ESRD QIP Payment Year 2018 Program Details

The Centers for Medicare & Medicaid Services (CMS) uses a variety of levers to support its Three-Part Aim and the six domains of care based on the National Quality Strategy (NQS). Those levers include:

- Continuous quality improvement (CQI) efforts;
- Transparency and robust public reporting;
- Coverage and payment decisions;
- Payment incentives;
- Conditions for coverage; and
- Grants, demonstrations, pilots, and research.

CMS strives to ensure that all of these complex levers work in concert in order to improve the quality and cost efficiency of national dialysis care for all beneficiaries. These various levers share a common goal—the provision of cost-efficient and clinically effective patient care—and they ideally complement each other to these ends. The End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) provides an important lever for safety, value, and quality for CMS.

The ESRD QIP promotes high-quality care delivered by outpatient dialysis facilities treating patients with ESRD. The first of its kind in Medicare, this program changes the way CMS pays for the treatment of ESRD patients by linking a portion of payment directly to facilities' performance on quality care measures. The ESRD QIP will reduce payments to ESRD facilities that do not meet or exceed certain performance standards.

For more information about the program, see http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/index.html. If you have questions about the program after reviewing this content, you may reach the CMS ESRD QIP staff by emailing ESRDQIP@cms.hhs.gov.

Please note that this document is an informal reference only, and does not constitute official CMS guidance. Please refer to the implementing regulations.

ESRD QIP Final Rule Governing Payment Year 2018

The final rule governing the ESRD QIP for Payment Year (PY) 2018, published in the *Federal Register* on November 6, 2014, outlines how CMS will implement the law establishing the program. The rule specifies the following in detail:

- **Measures selected** – Sixteen total measures (eleven clinical and five reporting) for assessing the quality of ESRD care
- **Performance period** – Timeframe during which CMS will collect data to evaluate facility performance

- **Methodology** – The process used to score facility performance
- **Payment reduction scale** – Scale used to determine payment reductions for facilities not meeting established performance standards.

The final rule also addresses public comments to the earlier proposed rule and CMS's responses to those comments.

Measuring Quality

Section 153(c) of the Medicare Improvements for Patients and Providers Act (MIPPA) requires CMS to use certain types of quality measures as part of the ESRD QIP. These include:

- Measures on anemia management that reflect the labeling approved by the Food and Drug Administration (FDA) for administration of erythropoiesis-stimulating agents (ESAs)
- Measures on dialysis adequacy
- Other measures as the Secretary of the Department of Health and Human Services (HHS) may specify on iron management, bone mineral metabolism, vascular access, and patient satisfaction.

For PY 2018, CMS selected sixteen measures for evaluating each facility. The resulting scores will be combined to establish the facility's Total Performance Score. Eleven of these measures are "clinical," meaning that they evaluate how well facilities meet clinical performance goals. The remaining five measures are related to "reporting," meaning that they evaluate facilities on the basis of the data they submit to CMS. By increasing the number, scope, and meaningfulness of clinical measures, the PY 2018 final rule illustrates that the ESRD QIP is evolving and becoming more sophisticated in its evaluation of dialysis facilities.

Not all facilities are eligible for a Total Performance Score in 2018. To receive a Total Performance Score, a facility must receive a score on at least one clinical measure **and** at least one reporting measure. To receive a score on a clinical measure, a facility must treat at least 11 patients (or experience 11 index discharges, in the case of the Standardized Readmission Ratio [SRR] measure) who are eligible for the measure. To receive a score on any of the reporting measures (and therefore to receive a Total Performance Score), a facility must obtain a CMS Certification Number (CCN) on or before June 30, 2016.

If a facility does not receive a Total Performance Score, this does not indicate that the facility provided low-quality care.

Clinical Measures Selected

The eleven clinical measures are categorized into three subdomains, reflecting domains of quality measurement based on the NQS.

- The Safety subdomain (making up 20% of the clinical measure domain) includes the National Healthcare Safety Network (NHSN) Bloodstream Infection measure of infections incurred by in-center hemodialysis outpatients.
- The Patient and Family Engagement/Care Coordination subdomain (30% of the clinical measure domain) includes (1) the In-Center Hemodialysis Survey Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) measure of patient satisfaction and (2) the SRR measure of unplanned patient readmissions to the hospital setting on a risk-adjusted basis.
- The Clinical Care subdomain (50% of the clinical measure domain) includes eight measures. Six of the measures are organized into two "measure topics;" Kt/V Dialysis Adequacy evaluates the

success of dialysis treatment in removing waste products from patients' blood, and Vascular Access Type examines the type of vascular access used to treat patients. The remaining three measures include (1) the Standardized Transfusion Ratio (STrR) measure of in-facility transfusions on a risk-adjusted basis and (2) Hypercalcemia, a measure of mineral metabolism.

Data to assess performance on these measures will be taken from Medicare claims, CROWNWeb, and other CMS and federal databases.

For the SRR and STrR clinical measures, the fewer incidents a facility reports, the better the facility will score; likewise, the fewer facility patients with Hypercalcemia or infections, the better the facility will score. For the dialysis adequacy measures, the greater the number of patients above the threshold, the better the facility will score. The more patients who respond to elements of the ICH CAHPS survey, the better the facility will score. The Vascular Access Type score is affected negatively if patients have catheters and positively if patients have fistulae.

For additional information about exclusions and measure calculations, see the "Final Measure Specifications for the PY 2018 ESRD Quality Incentive Program" section of http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html.

Reporting Measures Selected

The reporting measures require facilities to submit:

1. Hemoglobin or hematocrit values and ESA dosage (as applicable) via Medicare claims
2. Serum phosphorus levels in CROWNWeb
3. Conditions relating to patient experience of pain in CROWNWeb
4. Conditions relating to patient clinical depression in CROWNWeb
5. The Healthcare Personnel Influenza Vaccination Summary Report to NHSN.

For additional information about exclusions and measure calculations, see the "Final Measure Specifications for the PY 2018 ESRD Quality Incentive Program" section of http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html.

Facility Scoring

Period of Performance

The period of performance for PY 2018 is calendar year (CY) 2016. This timeframe was selected to allow enough time for CMS to:

1. Ensure that claims used in calculations are complete and accurate;
2. Calculate facility performance scores; and
3. Allow facilities to view their performance scores before public release and obtain additional information if needed.

Scoring for Clinical Measures

Facility performance will be evaluated against each measure; a facility receives a score based on the higher of its achievement or improvement on a measure. The comparison period for the PY 2018 clinical measures was CY 2014 for achievement and CY 2015 for improvement. The exception to this in PY 2018

is the ICH CAHPS measure, for which CY 2015 will serve as the comparison period for the achievement and improvement scoring methods alike.

Facilities receive achievement points on a measure based on where they fall on the achievement range. The **achievement range** begins at the achievement threshold, which is defined as the 15th percentile of facilities during the comparison period. It ends at the benchmark, which is defined as the 90th percentile of facilities during the comparison period. A facility will receive an achievement score of 0 if its performance on that measure falls below the achievement threshold, 1 – 9 if its performance falls within this range, and 10 points if it is at or above the benchmark.

Facilities may receive improvement points on a measure based on where they fall on the improvement range. The **improvement range** begins at the facility's prior performance rate on the measure during the improvement period (facility comparison rate) and ends at the benchmark. A facility will receive an improvement score of 0 if its performance falls below the facility's comparison rate, 0 – 9 if its performance falls within this range, and 10 if it is at or above the benchmark.

Scoring for Reporting Measures

The reporting scores are not calculated using achievement and improvement scores; instead, facilities receive points based on whether they meet certain reporting requirements. For the NHSN Healthcare Personnel Influenza Vaccination measure, if the facility satisfies the reporting requirements, then the facility will earn the full 10 points for the measure. For the Anemia Management, Mineral Metabolism, Pain Assessment and Follow-Up, and Clinical Depression Screening and Follow-Up reporting measures, facilities may be able to earn partial points for satisfying some of the reporting requirements. Please see the implementing regulations for more information.

Measure Weighting

The sixteen measures for the PY 2018 ESRD QIP do not contribute equally to the Total Performance Score. Each facility's score will be calculated according to the following measure weights:

- Clinical measures – 90 percent (according to the specific proportion allotted to each subdomain, as described earlier)
- Reporting measures – 10 percent

If a score is not received for a measure or measure topic(s), then the remaining measures and measure topics will be reweighted to add up to 90 percent (for the clinical measures) or 10 percent (for the reporting measures) of the total weight of the Total Performance Score.

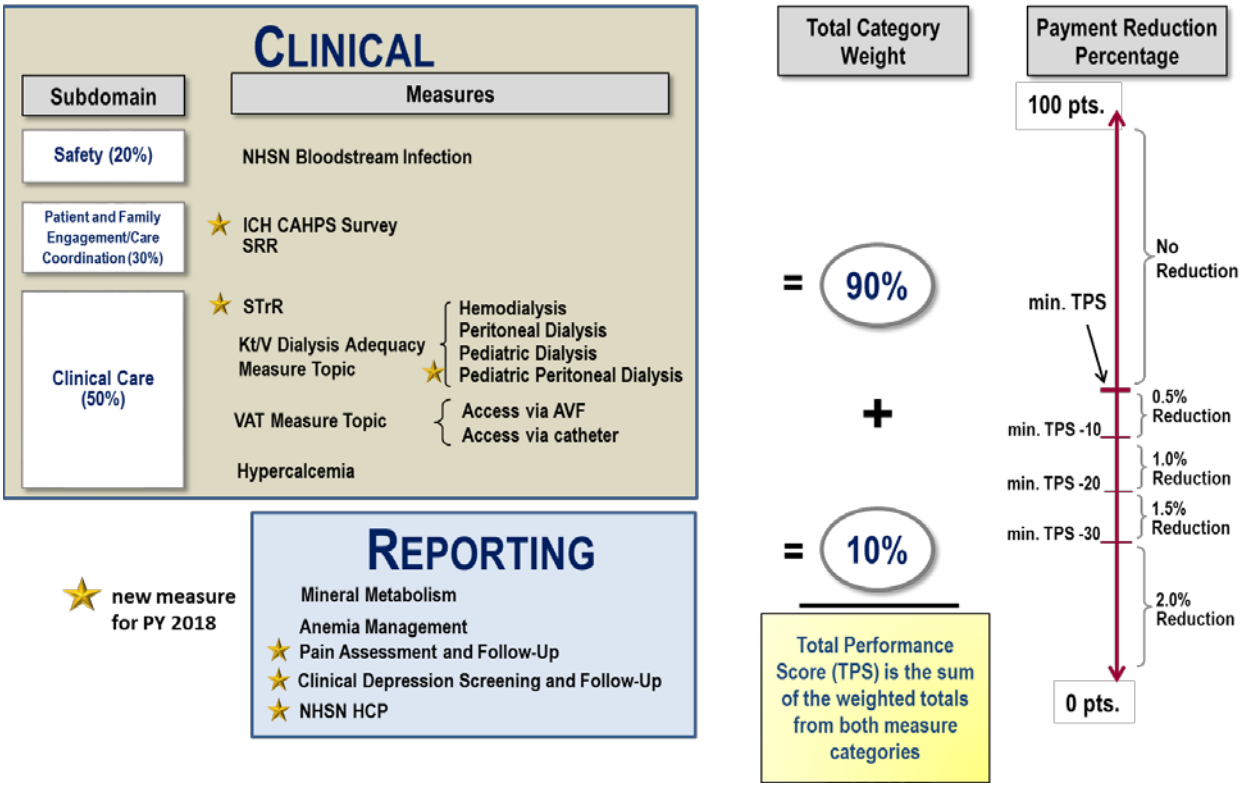
Calculating a Facility's Total Performance Score

A facility's Total Performance Score in PY 2018 is calculated by:

1. Multiplying each measure by its appropriate weight
2. Adding these weighted measures
3. Multiplying the sum by 10.

A facility's Total Performance Score can range from 0 – 100 points.

The following graphic illustrates the methodology that CMS uses for calculating PY 2018 performance scores and payment reductions.



Payment Adjustments

Section 153(c) of MIPPA directs the Secretary of HHS to develop a method to assess the quality of dialysis care provided by facilities and to link this performance to possible payment reductions. To receive full payment for PY 2018, facilities must have a Total Performance Score of at least 49 points. Facilities that fail to meet this standard may receive a payment reduction of up to two percent. This payment reduction will apply to all Medicare payments to that facility for services rendered in CY 2018.

Scale for Payment Reductions

PY 2018 payment reductions will apply to a facility according to the following chart:

Total Performance Score	Payment Reduction
49 to 100	No reduction
39 to 48	0.5%
29 to 38	1.0%
19 to 28	1.5%
0 to 18	2.0%

Preview Period

Facilities will have the opportunity to preview their scores and any resulting payment reductions prior to public release. The Preview Period will last for one month and occur in the summer of 2017. During this time, facilities can ask general clarification questions about how their scores were calculated. In addition, each facility can submit one formal inquiry regarding data or scoring-related issues if the facility believes a scoring error has occurred.