Improving payment for low-volume and isolated outpatient dialysis facilities

Nancy Ray and Andy Johnson

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Roadmap

- Overview of the ESRD PPS
- Medicare financial performance of isolated and rural dialysis facilities
- Commission principles on rural payment adjustments (2012)
- Design and issues with the low-volume payment adjustment (LVPA)
- Design and issues with the rural payment adjustment
- Improving the LVPA and rural adjustments to better target isolated facilities needed to ensure access to care

Overview of the ESRD PPS

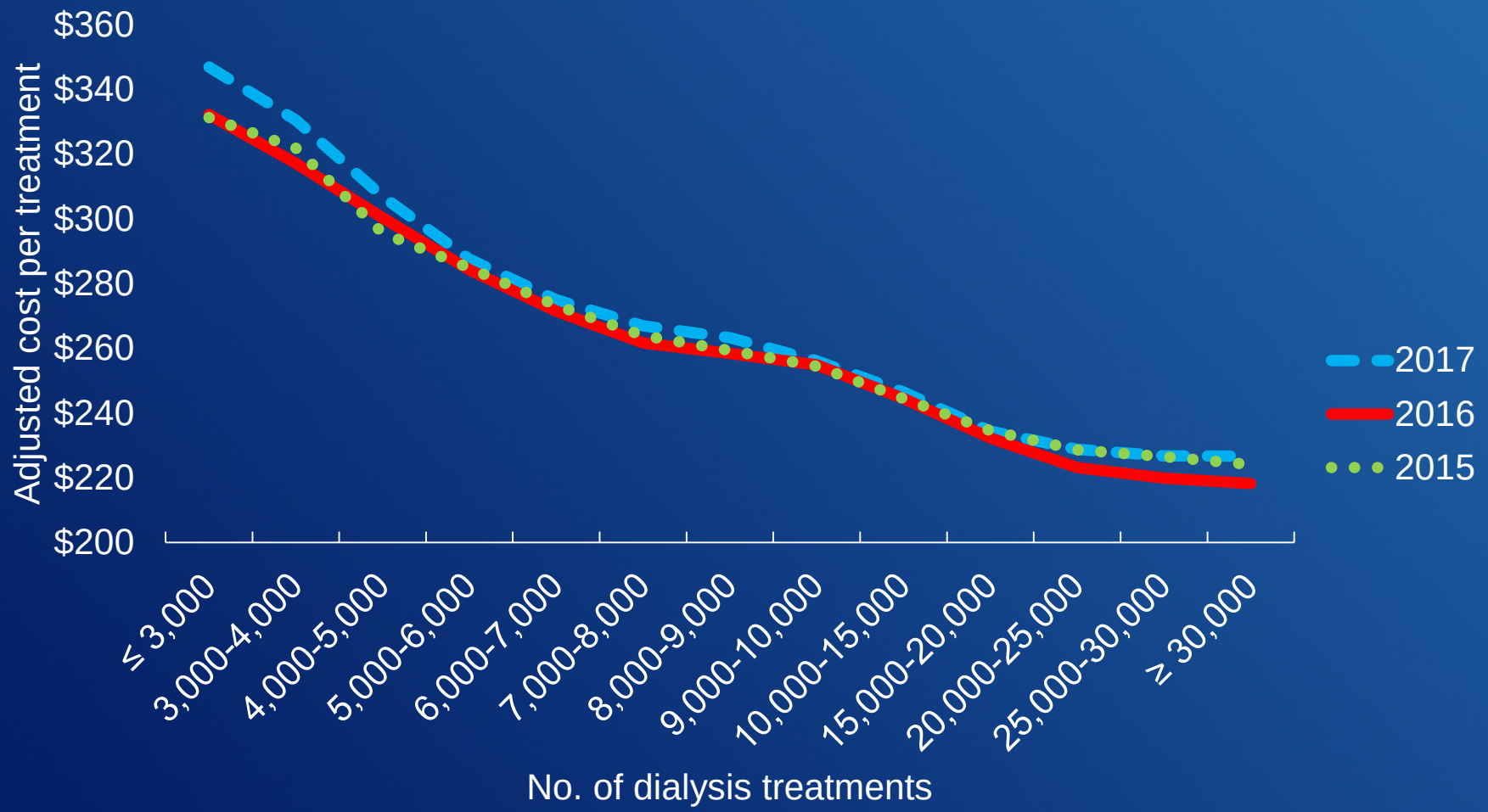
- CMS pays dialysis facilities under a bundled PPS
  - Since 2011, expanded bundle includes ESRD-related drugs and laboratory tests that were previously paid separately
  - In 2020, CMS will pay facilities separately for all new drugs without any offset to the PPS base payment rate under the revised transitional drug add-on payment adjustment policy
- Patient-level adjustments: Age, body mass index, body surface area, time since dialysis onset, acute comorbidities, chronic comorbidities
- Facility-level adjustments for low-volume and rural location

Low-volume and rural facilities had lower Medicare margins than high-volume and urban facilities

Type of freestanding dialysis facility	Medicare margin	% of freestanding dialysis facilities	% of total freestanding dialysis treatments
All	-1.1	100%	100
Urban	-0.4	82	88
Rural	-5.5	18	12
Treatment volume (quintile)			
Lowest	-21.3	20	7
Second	-10.6	20	12
Third	-3.4	20	17
Fourth	0.8	20	24
Highest	5.4	20	39

Note: Freestanding dialysis facilities furnish 95 percent of all Medicare FFS dialysis treatments.
Source: MedPAC analysis of freestanding dialysis cost reports and 100 percent claims submitted by dialysis facilities to CMS.

Dialysis facilities with low treatment volume have higher adjusted costs per treatment than high-volume facilities



Note: Cost per treatment adjusted for differences in the wage index. Preliminary and subject to change.
Source: MedPAC analysis of freestanding dialysis cost reports and 100 percent claims submitted by dialysis facilities to CMS.

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Commission's principles to evaluate rural special payments (2012)

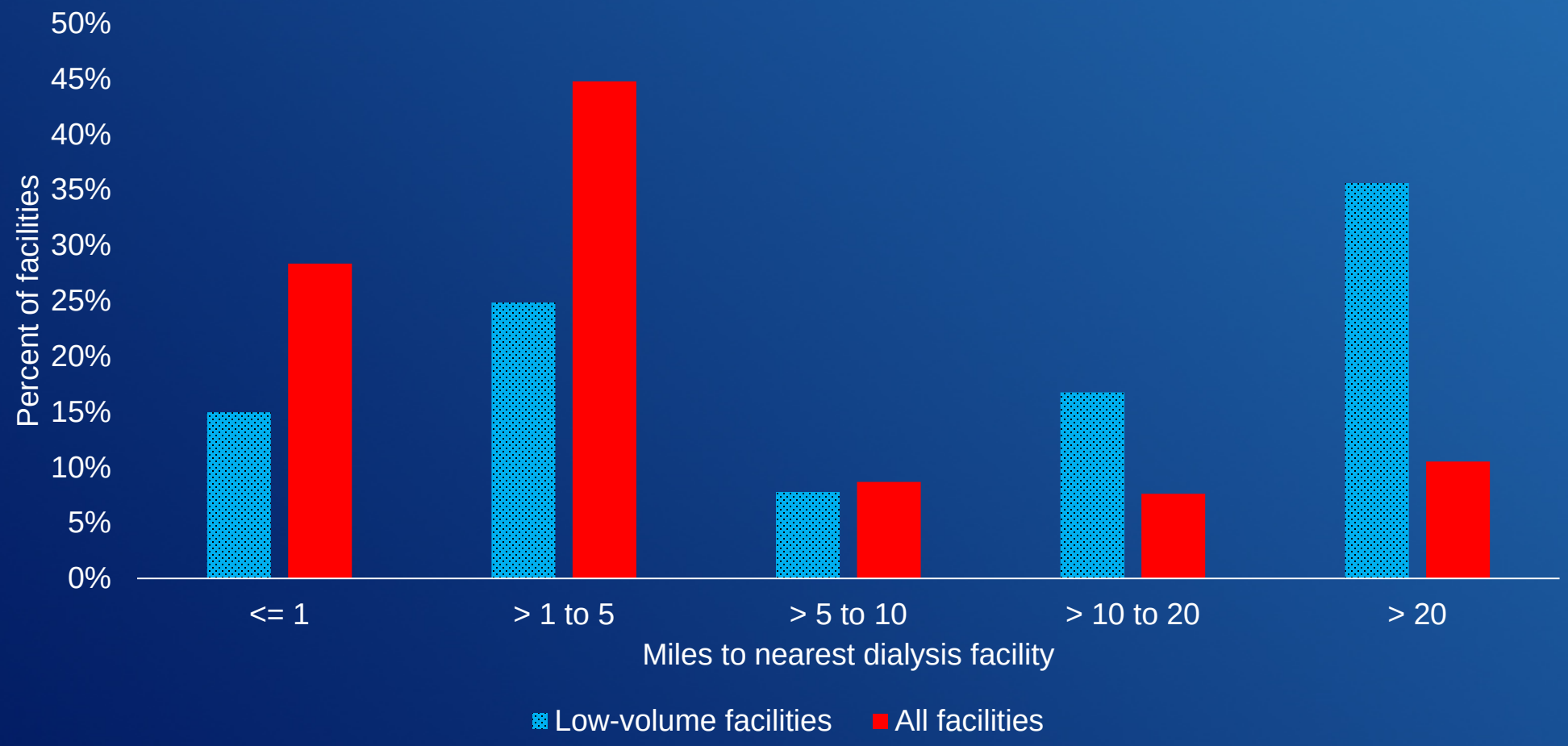
- Principles developed over several public meetings and published in June 2012 report
- Payments should be targeted toward low-volume isolated providers
- The magnitude of special rural payment adjustments should be empirically justified
- Rural payment adjustments should be designed in ways that encourage cost control on the part of providers

In 2017, about 5 percent of all dialysis facilities received the LVPA

- Base rate of LVPA facilities is increased by 23.9 percent
- LVPA criteria
  - Furnished less than 4,000 treatments in each of the 3 years before the payment year in question
  - Distance to nearest facility only considered for facilities under common ownership and within 5 miles of each other
  - 40 percent of LVPA facilities located within 5 miles of the nearest facility
- LVPA uses only one volume threshold of 4,000 treatments
  - So-called “cliff” effect may incentivize some facilities to limit services
  - Does not account for higher costs of facilities with relatively low volume (e.g., between 4,000 and 6,000 treatments per year)

Source: MedPAC analysis of claims and cost reports submitted by dialysis facilities to CMS, CMS’s Dialysis Facility Compare file, and CMS’s impact analysis for the calendar year 2019 ESRD PPS final rule. Data are preliminary and subject to change.

In 2017, 40 percent of LVPA facilities were located within 5 miles of the nearest dialysis facility



Source: MedPAC analysis of claims and cost reports submitted by dialysis facilities to CMS, CMS's Dialysis Facility Compare file, and CMS's impact analysis for the calendar year 2019 ESRD PPS final rule. Data are preliminary and subject to change.

All rural facilities receive adjustment, regardless of distance to other facilities and treatment volume

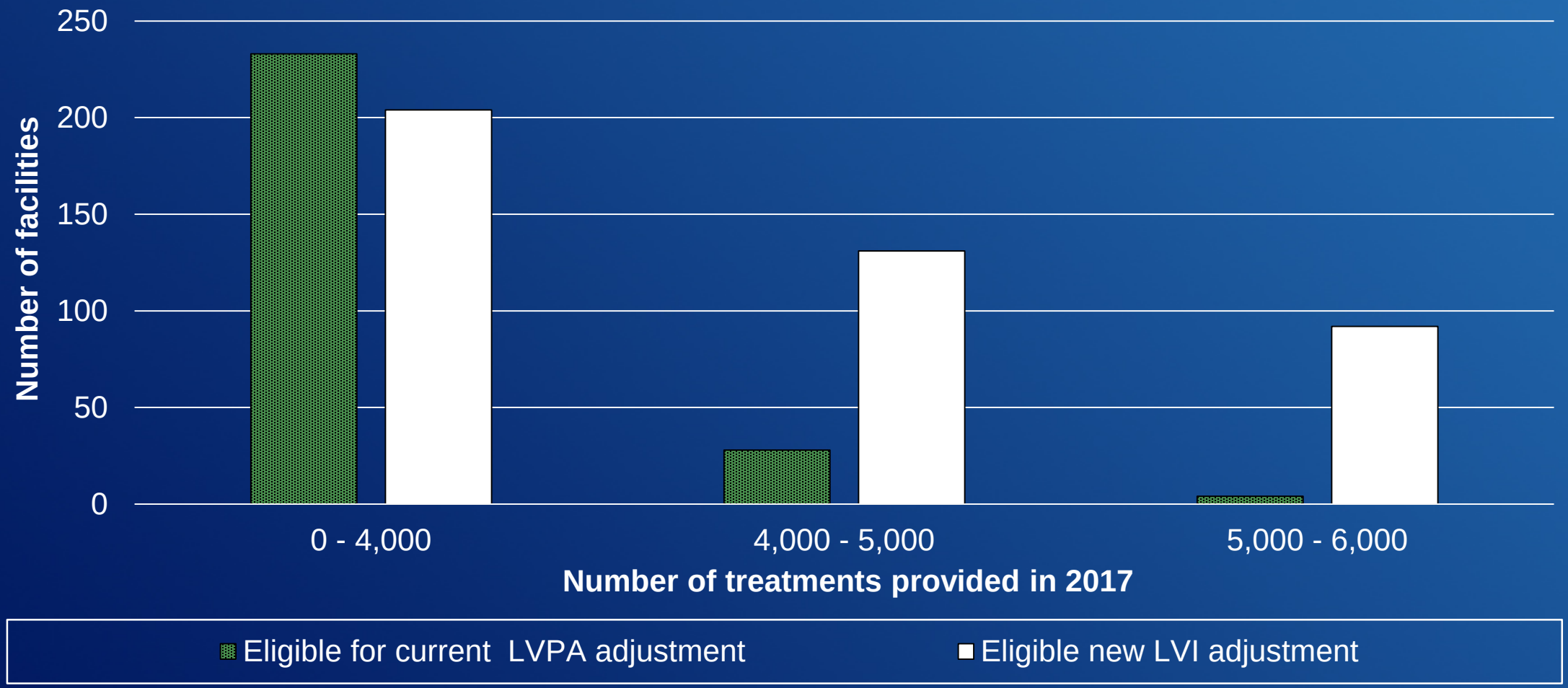
- Base rate of all rural facilities is increased by 0.8 percent
- In 2017, 18 percent of all dialysis facilities (n=1,272) were located in rural areas
  - About 30 percent of rural facilities were located within 5 miles of the nearest facility
  - 20 percent of rural facilities were high-volume, furnishing more than 10,000 treatments
  - High-volume freestanding facilities have, on average, lower adjusted costs per treatment than low-volume freestanding facilities (furnishing less than 4,000 treatments)

Source: MedPAC analysis of claims and cost reports submitted by dialysis facilities to CMS, CMS's Dialysis Facility Compare file, and CMS's impact analysis for the calendar year 2019 ESRD PPS final rule. Data are preliminary and subject to change.

Policy option: More accurately target low-volume and isolated (LVI) facilities

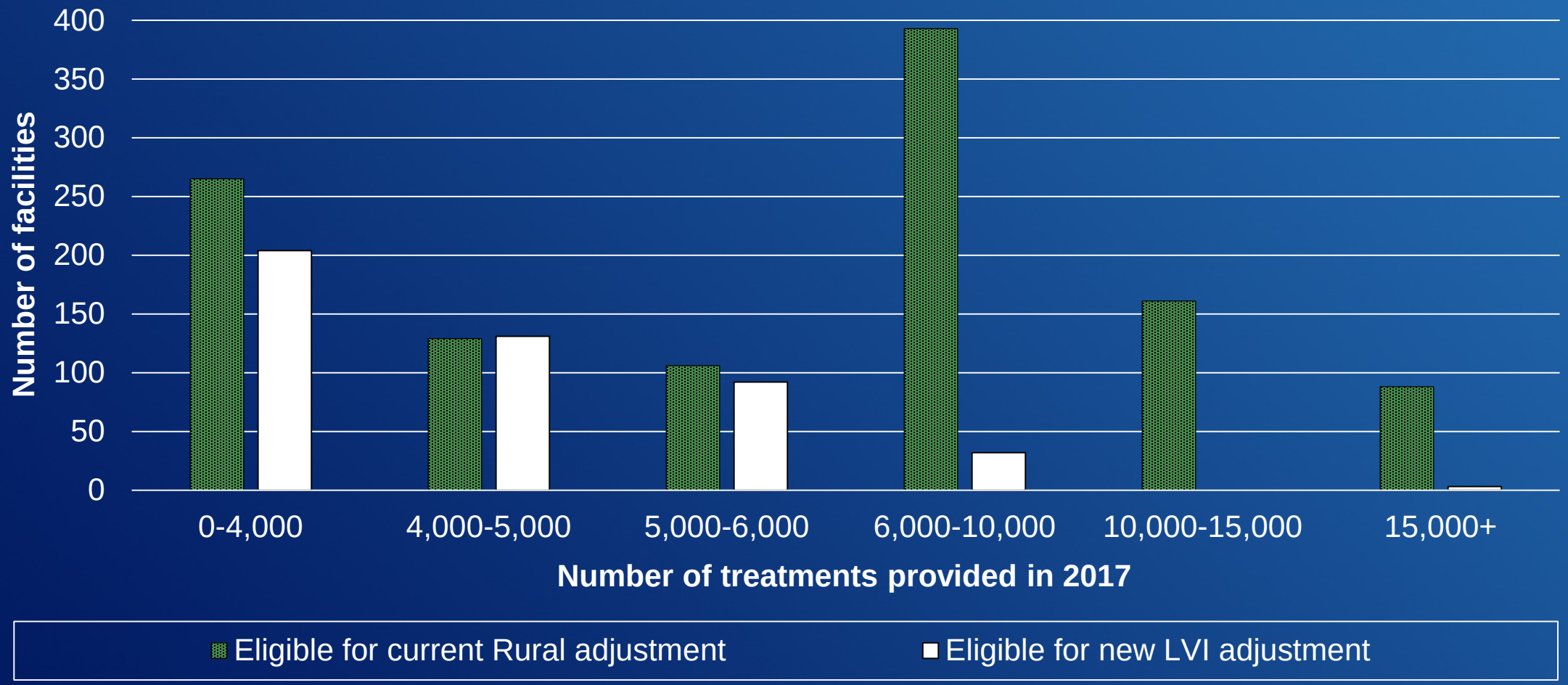
- Replace the two current adjustments for low volume and rural location with one adjustment that jointly applies two requirements:
  - Facility must be farther than 5 miles from nearest facility (regardless of ownership)
  - Facility must exhibit low volume over three preceding years
- To mitigate the LVPA's cliff effect and to more accurately account for higher costs in relatively low-volume facilities, identify low-volume facilities based on one of three categories:
  1. Fewer than 4,000 treatments in each of the 3 preceding years
  2. Fewer than 5,000 treatments in each of the 3 preceding years
  3. Fewer than 6,000 treatments in each of the 3 preceding years

Policy option would redistribute some LVPA payments from non-isolated to isolated facilities



Note: (LVPA) low-volume payment adjustment. (LVI) Low-volume and isolated. Analysis includes freestanding facilities (excludes hospital-based facilities) providing 6,000 or fewer treatments in 2017. Source: MedPAC analysis of claims and cost reports submitted by dialysis facilities to CMS. *Preliminary and subject to change.*

Policy option would shift broad rural adjustment from higher volume to isolated facilities



Note: (LVI) Low-volume and isolated. Analysis based on 2017 treatments includes freestanding facilities (excludes hospital-based facilities). Source: MedPAC analysis of claims and cost reports submitted by dialysis facilities to CMS. *Preliminary and subject to change.*

LVI adjustment would better account for higher cost in low-volume and isolated facilities

- Payment adjustment would be empirically estimated and proportional to average treatment costs
  - Analysis shows treatment costs align with LVI categories
- LVI adjustment would more accurately target high-cost facilities, particularly relatively low-volume facilities not receiving the LVPA
  - Medicare margin: facilities receiving LVPA (<4,000): -3%
  - Medicare margin: facilities not receiving LVPA (4-6,000): -17%

Note: (LVPA) low-volume payment adjustment. (LVI) Low-volume and isolated. Analysis only includes freestanding facilities (excludes hospital-based facilities).
Source: MedPAC analysis of claims and cost reports submitted by dialysis facilities to CMS. *Preliminary and subject to change.*

Summary

- A single LVI payment adjustment that targets low volume *and* isolated facilities could replace two current adjustments for low volume and rural location
- LVI adjustment would consider a facility's proximity to any other facility, not just those under common ownership
- LVI adjustment would expand the definition of low volume to mitigate the so-called cliff effect, and to account for the higher treatment costs of relatively low-volume facilities

Discussion

- In the fall, we plan to discuss
  - results of estimating payment adjustments
  - additional ESRD PPS concerns (e.g., patient-level adjustments, estimation methods)
  - ways to improve the transitional drug add-on payment adjustment
- We would appreciate feedback on aspects of the LVI adjustment and other factors to consider in future analysis