PY 2020 Final Rule NPC: Follow-Up Questions and Answers Provided via ESRD QIP Mailbox

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 the ESRD QIP section of CMS.gov. 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.

Background

On January 17, 2017, CMS conducted a National Provider Call (NPC) discussing the Payment Year (PY) 2020 Final Rule. Some attendees posed questions during the questions-and-answers portion of the call that required additional research to answer fully. CMS asked those participants to send their questions to the ESRD QIP mailbox for further examination. Other attendees expressed interest in receiving those answers as well. In an effort to meet this need, CMS offers this compilation of select mailbox questions received and responses provided relevant to the NPC in question.

Questions and Answers

1: Are home hemodialysis patients included in all areas of the ESRD QIP scoring system?

The majority of measures include home hemodialysis patients in their scoring:

- Comprehensive dialysis adequacy (adults)
- Hypercalcemia
- Anemia management (excludes home dialysis patients for whom a facility does not submit a claim during the claim month)
- Mineral metabolism (excludes home dialysis patients for whom a facility does not submit a claim during the claim month)
- Clinical depression screening and follow-up
- Pain assessment and follow-up
- Standardized readmission ratio
- Standardized transfusion ratio
- Vascular Access Type Measure Topic (fistula and catheter)

2: Slide 28 of today's presentation states: "Modification includes risk adjustment using Medicare claims for 210 prevalent comorbidities, in addition to incident comorbidities captured on Form 2728." Where would I find a copy of the 210 prevalent comorbidities?

The Standardized Hospitalization Ratio (SHR) measure uses a risk-adjustment model which consists of various patient characteristics, one of which includes prevalent comorbidities. A Technical Expert Panel (TEP) convened by CMS in 2015 identified a total of 210 prevalent comorbidities using a prioritization process. These comorbidities would be based on a patient's Medicare claims from the previous calendar year. For a full list of these prevalent comorbidities, please refer to the SHR Methodology Report published in June 2016 (Table 2, page 14).

3: With regard to the In-Center Hemodialysis (ICH) Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure, do facilities need to complete attestations in CROWNWeb if they have fewer than 30 completed surveys, or are they automatically excluded if they receive fewer than 30 completed surveys?

Facilities that administer two surveys during the performance period but receive fewer than 30 completed surveys will not receive a score on the measure, and they are not required to attest as such in CROWNWeb; the system will automatically exclude the facility from the measure. Nevertheless, in the case of a facility that has fewer than 30 completed surveys, its survey vendor is still responsible for submitting this survey data to CMS as per protocol.

Please note that the attestation for the ICH CAHPS clinical measure is specific to those facilities that did not treat at least 30 eligible patients during the "eligibility period," which is defined as the year prior to the performance period. Facilities that attest will not be scored on the measure, and do not need to submit survey data to CMS.

4: Regarding the Kt/V Dialysis Adequacy clinical measure, many of our patients still have high Kt/V > 2.5 even after retesting. Will this affect our facility's performance and/or a payment reduction? I understand that these patients will now be included in the denominator.

I also request clarification on these related points:

- **With the updated ESRD QIP PY 2019/2020, will the measure no longer include a maximum allowed value for the calculation?**
- **Is it correct to say that facilities reporting Kt/V of > 1.2, including the ones with values > 2.5, will not affect the facility's performance over the course of the year?**

For PY 2019 and beyond, the Kt/V comprehensive measure will not have an upper limit. For this measure, a higher performance rate indicates better quality. Patient-months eligible for the Kt/V measure with values greater than 2.5 will be counted in both the numerator and denominator of the measure. Therefore, including patient-months with values greater than 2.5 in the measure calculation will not negatively impact the facility's measure score. Whether these patient-months would impact payment is difficult to determine, however, because many other measures are included in the Total Performance Score (TPS).

5: What are the benchmark, achievement, and minimum TPS (mTPS) values for all the ESRD QIP clinical measures in the Calendar Year (CY) 2017/PY 2019 program?

The table below, reproduced from slides 23 and 24 of the NPC, shows the achievement thresholds, benchmarks, and performance standards for PY2019 ESRD QIP clinical measures.

Measure	Achievement Threshold (15th percentile)	Benchmark (90th percentile)	Performance Standard (50th percentile)
Vascular Access Type Measure Topic			
• Arteriovenous Fistula	53.66%	79.62%	65.93%
• Catheter *	17.20%	2.95%	9.19%
Kt/V Dialysis Adequacy	86.99%	97.74%	93.08%
Hypercalcemia *	4.24%	0.32%	1.85%
National Healthcare Safety Network (NHSN) Bloodstream Infection (BSI) *	1.738	0	0.797
Standardized Readmission Ratio (SRR) *	1.289	0.624	0.998
Standardized Transfusion Ratio (STrR) *	1.488	0.421	0.901
ICH CAHPS			
• Nephrologists' Communication and Caring	56.41%	77.06%	65.89%
• Quality of Dialysis Center Care and Operations	52.88%	71.21%	60.75%
• Providing Information to Patients	72.09%	85.55%	78.59%
• Overall Rating of Nephrologists	49.33%	76.57%	62.22%
• Overall Rating of Dialysis Center Staff	48.84%	77.42%	62.26%
• Overall Rating of the Dialysis Facility	51.18%	80.58%	65.13%

* On this measure, a lower rate indicates better performance.

The mTPS is established at 60 out of 100. Scores that are 60 or above will not incur a payment reduction, and scores below 60 will incur a payment reduction between 0.5% and 2.0%, depending on where the score falls between 0 and 59 points.

6: The achievement thresholds, performance standards and benchmarks for CY 2017/PY 2019 measures published in the *Federal Register* has a set of values that are different from the measure values in the ESRD QIP slide deck from your most recent call.

The slide deck reflects the technical correction published in December 2016, which is the accurate and definitive information of record.

7: If a patient is hospitalized for the entire month but is still an "active" patient assigned to the facility and no treatments are delivered, is the patient then in the denominator for that month? If a patient has one or more treatments in the month and then is hospitalized in the month, is the patient in the denominator for that month? What is the treatment amount that is required to place the patient in the denominator?

As long as a patient is not discharged from the facility in CROWNWeb, they will be included in the denominator for the Kt/V comprehensive measure. This is true even if the patient is hospitalized for the entire month. Also, no minimum treatment amount is required to include the patient in the denominator.

8: If a patient changes modality, will that person be included in the denominator for both modalities? Or is it just for the new modality?

For PY 2019, if a patient changes modality during the month, then that month will be excluded from the denominator for both modalities.

9: Although it is no longer considered a "clinical measure"—because it is in a different domain—will the NHSN BSI measure still be scored via Achievement and Improvement? And will CMS still choose the higher of the two? Finally, will the two Safety Domain measures count for purposes of TPS eligibility?

Although the NHSN BSI measure is now part of the Safety Domain, it is considered to be a clinical measure and will be calculated as such, using achievement and improvement scores. In addition, measures in the Safety Domain do not count towards TPS eligibility.

10: What is the method for calculation of Ultrafiltration rate? Should this be calculated by laboratory thru blood test with monthly blood test?

The Ultrafiltration rate (UFR) itself is calculated for a single session per month (CROWNWeb generally records data from the last session) using data elements for pre-dialysis weight, post-dialysis weight, and delivered minutes of dialysis. The formula for UFR is:

$$UFR = [(((\Delta wt\ kg)*1000)/(delivered\ time/60))/post\ wt\ kg]$$

For purposes of the Total Performance Score, the Ultrafiltration reporting measure is scored on how many months the facility provides the required data in CROWNWeb, according to the following formula:

$$\left[\frac{(\#\text{ months successfully reporting data})}{(\#\text{ eligible months})} \times 12\right] - 2$$

11: How should a pediatric facility complete the assessments in CROWNWeb for the Pain Assessment and Follow-Up reporting measure if it treated fewer than 11 eligible patients? Also, how do we address mentally incompetent patients over the age of 12 and 18?

The ESRD QIP system will automatically identify whether a facility and its patients are eligible for the measure when the data is extracted from CROWNWeb using the following criteria for exclusion.

For the Pain Assessment and Follow-up reporting measure:

Facility-level exclusions

- Facilities with fewer than 11 eligible patients during the performance period
- Facilities with a CMS Certification Number (CCN) certification date on or after July 1, 2017

Patient-level exclusions

- Patients who are younger than 18 years old as of April 30, 2017 for the August 1, 2017, reporting deadline, and as of October 31, 2017, for the February 1, 2018, reporting deadline
- Patients who are treated at the facility for fewer than 90 days between January 1 and June 30, 2017, for the August 1, 2017, deadline, and between July 1 and December 31, 2017, for the February 1, 2018, deadline.

In addition, a patient may not be eligible for these screenings if certain reasons are documented in the patient's medical record, but the facility would still need to report this in CROWNWeb.

To address mentally incompetent patients over the age of 12 and 18 for the Pain Assessment and Follow-up reporting measure, patients younger than 18 years old (as of April 30, 2017, for the August 1, 2017, reporting deadline, and as of October 31, 2017, for the February 1, 2018 reporting deadline) are not eligible. If the patient is 18 years old or above and if the facility has documentation that the patient is not eligible due to severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others, then it can select the "No documentation of pain assessment and the facility possesses documentation the patient is not eligible for a pain assessment using a standardized tool" option in CROWNWeb. One of the patient-specific criteria for making that patient not eligible is "Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools."

If the facility does not have any documentation on this, it can still report using the "No documentation of pain assessment and no reason is given" option in CROWNWeb.

12: How should a pediatric facility complete the assessments in CROWNWeb for the Clinical Depression Screening and Follow-Up reporting measure if it treated fewer than 11 eligible patients? Also, how do we address mentally incompetent patients over the age of 12 and 18?

The ESRD QIP system will automatically identify whether a facility and its patients are eligible for the measure when the data is extracted from CROWNWeb using the following criteria for exclusion.

For the Clinical Depression Screening and Follow-up reporting measure:

Facility-level exclusions

- Facilities with fewer than 11 eligible patients during the performance period
- Facilities with a CCN certification date on or after July 1, 2017

Patient-level exclusions

- Patients who are younger than 12 years old as of October 31, 2017
- Patients who are treated at the facility for fewer than 90 days between January 1 and December 31, 2017

In addition, a patient may not be eligible for these screenings if certain reasons are documented in the patient's medical record, but the facility would still need to report this in CROWNWeb.

To address mentally incompetent patients over the age of 12 and 18 for the Clinical Depression Screening and Follow-up reporting measure: If the patient is over 12 years old and if the facility has documentation that the patient is not eligible due to severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others, then the facility can select the "Screening for clinical depression not documented, but the facility possesses documentation stating the patient is not eligible" option in CROWNWeb. One of the patient-specific criteria for making that patient not eligible is "Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools."

If the facility does not have any documentation on this, then it can still report using the "Clinical depression screening not documented, and no reason is given" option in CROWNWeb.

13: What is the percentage that represents a month that "successfully reported" serum/plasma phosphorus values for each Medicare patient in CROWNWeb? This was previously 97%.

What is the percentage that represents a month that "successfully reported" hemoglobin (Hgb)/hematocrit (HCT) and erythropoiesis stimulating agent (ESA) (as applicable) for each Medicare patient on Medicare claims? This was previously 99%.

Are there "successfully reported" percentages for Pain Assessment and Clinical Depression Screening reporting too, or are those just assumed to be 100%?

The percentage that represents a month that "successfully reported" serum/plasma phosphorus values for each Medicare patient in CROWNWeb remains at 97%, and the percentage that represents a month that "successfully reported" Hgb/HCT and ESA (as applicable) for each Medicare patient on Medicare claims remains at 99%.

The Pain Assessment and Clinical Depression Screening reporting measures are slightly different in that they look at a yearly reporting rate, rather than a monthly rate as in Mineral Metabolism and Anemia Management. The pain and depression measures are calculated by taking the number of eligible patients reported during the performance period, divided by the total number of eligible patients during the performance period, and multiplying the result by 10. That number is then rounded to the nearest whole number, resulting in a score of up to 10 points. Please also note that the Pain Assessment reporting measure requires facilities to report twice for each patient during the performance period.