

# Improving Medicare payment for low-volume and isolated outpatient dialysis facilities

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# Why modify current low-volume and rural payment adjustment factors?

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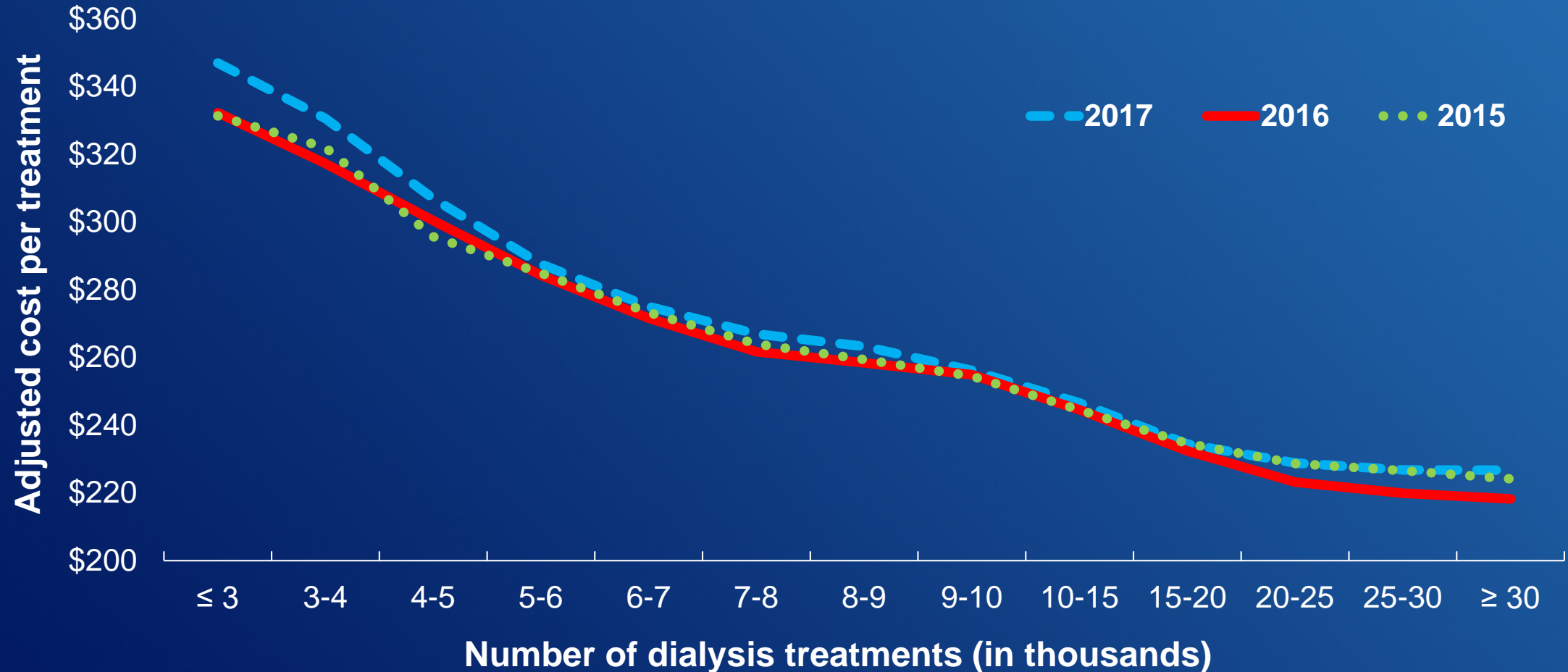
- Medicare financial performance of low-volume dialysis facilities
- Low-volume payment adjustment (LVPA) and rural payment adjustment does not focus on protecting isolated facilities critical to beneficiary access
- Design of LVPA and rural payment adjustment does not meet Commission principles on rural payment adjustments (2012)

# Overview of the ESRD PPS

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- CMS pays dialysis facilities under a bundled PPS
  - Since 2011, expanded bundle includes ESRD-related drugs and laboratory tests that were previously paid separately
- Patient-level adjustments: Age, body mass index, body surface area, time since dialysis onset, acute comorbidities, chronic comorbidities
- Facility-level adjustments for low-volume (LVPA), rural location, and wage index
- Added on to the base rate: Payments for self-dialysis training and outlier, and transitional drug add-on payments for calcimimetics

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

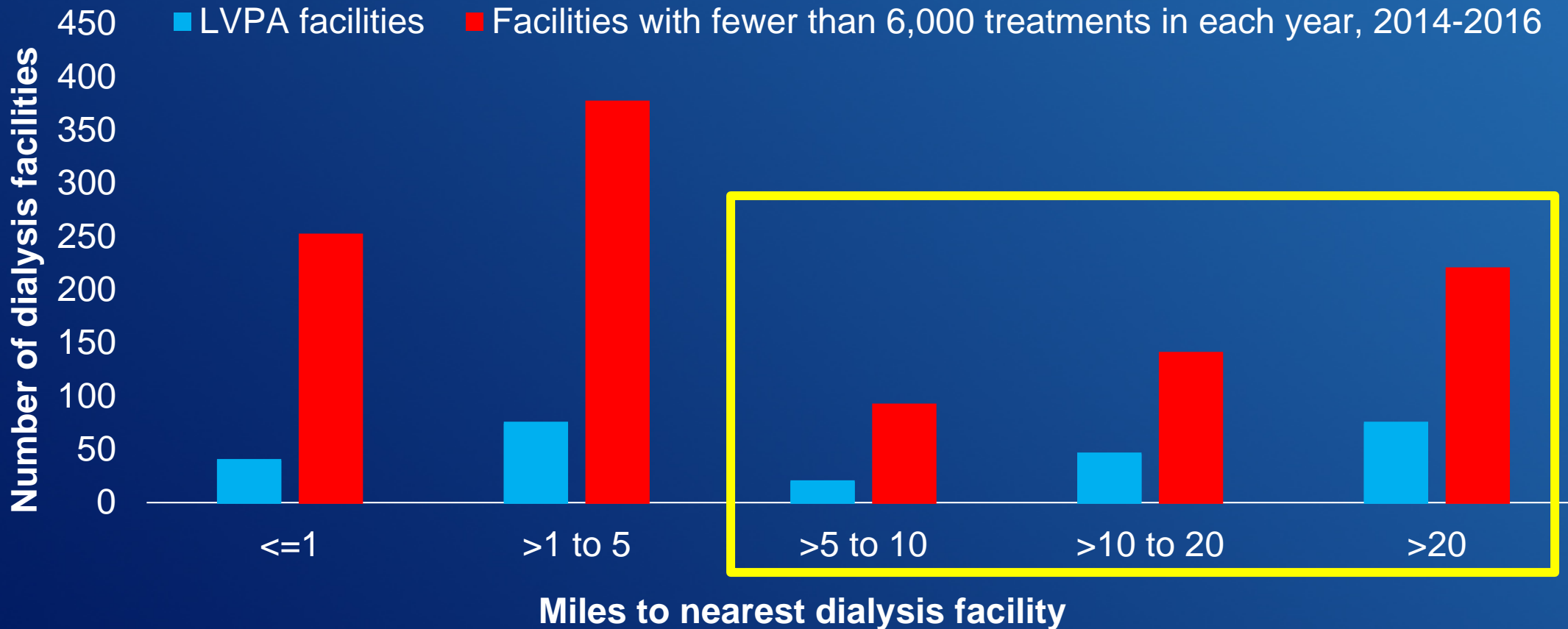


# LVPA does not target isolated and low-volume facilities

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- LVPA criteria:
  - Base rate of LVPA facilities is increased by 23.9 percent
  - 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
- Concerns with design of LVPA:
  - 40% of LVPA facilities are located close—within 5 miles—to other facilities
  - LVPA uses only one volume threshold of 4,000 treatments
  - Does not account for higher costs of facilities with relatively low volume (e.g., between 4,000 and 6,000 treatments per year)

# LVPA excluded some isolated, low-volume facilities in 2017



Analysis limited to freestanding dialysis facilities with cost report data for 2014-2016 and data on miles to the nearest 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.

# Rural adjustment does not target low-volume and isolated facilities

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- Since 2016, 0.8 percent adjustment applied to all facilities located in rural areas
- Concerns with rural adjustment
  - About 30 percent of rural facilities were located within 5 miles of the nearest facility
  - About 50 percent of rural facilities were high-volume, furnishing more than 6,000 treatments
  - High-volume freestanding facilities have, on average, lower adjusted costs per treatment than low-volume freestanding facilities

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.

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

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- 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

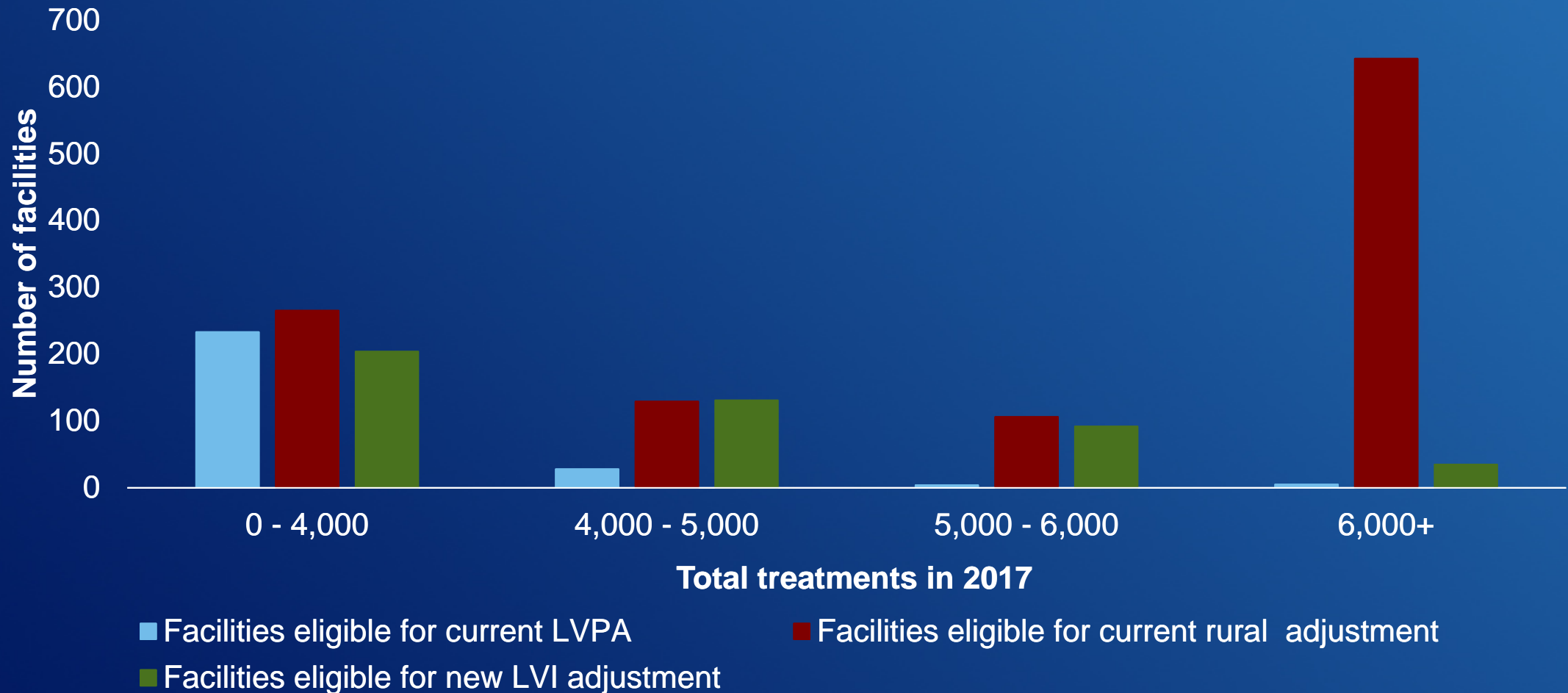


# Policy option: More accurately target low-volume and isolated (LVI) facilities (April 2019)

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- 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 payments from non-isolated and high-volume facilities



Note: (LVPA) low-volume payment adjustment. (LVI) Low-volume and isolated. Analysis 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.*

# MedPAC method for estimating LVI payment adjustments

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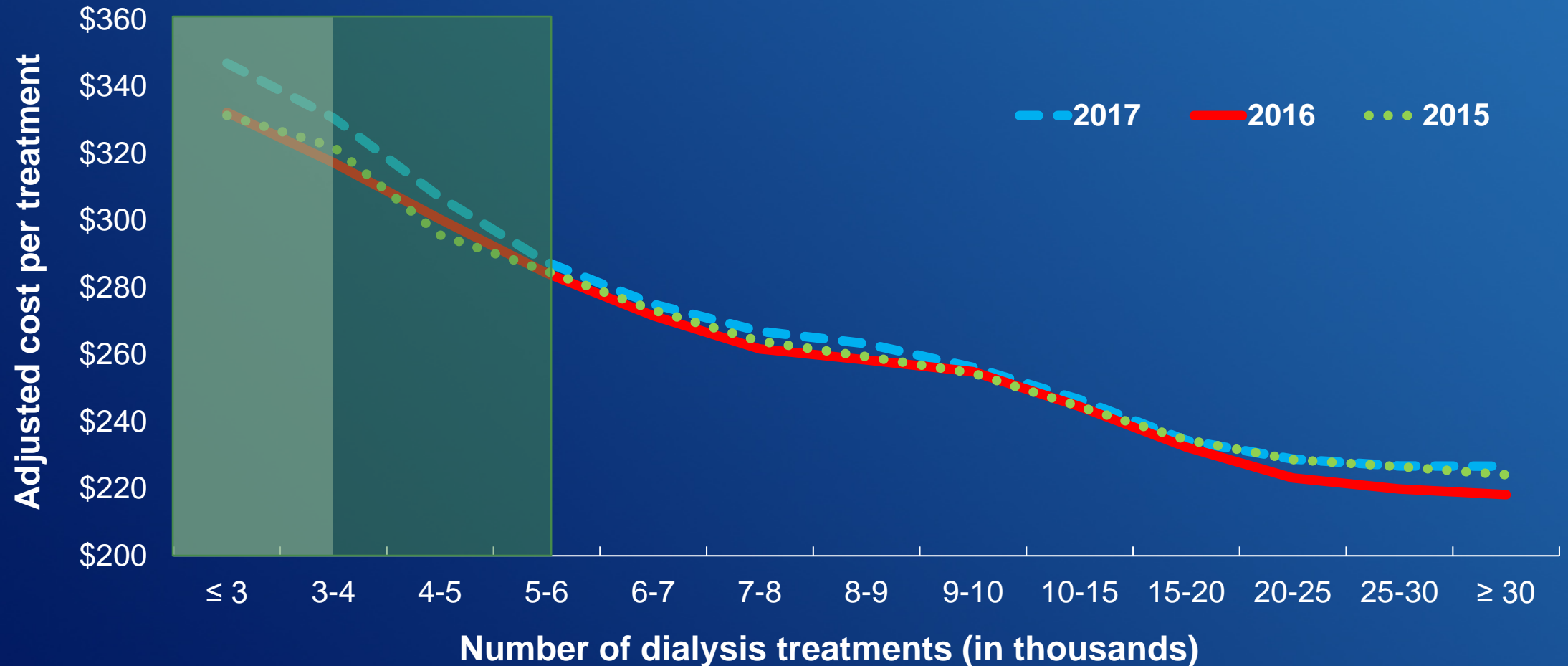
- Regression analysis of average treatment cost using freestanding facilities
  - Single facility-level regression
  - ESRD PPS explanatory variables
  - LVI category variables replaced current low volume and rural variables

# LVI payment adjustment better aligns with costs

	Payment increase
LVI Category 1	31%
LVI Category 2	27
LVI Category 3	19

- Size of the LVI category 1 adjustment would be similar to the current low-volume adjustment
- Results demonstrate benefit to expanding low volume definition to new facilities in LVI categories 2 and 3

# LVI payment adjustment would apply to more facilities with higher adjusted costs per treatment



# Impact of LVI on average Medicare payment rate

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- Payments generally increase for LVI-eligible facilities
  - Category 1: Payments roughly same (all facilities LVPA eligible)
  - Categories 2 & 3: Payments increase about 18 percent
- Payments decrease for low-volume facilities within 5 miles of another facility by about 20 percent
  - Current low-volume adjustment subsidizes low-volume facilities that are near other facilities
  - LVI targets facilities that are important for access to dialysis

# Summary

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- Current adjustments poorly target of low-volume and isolated facilities
- 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

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- We would appreciate feedback on aspects of the LVI adjustment and other factors to consider in future analysis
  - Based on Commission feedback, we can develop recommendation on applying the LVI in the ESRD PPS
- In the spring, we plan to discuss
  - Modeling alternative patient-level payment adjustment factors
  - Revising ESRD PPS estimation methods