbursable costs, such as electrocardiogram tests and employee compensation for time spent on physician billings, had not been excluded from the facility's cost per treatment.

Performing less work than required by HCFA's audit programs might have been justified in some cases had the auditors tested facility internal control systems for recording and reporting Medicare cost data. If the results of such testing show that controls are adequate and the auditor decides to rely on the controls, then less detailed testing of account balances may be warranted. However, we found that workpapers showed little evidence that the auditors had reviewed the facilities' internal controls as a basis for planning the audit and determining the extent of testing to be performed. In addition, although fieldwork standards for government audits require auditors to review the work of their staff to ensure the work was adequately performed, 3 of the 11 audits showed little or no evidence of supervisory review.

The problems with audit quality occurred for a number of reasons. First, ESRD audits are not routinely performed. Based on our discussions with the auditors and reviews of their workpapers, we concluded that some of the auditors did not understand the specialized procedures needed to audit ESRD facilities. Several auditors, for instance, did not recognize the significance of ensuring that costs paid separately from the composite rate be excluded from a facility's costs used for computing routine dialysis treatment costs. This situation probably happened because the auditors lacked sufficient training or experience in the ESRD area.

Second, HCFA's audit guidance was not always clear and understandable, confusing some auditors about the nature and extent of testing required. In addition, HCFA did not hold training sessions for the auditors, as it had in previous ESRD audits, to ensure that auditors understood what was expected. The HCFA project officer for the ESRD audits told us that the audit

programs contained some steps that were no longer relevant while others needed revision or clarification.

Another reason for the poor quality of the audits was the short time that some auditors had to complete the work. In February 1990, HCFA announced its plan to audit a sample of ESRD facilities and stated that the audits had to be completed by July 31, 1990. However, the auditors did not receive HCFA's audit programs for performing the audits until late March or April. Some of the auditors believed it was not possible to complete all the work HCFA required in the time available, especially if they were assigned multiple audits. Moreover, because of short notice from HCFA and other audit priorities, intermediaries did not always have staff available to begin the work immediately. One intermediary subcontracted nine audits to a CPA firm, but, according to officials of the firm, the intermediary only allowed them 2 months to complete the work. Reviews of ESRD cost reports are complicated and time-consuming. Based on our own work, we agree with those auditors who questioned the reasonableness of the time allotted for these audits.

Lastly, HCFA did not review the work to determine whether it was adequately performed. The absence of adequate oversight may be due to a belief within HCFA that the audits would not accomplish anything. Several HCFA officials told us, for example, that earlier audits had shown that the composite rate should be reduced but that HCFA had been unable to convince the Congress to lower the rate. In a March 1992 report,[8] the Prospective Payment Assessment Commission (ProPAC) recommended that HCFA annually audit a sample of cost reports to use in evaluating payments. In response, HCFA said such a proposal was not cost effective because the agency lacked authority to revise rates.

Integrated Facilities Provide Dialysis Treatment at Lower Cost

HCFA's 1990 audit sample included 62 independent dialysis facilities, 50 of which were horizontally integrated. Of the 50 chain facilities, 23 were part of NMC, which is also vertically integrated. We were unable to determine from HCFA data the extent to which other chain facilities were vertically integrated.

Our analysis of HCFA's audit sample showed that the cost of providing a dialysis treatment averaged $87.52 at an NMC facility and $101.31 at other chains. These costs were $34.33 and $20.54 less, respectively, than the

[8]Prospective Payment Assessment Commission, Report and Recommendations to the Congress (Mar. 1, 1992).

average costs for the 12 nonintegrated facilities in the sample. The lower costs of integrated firms presumably result from economies of scale. For example, chains can minimize their costs by allocating overhead expenses among more than one facility. Because of their size, they can obtain volume discounts when purchasing supplies. Likewise, such providers can purchase employee benefit packages, such as health insurance, for less than would be possible for a single facility. Additionally, vertically integrated firms can realize financial benefits from owning their own laboratory and pharmacy and from manufacturing their own supplies and equipment.

Conclusions

The Congress gave incentives for efficient and economical operation of dialysis facilities by directing that Medicare use prospective payment rates. Accordingly, HCFA established a prospective payment system based on the national median audited costs of providing dialysis. While the industry maintains that rates should be raised, the costs reported by facilities, in the most recent cost reports that were subject to audit, showed that rates under Medicare's prospective payment methodology were more than adequate. Audits of the reported cost data showed that costs were overstated. Moreover, our analysis of the quality of the audits indicated that, if they had been adequately performed, reported costs would have been reduced further.

As we have in the past, we support establishing Medicare payment rates prospectively based on the costs incurred by efficient and economical providers.[9] To determine what that level of costs is, we believe it is necessary to have accurate, audited cost data for a sample of providers. HCFA's most recent audits of ESRD facilities were not adequately performed. Thus, HCFA's cost report data base probably overstates actual allowable costs, and HCFA would arrive at lower payment rates with better audits. Better audits would give both HCFA and the Congress assurance that the data accurately reflect only allowable costs. Such data should be used to set prospective payment rates for dialysis services.

[9]See, for example, Medicare: Comments on HHS Proposal to Revise End Stage Renal Disease Facility Payment Rates (GAO/HRD-86-126BR, July 22, 1986) and Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (GAO/HRD-85-74, July 18, 1985).

Recommendations to the Secretary of Health and Human Services

To ensure that the future audits of dialysis facilities provide accurate and reliable cost data, we recommend that the Secretary of HHS direct the Administrator of HCFA to

- revise and update HCFA's audit guidance and instructions,
- ensure that the auditors understand the technical aspects of the ESRD program,
- provide sufficient time to complete the audits, and
- monitor and review the audits to ensure that audit standards are followed and required work is performed.

Agency Comments

In commenting on a draft of this report, HHS agreed with our findings and recommendations (see app. II). The agency said that it was planning a nationwide audit of ESRD facilities and was reviewing its audit program for this effort. HHS also said it would ensure that (1) the auditors involved in the effort understand the ESRD program and the technical aspects of the revised audit program, (2) sufficient time is permitted to complete the audits undertaken, and (3) HCFA monitors and reviews the audits. These planned actions are responsive to our recommendations, and their implementation should help ensure that the audit effort results in adequately audited cost data for ESRD facilities.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 3 days after its issue date. At that time we will send copies to the Director, Office of Management and Budget; the Secretary of Health and Human Services; the Administrator of the Health Care Financing Administration; and other interested parties.

If you or your staffs have any questions about this report, please contact me on (202) 512-7119. Major contributors are listed in appendix III.

Janet L. Shikles
Director, Health Financing
and Policy Issues

Contents

Abbreviations

CPA	certified public accountant
ESRD	end stage renal disease
GAAP	generally accepted accounting principles
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
NMC	National Medical Care, Inc.
OIG	Office of Inspector General
ProPAC	Prospective Payment Assessment Commission

Objectives, Scope, and Methodology

The former Chairman of the Senate Committee on Finance and the Chairman of the Subcommittee on Health, House Committee on Ways and Means, asked us to (1) determine the appropriateness of the cost definitions used by Medicare to set payment rates for dialysis services, (2) assess the quality of the most recent audits of these costs by the Health Care Financing Administration,[1] and (3) analyze the effect that vertical and horizontal integration has on facilities' costs.[2]

To understand the rate-setting process and issues related to ESRD costs and services, we met with representatives from HCFA, the National Renal Administrators Association, the Institute of Medicine, and ProPAC.

To determine the appropriateness of HCFA's definition of costs, we reviewed the written comments and testimony submitted by renal industry representatives for an Institute of Medicine public hearing on dialysis rate setting, held in February 1990. In addition, we examined Provider Reimbursement Review Board and court cases as well as past GAO reports that dealt with using Medicare cost principles to set prospective payment rates.

To assess the quality of the audits, we randomly selected 30 audits from among the 62 independent and 62 hospital-based ESRD facilities in HCFA's audit sample. However, due to the amount of time needed to review each audit, we post-stratified our original sample of 30 audits into three groups, or strata, and randomly selected 11 audits. These 11 audits consisted of three hospital-based, four NMC independent facilities, and four non-NMC independent facilities. We separately stratified NMC because that company represented more than one-third of the independent facilities in HCFA's sample. The 11 audits we reviewed were performed by seven intermediaries or their subcontractors. Together these intermediaries were responsible for auditing 55, or about 44 percent, of the 124 facilities in HCFA's sample.

We reviewed 11 audit reports and supporting workpapers to determine whether the work was conducted in accordance with HCFA's guidance and instructions and complied with government auditing standards for evidence. Because no absolute measurement criteria exist for evaluating

[1]ProPAC was required by the Omnibus Budget Reconciliation Act of 1990 to study alternative payment approaches and develop a methodology for updating the payment rate in subsequent years.

[2]The requests also asked us to describe separately billable, dialysis-related services that could be included in a new prospectively established payment rate. This issue will be addressed in a separate report.

compliance with audit standards, we relied on professional judgment. We discussed our findings and observations with appropriate HCFA officials and with representatives from the fiscal intermediaries and CPA firms that performed each audit.

Our sample included six independent facilities that were affiliated with three chains. We reviewed the supporting workpapers for two of three home office audits and two of three NMC regional office audits for these chain facilities.

To address the effect of integration on ESRD facilities' costs and services, we compared cost-per-treatment data between the integrated and nonintegrated independent facilities in HCFA's audit sample.

We conducted our work between June 1991 and November 1992. Our work was conducted in accordance with generally accepted government auditing standards with the exception that we did not verify the accuracy of HCFA's computerized files of the audited and unaudited costs for the 124 facilities in HCFA's 1990 audit sample.

Comments From the Department of Health and Human Services

Note: A GAO comment supplementing those in the report text appears at the end of this appendix.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR 2 1993

Ms. Janet L. Shikles
Director, Health Financing
and Policy Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Shikles:

Enclosed are the Department's comments on your draft report, "Medicare: Renal Facility Cost Reports Probably Overstate Costs Of Patient Care." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Bryan B. Mitchell
Principal Deputy Inspector General

Enclosure

Comments of the Department of Health and Human Services (HHS) on the General Accounting Office (GAO) Draft Report, "Medicare: Renal Facility Cost Reports Probably Overstate Costs of Patient Care"

Overview

We have reviewed GAO's draft report concerning the Health Care Financing Administration's (HCFA) audits of end-stage renal disease (ESRD) facilities. The report indicates the dialysis industry believes that Medicare dialysis payment rates need to be raised. HCFA, in its most recent audit of 124 dialysis treatment facilities, found that rates were not only adequate but should be lowered.

Although GAO agrees with Medicare's prospective payment methodology and that payment rates to dialysis facilities were more than adequate, it found that the audits of facilities to determine fairness of rates were inadequate. The report concludes with several recommendations for HCFA to review and update its audit guidelines and instructions.

GAO Recommendation

To ensure that the future audits of dialysis facilities provide accurate and reliable cost data, we recommend that the Secretary of HHS direct the Administrator of HCFA to:

-- revise and update its audit guidance and instructions;

Department Comment

We are in the process of revising the ESRD audit programs. We are planning a nationwide audit of renal facilities, and we will complete the revisions in the audit programs before beginning that nationwide audit.

See comment 1.

Through discussions with the auditors, we hope that GAO was able to identify specific problems with the audit programs. If so, it would be very helpful to HCFA if GAO would share these findings with us, and advise us of specific recommendations to improve or clarify the renal audit programs.

GAO Recommendation

-- ensure that the auditors understand the technical aspects of the ESRD program;

Department Comment

We agree, and we will ensure that all auditors of the fiscal intermediaries understand the ESRD program as well as the technical aspects of HCFA's revised and updated ESRD audit program prior to initiating the nationwide audit.

GAO Recommendation

-- provide sufficient time to complete the audits; and

Department Comment

For the 1988 renal audits, each auditor needed about 100 hours to complete an audit, as documented by the results. In the nationwide audit, we will ensure that each auditor is permitted sufficient time to complete the audits that are undertaken, although limited resources may affect the number of audits undertaken.

GAO Recommendation

-- monitor and review the audits to ensure that audit standards are followed and required work is performed.

Department Comment

We agree with GAO that if audits are to be conducted, those audits must be monitored and reviewed to ensure that audit standards are followed and required work is performed. This is a basic management and oversight function of HCFA. In the nationwide audit, we will perform this function.

The following is GAO's comment on the Department of Health and Human Services' letter dated April 2, 1993.

GAO Comment

1. We identified numerous changes to the renal facility audit program that we believe would strengthen and improve it. We provided detailed information on these to officials from HCFA's Bureau of Program Operations.

Major Contributors to This Report

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