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CMS Finalizes Policy and Payment Rate Changes for End-Stage Renal Disease Facilities in 2014

CMS strengthens incentives to improve outcomes for patients with ESRD

On November 22, CMS issued a final rule that updates Medicare policies and payment rates for 2014 for dialysis facilities paid under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS). CMS received extensive public comment on the proposed rule, issued in July. CMS carefully reviewed the comments and has decided to implement a three- to four-year transition for the drug utilization adjustment to the base rate mandated by Congress as part of the American Taxpayer Relief Act, and overall payments for 2014 will see a zero percent change.

The rule also finalized a 50 percent increase to the home dialysis training add-on payment adjustment that is made for both peritoneal dialysis and home hemodialysis training treatments.

While the ESRD PPS, implemented in 2011, was effective for renal dialysis services furnished on or after January 1, 2011, the statute provided for a 4-year transition period during which the ESRD facilities were paid a blended payment with a portion of payments based on the composite rate methodology and a portion based on the new PPS rate. In 2014, the final year of the 4-year transition period, all ESRD facilities will be paid 100 percent of the ESRD PPS rate for renal dialysis services furnished on or after January 1, 2014.

The final rule will also strengthen the ESRD Quality Incentive Program (QIP), which creates incentives for dialysis facilities to improve the quality of care and patient outcomes for beneficiaries diagnosed with ESRD. For the ESRD QIP Payment Year (PY) 2016 program (which will rely on measures of dialysis facility performance during 2014), CMS is finalizing 11 measures addressing infections, anemia management, dialysis adequacy, vascular access, mineral metabolism management, and patient experience of care. We are also finalizing the method by which performance scores will be calculated by weighting clinical measures at 75 percent of the total performance score and weighting the reporting measures at 25 percent. The ESRD QIP will reduce payments to ESRD facilities that do not meet or exceed certain performance standards.

Both the ESRD PPS and the ESRD QIP were mandated by the Medicare Improvements for Patients and Providers Act of 2008. The ESRD PPS is intended to improve efficiency and reduce incentives to use more items and services than needed for appropriate care, while the ESRD QIP is intended to promote improvement in the quality of care provided to Medicare beneficiaries with ESRD.

Additionally, the final rule includes several provisions related to Medicare policies on durable medical equipment (DME). CMS is finalizing clarification of the 3-year minimum lifetime requirement for DME and the distinction between routinely purchased and capped rental DME. The rule also finalizes the implementation of budget-neutral fee schedules for splints and casts, and intraocular lenses inserted in a physician's office as well as a few technical amendments and corrections to existing regulations related to payment for durable medical equipment, prosthetics, and orthotics items and services.

Full text of this excerpted [CMS press release](#) (issued November 22).

- [Final Rule](#)
- [ESRD Center](#)

Medicare Finalizes Home Health Payments for 2014

Changes promote lower costs for beneficiaries and taxpayers

On November 22, CMS issued the final CY 2014 home health care payment rule. The final policies in this rule better align Medicare payments with home health agencies' costs providing care, while lowering costs to taxpayers and the 3.5 million Medicare beneficiaries who receive home health services nationwide.

The CY 2014 final rule reduces Medicare payments under the Home Health Prospective Payment System (HH PPS) by 1.05 percent. This amount reflects the combined effects of an increase in the home health payment update percentage of 2.3 percent, offset by a decrease of 2.7 percent—the result of rebasing the adjustments required by the Affordable Care Act—and a 0.6 percent decrease due to a refinement of the HH PPS Grouper.

As required by the Affordable Care Act, CMS must begin phasing in rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates and the NRS conversion factor to reflect changes since the inception of the HH PPS, such as change in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. Prior to the Affordable Care Act, rates were based on analyses of home health agency cost and service utilization data available in 2000, when the HH PPS originally was implemented.

The final rule adds two new quality measures, which will require HHAs to report unnecessary hospital readmission rates and preventable trips to the emergency room. These measures support critical reforms laid out in the Affordable Care Act. The final rule reduces the number of home-health quality measures reported by home health agencies.

Full text of this excerpted [CMS press release](#) (issued November 22).

- [Final Rule](#)
- [Home Health PPS website](#)



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