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CMS announces stronger incentives to improve ESRD treatment outcomes

Final rule updates policies and payment rates for dialysis facilities in 2012

The Centers for Medicare & Medicaid Services (CMS) today issued a final rule that updates Medicare policies and payment rates for 5,503 dialysis facilities paid under the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) that was first implemented in calendar year (CY) 2011.

The final rule will also strengthen incentives for improved quality of care and better outcomes for beneficiaries diagnosed with ESRD through improvements to the ESRD Quality Incentive Program (QIP). The provisions in the final rule will be effective for payments to dialysis facilities furnished on or after Jan. 1, 2012; and the new requirements for the ESRD QIP described in today's final rule will affect the payment rates in payment years (PY) 2013 and 2014.

Payment rates for dialysis treatments will increase by 2.1 percent in CY 2012, representing the ESRD market basket increase of 3.0 percent less a productivity adjustment of 0.9 percent, as required by statute. CMS estimates that Medicare payments to ESRD facilities in CY 2012 will total $8.3 billion.

"This is the second year of a four year transition to the new fully bundled payment system for certain dialysis facilities, although nearly 90 percent of facilities have chosen to forgo the transition and be paid entirely under the new system," said Jonathan Blum, deputy administrator and director of the Center for Medicare. "We believe that the policies and rate changes we are announcing today will ensure that beneficiaries diagnosed with ESRD will continue to have access to the care they need."

The final rule also strengthens the QIP. Under the QIP, payments to individual facilities are reduced if the facility does not achieve a certain total performance score based on their performance with respect to measures that assess the quality of dialysis care the facility provided.

The initial ESRD QIP, finalized in a rule earlier this year, will affect payments to individual facilities in PY 2012 based on their performance on performance standards CMS established with respect to two anemia management measures and one measure of dialysis adequacy.

The final rule changes the QIP performance measures for PY 2013 by retiring the anemia management measure of hemoglobin level less than 10 grams per deciliter measure from the initial measure set.

This decision is consistent with new medical evidence regarding the safety of a common treatment for anemia in dialysis patients – administration of erythropoiesis-stimulating agents (ESAs). In addition, this change is consistent with the recent labeling for ESAs approved by the U.S Food and Drug Administration (FDA). For PY 2013, CMS will give equal weight to the two finalized measures: (1) an anemia management measure of hemoglobin levels greater than 12 grams per deciliter and (2) a hemodialysis adequacy measure as measured by a Urea Reduction Ratio (URR) of at least 65 percent.

"CMS believes that new concerns about the safety of ESAs for dialysis patients strongly argue for providers to work more closely with their patients to develop anemia management strategies that respond the patient's unique medical issues, rather than adopting a one-size fits all approach to care," said Patrick Conway, M.D., CMS chief medical officer and director of the Agency's Office of Clinical Standards & Quality. "This patient-centered approach should result in better treatment outcomes. We plan to monitor hemoglobin levels by facility and to transparently share this information with consumers."

ESAs promote the production of red blood cells in patients with certain types of anemia, including anemia related to kidney disease. New medical evidence about the risks and benefits of ESA use in patients with kidney disease or kidney failure led the FDA to approve a new label for these drugs to that offers guidance on how these drugs should be prescribed and used.

CMS is continuing to work on ways to address the incentives for treating anemia in dialysis patients in various programs, including the ESRD QIP. In the meantime, CMS also plans to actively

monitor patients' clinical outcomes to ensure that the retirement of this measure does not harm patients.

"CMS stresses that it continues to believe that anemia management is a critical part of treatment for patients on dialysis," said Dr. Conway. "The anemia management and therapy should be determined by the patient's physician in light of the patient's individual needs and in consultation with the patient."

For PY 2014, CMS is retaining one anemia management measure (hemoglobin level greater than 12 grams per deciliter) and the dialysis adequacy measure (URR of at least 65 percent). CMS is also adopting four new measures that expand the breadth of the program and will give greater insight into the quality of care Medicare patients with ESRD receive in dialysis facilities. Specifically, CMS is adopting the following six measures for PY 2014:

- Dialysis adequacy, as measured through the URR, which assesses the percentage of patients with a URR of at least 65 percent;
- Anemia management, as measured by the rate of patients with a hemoglobin level greater than 12 grams per deciliter;
- Percent of patients receiving treatment through an arteriovenous fistula or catheter– types of vascular access used to connect patients' bloodstreams to dialysis equipment for cleansing;
- Whether the facility reports certain dialysis-related infections to the Centers for Disease Control & Prevention's National Healthcare Safety Network;
- Whether the facility administers a patient experience of care survey; and
- Whether the facility monitors phosphorus and calcium levels on a monthly basis.

The final rule also adopts two changes to how CMS will score a facility's performance under the QIP—one change relates to the two-measure framework for PY 2013, and the second change outlines how CMS would score facilities on the six measures adopted for PY 2014. The PY 2014 scoring methodology will more closely align the QIP with the scoring methodology adopted for the Medicare Hospital Inpatient Value-Based Purchasing Program.

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 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 facility's case mix and a limited number of patient's characteristics. The

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 quality of care provided to Medicare beneficiaries with ESRD.

The final rule also includes several provisions that are not related to the ESRD PPS and QIP, including the extension (through CY 2011) of certain payment rate increases for ground ambulance services and certain rural area designations for purposes of air ambulance payment, and establishing a 3-year minimum lifetime requirement for equipment to be considered durable for purposes of coverage as durable medical equipment.

For more information about the final rule, please see:
http://www.ofr.gov/OFRUpload/OFRData/2011-28606_PI.pdf.

The final rule will appear in the Nov. 10, 2011, *Federal Register*.

For more information about the ESRD PPS and QIP, please see:
http://www.cms.gov/center/esrd.asp

Additional CMS Fact Sheets on ESRD can be found here:

http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4148

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