



Brief Summary of ESRD QIP Final Rule
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The Centers for Medicare and Medicaid Services (CMS) issued the End Stage Renal Disease (ESRD) Quality Improvement Program (QIP) Final Rule on December 29, 2010.

Quality Measures. CMS finalized the quality measures to be used in the QIP, which include two measurements of anemia management and one of adequacy of hemodialysis, as follows:

- Percentage of Medicare patients with an average Hemoglobin < 10g/dL;
- Percentage of Medicare patients with an average Hemoglobin > 12g/dL; and
- Percentage of Medicare patients with an average Urea Reduction Ratio (URR) \geq 65 percent.

The Agency noted that it will eventually replace the URR measure with a Kt/V measure.

Performance Standards. The Agency finalized the standards as proposed. The performance rates are as follows:

- For the anemia management measure "Hemoglobin Less Than 10g/dL" the national performance rate is 2 percent.
- For the anemia management measure "Hemoglobin More Than 12g/dL" the national performance rate is 26 percent.
- For the proposed "Hemodialysis Adequacy Measure" the national performance rate is 96 percent.

CMS finalized calendar year 2010 as the initial performance period, which is the most current year that affords the Agency adequate time to collect and analyze the data and calculate individual and total performance scores.

Performance Scores. CMS finalized the scoring methodology as proposed. The Agency will assign 10 points to each of the measures, and providers and facilities that do not meet the initial performance standards would score lower than 10 points, with lower scores corresponding to performance further below the standard. CMS will subtract 2 points for every 1 percentage point the performance falls below the standard.

Weighting the Measures. CMS finalized its proposal to weight the "Hemoglobin Less Than 10g/dL" measure 50 percent of the total performance score, and the other two measures 25 percent each. As described in the Proposed Rule, the Agency elected to give additional weight to this measure to establish a disincentive to under-treat patients for anemia and to reflect the clinical importance of the measure. The Agency stated that it will reevaluate the weighting methodology as new measures are adopted in the QIP.



Payment Reductions. CMS finalized the payment reductions as proposed. CMS interpreted MIPPA to require the Secretary to reduce payments by up to 20 percent and will use 0.5 increments to reduce payments.

Unit of Payment. Performance-based payment reductions will apply to the monthly payment amount. CMS will apply the payment reduction following any other applicable adjustments, including case-mix, wage index, outlier, and blended amount under the transition.

Public Reporting. CMS finalized that it will share confidential, specific quality data with providers and facilities electronically using the secure Dialysis Facility Reports (DFR) framework. CMS will provide the "draft DFRs" to providers/facilities and allow 30 days to review the data and submit questions or comments to the Agency. The Agency will also submit certificates containing the aforementioned QIP performance scores and national comparisons once annually to facilities and providers in a generally accessible electronic file. Each provider and facility will be required to display the unaltered certificate within 5 business days of CMS sending it. The certificate must be displayed prominently in plain sight in an area containing other patient-directed materials. CMS will use the DFC website to report the performance scores.

Future Considerations. In the Final Rule, CMS stated that it will use the informal rulemaking process for making changes to the ESRD QIP in the future whenever possible. The Agency may issue procedural guidance for changes not impacting measures, weighting, or scoring methodologies.

CMS indicated that it will launch an ESRD services monitoring program to track changes in beneficiary access and quality of care following the implementation of the ESRD PPS and QIP. The Agency will also conduct an evaluation of the impact of the QIP on access and quality of care for Medicare ESRD beneficiaries. CMS will use CROWN Web, claims data, patient activity reports, provider forms, and other quantitative and qualitative data sources in the monitoring program and evaluation.

CMS noted that the Agency is currently developing measures in the areas of patient satisfaction, iron management, bone mineral metabolism, vascular access, K t/V, access infection rate, fluid weight management, and pediatric measures. The measures under development are ones that could be applied to all modalities. The Agency will require providers to submit data to establish a baseline for each of the measures under development "as soon as is practicable." In the Final Rule, CMS stated that it intends to see input of the ESRD community when considering the feasibility of adopting new measures for the QIP. CMS acknowledged the importance of collecting real-time data for timely measurement of performance and noted that the Agency is working to expand the scope of CROWN Web and will explore the feasibility of using it to collect QIP data.