LVPA

Medicare's Payment for Renal Dialysis Services Allows for a Low-Volume Payment Adjustment (LVPA)

Center for Medicare Services

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Low-Volume Payment Adjustment

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ESRD PPS Legislation

- Section 153(b) of the Medicare Improvements for Patients and Providers Act of 2008

  Implemented the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS), Effective January 1, 2011

  - Annually updated base rate
  - Patient-level and facility-level adjustments
    - Case-mix adjustments include age, body size, 6 categories of comorbidities, and onset of dialysis.
    - Facility-level adjustments include low-volume and wage index.
  - Add-on Adjustments
    - Home dialysis training
    - Outlier payment for high cost patients

Low-Volume Adjustment

Section 1881(b)(14)(D)(iii) of the Social Security Act

"Shall include a payment adjustment that reflects the extent of which costs incurred by low-volume facilities (as defined by the Secretary) in furnishing renal dialysis services exceed the costs incurred by other facilities in furnishing such services, and for payment for renal dialysis services furnished on or after January 1, 2011, and before January 1, 2014, such payment adjustment shall not be less than 10 percent."

Regulations

- CMS finalized the LVPA in our CY 2011 ESRD PPS final rule (75 FR 49118) and codified the regulation at 42 CFR Sec. 413.232.

- Specifically, we define a low-volume ESRD facility in the CFR at section 413.232(b) where we list two eligibility requirements:
  - Treatment threshold
  - Ownership status

Eligibility Definitions

- Section 413.232(b)(1)

  Furnished less than 4,000 treatments in each of the 3 cost reporting years (based on as-filed or final settled 12-consecutive month cost reports, whichever is most recent) preceding the payment year.

- Section 413.232(b)(2)

  Has not opened, closed, or received a new provider number due to a change in ownership in the 3 cost reporting years (based on as-filed or final settled 12-consecutive month cost reports, whichever is most recent) preceding the payment year.

Number of Treatments

All treatments furnished by the facility, regardless of the payer type or dialysis modality, are counted toward the treatment threshold.

- Medicare, private insurance and other payer types must be totaled for an aggregate.
- This aggregate must include all treatment modalities' furnished by the facility including those furnished to home patients (Home Hemodialysis and Peritoneal Dialysis).
- This aggregate must include both pediatric and adult treatments.

Eligibility
Requirements after 2011

- Number of treatments

  The number of the treatments considered furnished by the ESRD facility shall equal the aggregate number of treatments furnished by the ESRD facility and the number of treatments furnished by other ESRD facilities that has 5% of more common ownership, and is within 25 miles or less.

Eligibility Conditions

- Common Ownership is defined in 413.232(e)

  Means the same individual, individuals, entity, or entities, directly, or indirectly, own 5 percent or more of each ESRD facility.

  - The eligibility requirements for common ownership does not apply to ESRD facilities that were in existence and certified for Medicare participation prior to January 1, 2011.
  - The 25 miles or less requirement does not apply to ESRD facilities that were in in existence and certified for Medicare participation prior to January 1, 2011.

Eligibility Limitations

- ESRD facilities must furnish, to their Medicare Claims Processing Contractor, an attestation confirming that they meet the eligibility requirements.

- The mandatory deadline for the submission of the attestation is November 1st of each preceding payment year.

- The low-volume adjustment only applies to dialysis sessions furnished to adult patients. Pediatric dialysis sessions are not eligible for the low-volume payment adjustment.

Methodology Considerations

- ESRD facilities that believe that they may exceed the 4,000 treatment threshold in the payment year must use their own procedures for tracking the number of furnished treatments and notify their Medicare Claims Processing Contractor when they no longer qualify for the payment adjustment.

Methodology Considerations

- The requirement of three 12-consecutive month cost reports, establishes a 3-year eligibility period. Looking across data for three years provides us with a sufficient span of time to view consistency in business operations.

- Facilities that reach the 4,000 treatment threshold lose LVPA eligibility, until they can attest that they qualify.

- The LPVA is not a rural adjustment.

CMS LVPA Implementation

- ESRD facilities must submit an attestation
  - Mandatory deadline of November 1st
- FI or A/B MACs will verify ESRD facility eligibility
  - Review the 12-consecutive month cost reports ending in the 3 years preceding the payment year for total treatment count.
    - Worksheet C for independent
    - I series for hospital-based
  - Ownership status
    - Opened, closed, or had a change of ownership
  - ESRD facilities certified on or after January 1, 2011

CMS LVPA Implementation

- Discontinuation of the LVPA
  - The ESRD facility contacts their FI or A/B MAC
    - The ESRD facility is no longer eligible for the adjustment.
  - Did not meet eligibility criteria as stated in the attestation
    - The ESRD facility did not meet the treatment threshold criteria for third eligibility year.
    - Recoupment
  - ESRD facility did not submit their attestation prior to deadline.
    - The attestation must be submitted every November 1st.

GAO Report 13-287

The Government Accountability Office (GAO) report, *"CMS Should Improve Design and Strengthen Monitoring of Low-Volume Adjustment."* was published on March 1, 2013. The report considers;

- the extent to which costs incurred by low-volume facilities exceed the costs incurred by other facilities, and
- If the magnitude of the adjustment at 18.9 percent, encourages small ESRD facilities to continue operating in areas where beneficiary access might be jeopardized if such facilities closed.

GAO Findings

- The average cost per treatment in LVPA-eligible facilities was approximately 16 percent higher compared to the average per treatment costs of all freestanding ESRD facilities.

- Nearly 30 percent of eligible facilities were located with 1 mile of another facility, and 54 percent were with 5 miles.

- Medicare overpaid an estimated $5.3 million to dialysis facilities that did not meet eligibility requirements.

Recommendations

- Require Medicare Administrative Contractors (MACs) to promptly recoup LVPA payments that were made in error.
- Investigate errors and clarify payment policy to ensure that future LVPA payments are made to only eligible facilities.
- Ensure that regulations and guidance is clear, timely, and effectively disseminated to both dialysis facilities and MACs.
- Improve LVPA payment monitoring.

CMS Concurrence

- The payment problems identified in the GAO report undermine the purpose of the LVPA, which is encouraging ESRD facilities to continue to operate in areas where beneficiary access might be jeopardized without a payment adjustment.

- CMS concurred with the GAO report and is considering their recommendations.

Frequently Asked Questions

Question - For an ESRD facility to be eligible for the LVPA beginning January 1, 2014, what years are the Fiscal Intermediary (FI) OR A/B MAC reviewing?

Answer - The ESRD facility must have furnished less than 4,000 treatments in each of the three years immediately preceding the payment year. This three year period covers the facility's three 12 consecutive month cost reporting periods immediately preceding the ESRD PPS payment year beginning January 1, 2014. The ESRD facility will need to have met the low-volume criteria for cost reporting periods ending in 2011, 2012, and 2013.

Frequently Asked Questions

- Question - Once an ESRD facility is determined to be eligible for the LVPA for a particular year, is the ESRD facility required to submit an attestation on a yearly basis?

- Answer - Yes. ESRD facilities eligible to receive the LVPA are required to submit an attestation on a yearly basis, that is, no later than November 1st of each year.

Frequently Asked Questions

Question - If a hospital has a hospital-based and a satellite ESRD facility, can the hospital-based ESRD facility qualify for the LVPA if the satellite facility does not?

Answer - No. The hospital-based ESRD facility and the satellite ESRD facility are considered to be part of one hospital complex because the cost of dialysis treatments from both dialysis facilities are aggregated when configuring the hospital's cost report.

Frequently Asked Questions

Question - Can a facility with a change of ownership in the past 3 eligibility years, but does not have a change in the provider number qualify for the LVPA?

Answer - Yes. In a change of ownership, where the buyer inherits the sellers Provider Transaction Access Number (PTAN) and assumes the seller's debt and liability by continuing business as usual, can qualify for the LVPA.

Frequently Asked Questions

Question - Is the LVPA based on treatments furnished in each cost reporting year or calendar year?

Answer - To qualify for the LVPA, the ESRD facility must have furnished less than 4,000 dialysis treatments and has not opened, closed, or received a new provider number due to a change in ownership in each of the 3 years preceding the payment year. This 3 year period covers the facility's three 12 consecutive month cost reporting periods immediately preceding the ESRD PPS payment year beginning January 1st.

Frequently Asked Questions

Question - What does CMS mean when they state, “12-consecutive month cost reports”?

Answer - The three year eligibility period is the facility’s three 12 consecutive month cost reporting periods ending immediately before the ESRD PPS payment year beginning January 1st. FIs or A/B MACs are required to only verify cost reports that report costs for 12 consecutive months. FIs or A/B MACs cannot accept two short period cost reports and add them together to come up with a total of 12 months nor can they accept a cost report that is greater than 12 months.

Resources

CY 2011 ESRD PPS final rule; 75 FR 49117 through 49125 – Issued August 12, 2010

MLN Matters® Article #MM7064 "ESRD PPS and Consolidated Billing for Limited Part B Services" - Related CR Release Date: January 14, 2011

MLN Matters® Article #MM7388, "ESRD Low Volume Adjustment and Establishing Quarterly Updates to the ESRD PPS " - Related CR Release Date: April 22, 2011

CY 2012 ESRD PPS final rule; 76 FR 70236 through 70237 - Issued November 10, 2011

MLN Matters® Article #MM7626, "Recoupment of Incorrect Payments Made Under the ESRD PPS for the Low-Volume Payment Adjustment" - Related CR Release Date: November 18, 2011

CMS ESRD Payment website

Closing Remarks

Thank you for your time today.

Please submit additional inquiries to Stephanie.Frilling@cms.hhs.gov or Michelle.Cruse@cms.hhs.gov.

Please submit LVPA facility eligibility inquires directly to your MAC.

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