

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201



Office of Media Affairs

MEDICARE NEWS

FOR IMMEDIATE RELEASE
July 26, 2010

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CMS ANNOUNCES NEW PROSPECTIVE PAYMENT SYSTEM FOR END-STAGE RENAL DISEASE FACILITIES

***PROGRAM WOULD REWARD EFFICIENT, HIGH QUALITY CARE
FOR PEOPLE WITH END-STAGE RENAL DISEASE***

The Centers for Medicare & Medicaid Services (CMS) today issued a final rule that will change how Medicare pays for dialysis services for Medicare beneficiaries who have end-stage renal disease (ESRD). CMS also issued a proposed rule that would establish a new quality incentive program (QIP) to promote high quality services in dialysis facilities by linking a facility's payments to performance standards. The QIP is the first pay-for-performance program in a Medicare fee-for-service payment system.

“The new payment system and quality incentive program for dialysis services have significant potential to improve patient outcomes and promote efficient delivery of health care services,” said CMS Administrator Donald Berwick, M.D. “In addition, for the first time in any of our payment systems, the quality of care facilities furnish to patients will be reflected in their payment rates.” Currently, facilities only report on whether they have complied with quality measures.

The final rule establishing the new prospective payment system (PPS) provides for a payment adjustment for home dialysis training when clinically appropriate. This adjustment, which CMS adopted in response to public comments on the ESRD PPS proposed rule that strongly supported home dialysis, will help ensure that ESRD patients are learning the skills and techniques they need to properly receive their dialysis treatment at home.

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Both the new prospective payment system and the proposed QIP were required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The law requires the ESRD PPS to pay dialysis facilities a single bundled rate for renal dialysis services and home dialysis, while the proposed QIP promotes quality of service furnished by these facilities by creating payment incentives for them to take steps to improve patient outcomes.

ESRD was the first category for Medicare eligibility based on a specific diagnosis, without regard to the age of the patient. Patients are diagnosed with ESRD when their kidneys are no longer able to perform the function of removing excess fluids and toxins from their blood. The only cure for ESRD is a kidney transplant, but in the absence of a transplant, the patient must rely on dialysis to filter his/her blood. There are more than 330,000 individuals in the United States with ESRD, of whom the great majority are Medicare beneficiaries.

Currently, Medicare pays for certain dialysis services under a partial bundled rate, referred to as the composite rate. Payments for these composite rate services represent about 60 percent of total Medicare payments to ESRD facilities. The remainder of Medicare spending for dialysis services is for separately billable items such as drugs, supplies and non-routine laboratory testing. In 2007, there were about 600 hospital-based and 4,330 freestanding ESRD facilities furnishing outpatient maintenance dialysis services to nearly 330,000 Medicare patients. Total Medicare payments for these services were \$9.2 billion including the dialysis treatments and other ESRD-related items such as drugs.

The new ESRD PPS provides a single bundled case-mix adjusted payment to dialysis facilities for renal dialysis services such as dialysis treatments and supplies, certain ESRD-related drugs, and ESRD-related clinical laboratory tests beginning on Jan. 1, 2011. Although CMS has determined that the definition of renal dialysis services includes ESRD-related oral drugs without injectable equivalents (or other forms of administration), CMS is delaying paying for those drugs under the ESRD PPS until Jan. 1, 2014.

The final rule sets a base payment rate of \$229.63 for each dialysis treatment. This payment rate includes payment for the services in the current composite rate, as well as most items and services that are currently paid separately. The base rate was derived from 2007 claims data for both composite rate and separately billable services and updated to reflect projected 2011 prices.

The base payment rate would be adjusted for case-mix factors including patient's age, body size, and time on dialysis. By accounting for more characteristics of patients, the new PPS will target payments more appropriately, paying higher rates to those facilities with the most costly dialysis patients. Separate case-mix adjustments will apply to pediatric patients. In the final rule, CMS also adopts facility level adjustments including a geographic wage index and an

adjustment for low-volume facilities that furnish fewer than 4,000 dialysis treatments and meet certain other criteria. The final rule also includes an outlier payment policy that will pay facilities more for patients whose care is significantly more costly than the Medicare payment amount.

In the ESRD PPS final rule, CMS also has reduced the number of case-mix co-morbidity adjustments. In addition, at this time, CMS is not finalizing a case-mix payment adjustment based on the patient's sex, race or ethnicity. CMS has been reviewing and updating its processes for collecting and validating patient-level race and ethnicity data from dialysis facilities, which will ensure that CMS has the most accurate information possible for the races and ethnicities of all patients with ESRD. As this work continues, CMS will assess whether this effort will position the Agency to incorporate such an adjuster for payment in the future. CMS plans to continue studying the issue to ensure that all beneficiaries with ESRD have access to quality care, and in the meantime, plans to implement an active monitoring program to respond to concerns about disparities in access to care.

In addition to finalizing the ESRD PPS payment policies and rates for calendar year 2011, CMS issued a proposed rule that would establish performance standards and a scoring methodology for the Quality Incentive Program required by MIPPA to ensure quality of care for patients with ESRD.

“The ESRD QIP is a critical tool for encouraging and supporting dialysis facilities to focus their energies thoroughly on the quality of the dialysis care they provide to Medicare beneficiaries,” said Berwick.

In the ESRD PPS final rule, CMS adopted the three quality measures that will be used in the initial implementation of the QIP. Two of these measures reflect whether patients are receiving appropriate treatment for anemia – that is, whether the amount of iron in the blood is neither too low, nor too high. The third measure captures patients' urea reduction ratio, which indicates how well dialysis treatments are removing wastes from patients' bodies. The law requires CMS to reduce the payment rates to a dialysis facility by up to 2.0 percent if that facility fails to meet or exceed the established performance scores with regard to performance standards established for each quality measure.

Facilities failing to meet or exceed specified total performance scores will receive reduced reimbursement for dialysis services furnished on or after Jan. 1, 2012.

The QIP proposed rule also discusses options for making individual facility performance scores available both to dialysis patients and to the general public as required by the law.

CMS will accept comments on the QIP proposed rule until Sept. 24, 2010, and will respond to them in a final rule to be issued later this year.

To view the ESRD PPS Final Rule and the QIP Proposed Rule, see: www.ofr.gov/inspection.aspx.

For more information, please see: www.cms.gov/center/esrd.asp.

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