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END-STAGE RENAL DISEASE

CMS Should Improve Design and Strengthen Monitoring of Low-Volume Adjustment

GAO Highlights

Accountability * Integrity * Reliability

Highlights of GAO-13-287, a report to congressional committees

Why GAO Did This Study

Medicare spent about $10.1 billion in 2011 on dialysis treatments and related items and services for about 365,000 beneficiaries with end-stage renal disease (ESRD). Most individuals with ESRD are eligible for Medicare. As required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), CMS implemented the LVPA to compensate dialysis facilities that provided a low volume of dialysis treatments for the higher costs they incurred. MIPPA required GAO to study the LVPA; GAO examined (1) the extent to which the LVPA targeted low-volume, high-cost facilities that appeared necessary for ensuring access to care and (2) CMS's implementation of the LVPA, including the extent to which CMS paid the 2011 LVPA to facilities eligible to receive it. To do this work, GAO reviewed Medicare claims, facilities' annual reports of their costs, and data on dialysis facilities' location to identify and compare facilities that were eligible for the LVPA with those that received it.

What GAO Recommends

To more effectively target the LVPA and ensure LVPA payment accuracy, GAO recommends that the Administrator of CMS consider restricting payments to low-volume facilities that are isolated; consider changing the LVPA to a tiered adjustment; recoup 2011 LVPA payments that the Medicare contractors made in error; improve monitoring of those contractors; and improve the clarity and timeliness of guidance. The Department of Health and Human Services, which oversees CMS, agreed with GAO's recommendations.

View GAO-13-287. For more information, contact James C. Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

The low-volume payment adjustment (LVPA) did not effectively target low-volume facilities that had high costs and appeared necessary for ensuring access to care. Nearly 30 percent of LVPA-eligible facilities were located within 1 mile of another facility in 2011, and about 54 percent were within 5 miles, indicating these facilities might not have been necessary for ensuring access to care. Furthermore, in many cases, LVPA-eligible facilities were located near high-volume facilities. Among the freestanding facilities in GAO's analysis, LVPA-eligible facilities had substantially higher costs per dialysis treatment than the average facility ($272 compared with $235); however, so did other facilities that provided a relatively low volume of treatments (and were isolated) but were ineligible for the LVPA. The design of the LVPA gives facilities an adverse incentive to restrict service provision because facilities could lose a substantial amount of Medicare revenue over 3 years if they reach the treatment threshold. In another payment system, the Centers for Medicare & Medicaid Services (CMS) implemented a tiered adjustment that decreases as facility volume increases. Such an adjustment could diminish the incentive for dialysis facilities to limit service provision and also more closely align the LVPA with the decline in costs per treatment that occurs as volume increases.

Medicare overpaid an estimated $5.3 million in 2011 to dialysis facilities that were ineligible for the LVPA and did not pay an estimated $6.7 million that same year to facilities that were eligible. The payment problems occurred primarily because the guidance issued by CMS on facility eligibility was sometimes not clear or timely and CMS's monitoring of the LVPA was limited. For example, the majority of the ineligible facilities that received the LVPA were hospital-affiliated facilities that failed the volume requirement. Although CMS gave the Medicare contractors guidance for determining how to count treatments when facilities are affiliated with hospitals, the agency did not issue that guidance until July 2012. CMS has conducted limited monitoring of the LVPA, which has left CMS with incomplete information about LVPA administration and payments. For example, CMS was unaware as of January 2013 whether its contractors had recouped erroneous 2011 LVPA payments. In addition, CMS had requested information from its contractors about the implementation of the 2011 LVPA, such as which facilities were eligible for or had received the LVPA, but had not yet verified whether the information it received was complete or in a usable form. Without complete information about the administration of this payment adjustment, CMS is not in a position to ensure that the LVPA is reaching low-volume facilities as intended or that erroneous payments to ineligible facilities are recouped.