

CMS NEWS

FOR IMMEDIATE RELEASE

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CMS proposes policy and payment rate changes for End-Stage Renal Disease facilities in 2013

Proposals would also strengthen incentives to improve outcomes for patients with ESRD

The Centers for Medicare & Medicaid Services (CMS) today issued a proposed rule that would update Medicare policies and payment rates for End-Stage Renal Disease (ESRD) facilities paid under the ESRD Prospective Payment System (PPS) for calendar year (CY) 2013. The proposed rule would also strengthen incentives for improved quality of care and better outcomes for patients through improvements to the ESRD Quality Incentive Program (QIP). Performance scores on the QIP measures during a proposed CY 2013 performance period would affect payments to dialysis facilities in CY 2015.

In addition to other updates, payment rates for outpatient maintenance dialysis treatments are anticipated to increase by 2.5 percent in CY 2013. This reflects the ESRD bundled market basket increase of 3.2 percent reduced by a productivity adjustment of 0.7 percent, as required by statute. CMS estimates that Medicare payments to the 5,633 ESRD facilities in CY 2013 will total \$8.7 billion. When all policy changes are considered together, payments to ESRD facilities are expected to increase by 3.1 percent in 2013.

“As we enter the third year of our four year transition to the new fully bundled payment system for certain dialysis facilities, 90 percent of facilities are voluntarily receiving payments under the new system,” said Jonathan Blum, CMS deputy administrator and director of the agency’s Center for Medicare. “We believe that the policies and rate changes proposed today will continue to help ensure that beneficiaries diagnosed with ESRD continue to get the care they need.”

The proposed rule would continue to focus on clinical measures and expand the scope of the reporting measures included in the ESRD QIP to encompass a broader range of patient populations who receive dialysis care and to address concerns about the quality of life experienced by patients on dialysis. Specifically, CMS is proposing that ESRD facilities collect data for four reporting measures to capture information about how well each facility:

- Manages patients' anemia, a common side-effect of hemodialysis;
- Reports dialysis infection events to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN);
- Monitors patients for abnormalities in phosphorous and calcium levels; and
- Surveys patients to learn about their experiences of care.

“The CMS proposals for the Quality Incentive Program aim to improve the quality of dialysis services furnished to people diagnosed with End-Stage Renal Disease,” said Patrick Conway, M.D., CMS chief medical officer and director of the agency’s Office of Clinical Standards and Quality. “The QIP proposal results in 11 measures essential for patient-centered care including anemia management, preventing bloodstream infections, dialysis access and adequacy, and patient experience.”

Both the ESRD PPS and the QIP were mandated by the Medicare Improvements for Patients and Providers Act of 2008. The previous ESRD payment system consisted of a composite rate payment for a defined set of services, including certain laboratory tests, drugs and other supplies, while separate payments were made for any ESRD-related items or services furnished as part of the dialysis treatment but for which no payment was made under the composite rate. The composite rate payment was adjusted to reflect the ESRD facility’s geographic location and a limited number of patient’s characteristics. The new bundled ESRD PPS is intended to improve efficiency and reduce incentives to use more items and services than needed for appropriate care, while the QIP is intended to promote continued improvement in the quality of care provided to Medicare beneficiaries with ESRD.

This proposed rule would also codify provisions of The Middle Class Tax Extension and Job Creation Act of 2012 that require reductions in bad debt reimbursement to all providers eligible to receive bad debt reimbursement; these provisions are specifically prescribed by Congress and thus, are generally self-implementing.

The proposed rule will appear in the July 11, 2012, Federal Register. CMS will accept comments on the proposed rule until Aug. 31, 2012, and will respond to comments in the final ESRD PPS rule for CY 2013.

For more information, see:

<http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1>

For more information about the ESRD PPS and QIP, please see:

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Medicare proposals to update policies and payment rates for the End-Stage Renal Disease Prospective Payment System for CY 2013

OVERVIEW: On July 2, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after Jan. 1, 2013. The proposed rule also proposes changes to the ESRD Quality Incentive Program (QIP) that provides payment incentives to dialysis facilities to improve the quality of dialysis care. Under the QIP, facilities that do not achieve a high enough total performance score with respect to quality measures established in regulation receive a reduction in their payment rates under the ESRD PPS.

In addition, the proposed rule proposes to codify in regulations reductions in bad debt payments for all Medicare providers eligible for bad debt reimbursement that were mandated by the Middle Class Tax Extension and Job Creation Act of 2012.

This Fact Sheet addresses general provisions of the ESRD PPS in the proposed rule. The QIP is discussed in a separate fact sheet also issued today.

BACKGROUND: The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required CMS to implement a fully bundled PPS for renal dialysis services furnished to Medicare beneficiaries effective Jan. 1, 2011. The ESRD PPS replaced a payment methodology which provided for payment of a composite rate for a defined set of dialysis services, plus separate payment for ESRD-related services that were not included in the composite rate. Under the ESRD PPS, Medicare makes a single prospectively determined payment to ESRD facilities for all renal

dialysis services furnished for outpatient maintenance dialysis, including ESRD- related drugs and biologicals (with the exception of certain oral drugs until 2014) and other ESRD-related items and services that were formerly separately payable under the previous payment methodologies. The bundled payment rate is adjusted for a number of factors relating to patient characteristics. There are additional adjustments for ESRD facilities that have a low patient volume and for facilities that offer home dialysis training. For high-cost patients, an ESRD facility may be eligible for outlier payments.

The statute required Medicare to implement the ESRD PPS for dialysis services furnished on or after Jan. 1, 2011, but provided for a four-year transition period during which dialysis facilities would be paid a blended rate based on the composite-rate methodology and the new PPS. However, the statute allowed dialysis facilities to make a one-time election to forego the transition and receive payment entirely under the ESRD PPS. More than 87 percent of facilities elected to be paid entirely under the ESRD PPS. For those facilities that are being paid under a blended rate, CY 2013 is the final year of the transition. The proposed blended rate for CY 2013 is 75 percent of the ESRD PPS and 25 percent of the composite payment rate.

PROPOSED CHANGES TO THE ESRD PPS FOR CY 2013:

Updated Payment Rates for the ESRD PPS and the Composite Rate Portion of the Blended Payment: CMS projects that the 2013 ESRDB market basket update will be 3.2 percent, although this may change in the final rule based on more recent data. CMS also projects that the multi-factor productivity (MFP) adjustment as required by statute for CY 2013 will be 0.7 percent. Therefore, CMS is projecting an update of 2.5 percent to the ESRD PPS base rate in CY 2013. After applying a proposed wage index budget-neutrality adjustment factor of 1.000826, the resulting proposed base rate for the ESRD PPS is \$240.88.

The 2.5 percent update would also apply to the composite rate portion of the blended payment for facilities that are in the transition period. After applying the 2.5 percent update, the resulting proposed composite base rate is \$145.49.

Outlier Policy: Under the ESRD PPS, ESRD facilities may qualify for outlier payments when the costs of furnishing outlier services to an individual patient exceed the predicted outlier services amount by a certain threshold. For CY 2013, CMS proposes to use 2011 claims data to update the outlier services' fixed-dollar loss and Medicare Allowable Payment (MAP) amounts. As a result, CMS is proposing to reduce the fixed-dollar loss amount for pediatric patients from \$71.64 to \$50.15 and the MAP amount to from \$45.44 to \$43.63. For adult patients, CMS is proposing to

reduce the fixed-dollar loss amount from \$141.21 to \$113.35 and the MAP amount from \$78.00 to \$61.06. These reductions mean that more cases may qualify for outlier payments.

Transition Budget Neutrality Adjustment: For CY 2013, CMS is proposing to apply the transition budget neutrality adjustment methodology used in CY 2011, yielding a 0 percent transition budget neutrality adjustment for both the blended payments and the payments under the 100 percent ESRD PPS for CY 2013.

Update to the Composite Rate Drug Add-On for CY 2013: For CY 2013, CMS proposes to apply the current methodology to compute the drug add-on payment for the composite rate portion of the blended payment during the transition, resulting in a 0 percent update. Because the ESRD bundled rate (ESRDB) market basket minus productivity that is applied to the composite rate increases the composite rate, the add-on adjustment of 14.3 percent is reduced to 14.0 percent to maintain the drug add-on at \$20.33.

Wage Index and Wage Index Floor: For CY 2013, CMS is not proposing any changes to the methodology for the wage index nor the application of the wage index budget-neutrality adjustment factor. For CY 2013, CMS proposes to continue to gradually decrease the wage index floor under the composite rate payment system and under the ESRD PPS by 0.05. Therefore, CMS proposes to reduce the wage index floor from 0.55 to 0.50. As indicated above, the proposed wage index budget neutrality adjustment is 1.000826 for the ESRD PPS and for the ESRD PPS portion of the blended payments, and the proposed wage index budget-neutrality adjustment factor for the composite portion of the ESRD PPS blended payment is 1.001538.

Impact Analysis: CMS projects that the proposed updates for CY 2013 would increase total payments to all dialysis facilities by 3.1 percent over CY 2012. For hospital-based ESRD facilities, CMS projects an increase in total payments of 3.7 percent, while for freestanding facilities, the projected increase in total payments would be 3.0 percent. CMS also projects that urban ESRD facilities will receive an estimated increase in payments of 3.1 percent while rural facilities will receive a 3.0 percent increase. CMS projects that dialysis facilities in Puerto Rico and the Virgin Islands will receive a 0.4 percent increase in estimated payments.

Bad Debt: CMS is proposing to codify the provisions of section 3201 of the Middle Class Tax Extension and Job Creation Act of 2012 (Pub. L. No. 112-96) that requires reductions in bad debt reimbursement to all providers eligible to receive bad debt reimbursement; these provisions are specifically prescribed by Congress and thus, are generally self-implementing.

The proposed rule will appear in the July 11, 2012, Federal Register. CMS will accept comments on the proposed rule until Aug. 31, 2012, and will respond to comments in the final ESRD PPS rule for CY 2013.

For more information, please see:

<http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1>

For more information about the ESRD PPS and QIP, please see:

<https://www.cms.gov/Center/Special-Topic/End-Stage-Renal-Disease-ESRD-Center.html>

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Medicare proposals for new requirements for the ESRD Quality Incentive Program, including for Payment Year 2015

OVERVIEW:

On July 2, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after Jan. 1, 2013. The proposed rule also proposes changes to the ESRD Quality Incentive Program (QIP) that provides payment incentives to dialysis facilities to improve the quality of dialysis care. Under the QIP, facilities that do not meet or exceed the specified total performance score with respect to quality measures established in regulation receive a reduction in their payment rates under the ESRD PPS.

In addition, the proposed rule proposes to codify in regulations the reductions in bad debt payments for all Medicare providers eligible for bad debt reimbursement that were mandated by the Middle Class Tax Extension and Job Creation Act of 2012.

BACKGROUND:

The ESRD QIP, which adjusts payments to dialysis facilities based on their performance on measures of quality, builds upon longstanding efforts by CMS to improve the quality of dialysis services furnished to people with Medicare. The proposed rule for calendar year 2013 proposes to update requirements for the QIP, including the measures and scoring methodologies that would affect payments to dialysis facilities in payment year (PY) 2015.

With respect to the PY 2015 QIP, the proposed rule proposes to adopt new clinical and reporting measures, as well as expand the scope of two reporting measures currently included in the ESRD QIP, to encompass a broader range of issues faced by patients who receive dialysis care and to address concerns about the quality of life experienced by patients on dialysis.

PROPOSED MEASURES AND WEIGHTING FOR PY 2015 QIP

For PY 2015 payment determination, CMS proposes a total of 11 measures—seven clinical measures and four reporting measures. Clinical measures assess the quality of care provided to individual patients using facility performance on specific clinical indicators. Reporting measures assess whether a facility has reported quality-of-care data as outlined in rulemaking to support quality improvement efforts.

The four proposed reporting measures would capture information about how the facility:

- Manages patients' anemia, a common side-effect of hemodialysis;
- Reports dialysis infection events to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN);
- Monitors patients for mineral metabolism abnormalities in phosphorous and calcium levels; and
- Surveys patients to learn about their experiences of care.

The proposed anemia management reporting measure is new, while the NHSN and mineral metabolism reporting measures are expanded from their introduction for the PY 2014 QIP. Furthermore, the proposed patient experience of care measure remains unchanged from PY 2014, and remains tied to the In-center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) survey instrument.

CMS is proposing to adopt a new Kt/V Dialysis Adequacy measure topic and retain the Vascular Access Type measure topic, each of which are composed of multiple measures. For purposes of calculating the total performance scores (TPS), CMS proposes to weight the individual measure score(s) applicable to a given facility within a measure topic to create a single score for the measure topic.

CMS is proposing to weigh individual scores for the reporting measures that apply to a given facility equally to make up 20 percent of the facility's TPS.

A complete list of measures proposed for the PY 2015 ESRD QIP is available in the Appendix to this fact sheet.

DETERMINING TOTAL PERFORMANCE SCORES FOR PY 2015 QIP

In the CY 2013 proposed rule, CMS is proposing to calculate TPSs for PY 2015 using a similar methodology as was adopted for PY 2014 in the CY 2012 ESRD PPS final rule. Each facility would receive a TPS between 0 to 100 points.

CMS uses clinical and reporting measure scores alike to calculate each facility's TPS. To calculate the minimum TPS required to avoid receiving a payment reduction, however, CMS proposes to use only clinical measure scores, and to set those scores at the performance standard, which is based on the national performance rate (defined as the 50th percentile of national facility performance in Calendar Year 2011).

Under CMS' proposal, facilities would earn points on applicable clinical measure topics by comparing their performance during 2013 to: 1) the a national standard based on 2011 data (the "achievement score"); or 2) facilities' own performance during 2012 (the "improvement score"). CMS would then apply the higher of the two scores when computing the TPS.

CMS is proposing to apply a measure rate adjustment to the clinical measure topic scores of facilities that report between 11 and 25 eligible cases per month to encourage quality improvement in these facilities and measure their performance accurately.

CMS is proposing that facilities will receive a TPS as long as they are eligible for at least one clinical measure and one reporting measure.

CMS is proposing to reduce payments to facilities in PY 2015 that do not meet or exceed a minimum total performance score. CMS is proposing to impose percent payment reductions of 0.5 percent for facilities whose TPS falls below the minimum total performance score by up to 10

points; 1.0 percent for facilities whose TPS is 11 to 20 points below the minimum; 1.5 percent for facilities that score 21 to 30 points below the minimum; and 2.0 percent for facilities whose TPS is more than 30 points below the minimum.

ADDITIONAL QIP-RELATED PROPOSALS

CMS is proposing to clarify existing regulations that govern how facilities communicate with their patients about the ESRD QIP. In particular, the proposed rule makes clear the obligation of facilities to post their Performance Score Certificates in a prominent location, and proposes that facilities display an English and Spanish version (both of which would be provided by CMS). Because communicating with patients is a key element of high-quality care, CMS proposes that this requirement be adopted as quickly as possible, in PY 2014.

CMS is also requesting comments on topics for future measure development, including:

- Standard Mortality Ratio;
- Standard Hospitalization Ratio—Admissions;
- 30-day readmissions;
- Issues pertaining to population/community health ,
- Efficiency/cost of care concerns;
- Health-related quality of life;
- Access to care; and
- Blood transfusion.

The proposed rule will appear in the July 11, 2012, *Federal Register*. CMS will accept comments on the proposed rule until Aug. 31, 2012, and will respond to comments in the final ESRD PPS rule for CY 2013 to be issued by Nov. 1, 2012.

For more information about the proposed rule, please see:

<http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1>

For more information about the ESRD PPS and QIP, please see:

<https://www.cms.gov/Center/Special-Topic/End-Stage-Renal-Disease-ESRD-Center.html>

APPENDIX

ESRD QIP PY 2015 Proposed Measures

TOPIC	MEASURE TITLE	MEASURE TYPE
Anemia Management	Hemoglobin Greater than 12 g/dL	Clinical
	Anemia Management*	Reporting
Dialysis Adequacy	Kt/V for Adult Patients on Hemodialysis*	Clinical
	Kt/V for Adult Patients on Peritoneal Dialysis*	Clinical
	Kt/V for Pediatric Patients on Hemodialysis*	Clinical
Vascular Access	Vascular Access Type (e.g., Arteriovenous Fistula, Catheter)	Clinical
Bone Mineral Metabolism	Hypercalcemia*	Clinical
	Mineral Metabolism**	Reporting
Patient Safety	Dialysis Event through Center for Disease Control & Prevention's National Healthcare Safety Network**	Reporting
Patient Experience of Care	In-center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS)	Reporting

* = New measure for PY 2015 and thereafter.

** = Expanded measure definition for PY 2015 and thereafter.

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