ESRD QIP Payment Year 2025 Fact Sheet

The Centers for Medicare & Medicaid Services (CMS) uses a variety of levers to support its Strategic Pillars plan, the goals within its National Quality Strategy, and the CMS Meaningful Measures 2.0 framework to help ensure healthcare safety, value, and quality. Those levers include:

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

CMS strives to ensure that all these complex levers work together 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 beneficiaries.

The ESRD QIP promotes high-quality care for outpatient dialysis facilities that treat 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 facility performance on quality care measures. The ESRD QIP reduces payments to ESRD facilities that do not meet or exceed certain performance standards.

For more information about the ESRD QIP, visit Medicare's *ESRD Quality Incentive Program* web page. If you have questions about the program after reviewing this content, contact the CMS ESRD QIP Team via the QualityNet Question & Answer Tool.

ESRD QIP Final Rule Governing Payment Year 2025

This Fact Sheet is an informal reference only and does not constitute official CMS guidance. Please refer to the ESRD Prospective Payment System (PPS) Final Rule document for additional information regarding ESRD-care regulations. This final rule applies updates and revisions to the ESRD PPS for calendar year (CY) 2023 that governs the ESRD QIP for payment year (PY) 2025 and PY 2026. It was published in the *Federal Register* on November 7, 2022. Additionally, the final rule outlines how CMS will implement the law establishing the program. Policies pertaining to PY 2024 and PY 2025 appear in the CY 2022 final rule, published November 8, 2021, in the *Federal Register*. The final rule specifies the following in detail:

- **Measures selected** – 15 total measures (three Care Coordination, four Clinical Care, one Patient & Family Engagement, one Safety, and six 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 rules address public comments to the earlier proposed rules and CMS responses to those comment

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 the following:

- 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 including iron management, bone mineral metabolism, vascular access, and patient satisfaction, as specified by the Secretary of the Department of Health and Human Services (HHS)

Note: CY 2023 is the performance period for PY 2025. For PY 2025, CMS has selected 15 measures for evaluating each facility. Each measure is assigned to one of the five ESRD QIP measure domains: Care Coordination, Clinical Care, Patient & Family Engagement, Safety, and Reporting

These domains align with CMS's Meaningful Measures Initiative, which identified the highest priorities for quality measurement and improvement. Each measure is assigned an individual measure weight that contributes to the facility score; the resulting measure scores are combined to establish the facility's Total Performance Score (TPS). Please refer to the *Facility Scoring* section of this document for additional details pertaining to the individual measure percentage weights. The 15 measures are classified as either a "clinical" measure or a "reporting" measure:

- Nine of the measures are "clinical." The clinical measures evaluate the quality of services provided to patients by how well facilities meet clinical performance goals. Clinical measures use the *outcomes* of reported data to calculate a score.
- Six of the measures are "reporting." The reporting measures evaluate the data that have been reported by facilities and are required to be submitted. Reporting measures use the *rate* of reported data to calculate a score.

Not all facilities will be eligible for a TPS in PY 2025. To receive a TPS, a facility must be eligible to receive a score on at least one measure in two domains. For each measure clinical measure, facilities must meet the minimum data requirements to receive a score. The Standardized Hospitalization Ratio (SHR) measure has a minimum data requirement of 5 patient-years at risk. The Standardized Readmission Ratio (SRR) measure has a minimum data requirement of 11 index discharges.

The In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS®) Survey measure requires facilities to have 30 or more survey-eligible patients to receive a score on the measure. For the Standardized Transfusion Ratio (STrR) measure, the minimum data requirement is 10 patient-years at risk. For all other clinical measures, the minimum data requirement is 11 qualifying patients.

CMS will calculate ESRD QIP scores for each reporting measure by determining whether a facility reported required data in the ESRD Quality Reporting System (EQRS) or the National Healthcare Safety Network (NHSN) system, in accordance with the requirements for the measure in question.

If a facility does not receive a TPS, this does not indicate that the facility provided low-quality care. It could mean that they did not treat enough eligible patients to receive a TPS. For additional information about exclusions and measure calculations, see the *CMS ESRD QIP CY 2023 Measure Technical Specifications* document.

Care Coordination Measure Domain

The Care Coordination Measure Domain has changed for PY 2025; this domain still includes three clinical measures. However, starting in PY 2025, the Clinical Depression Screening and Follow-up reporting measure is part of the Reporting Measure Domain, a new domain as of PY 2025. This domain represents 30 percent of a facility's TPS. The Care Coordination Measure Domain requires facilities to submit the following information:

1. **SRR**: The SRR evaluates the unplanned patient readmissions to the hospital. (The lower the SRR rate, the better the facility will score towards the TPS.)*
2. **SHR**: The SHR evaluates the hospitalization occurrences on a risk-adjusted basis. (The lower the SHR rate, the better the facility will score towards the TPS.)**
3. **PPPW:** The Percentage of Prevalent Patients Waitlisted (PPPW) evaluates the percentage of patients on the kidney or kidney-pancreas transplant waitlist. (The higher PPPW percentage, the better a facility will score towards the TPS.)

Data to assess performance on these measures are taken from EQRS, Medicare claims, Organ Procurement and Transplant Network (OPTN), Nursing Home Minimum Dataset, CMS Medical Evidence Forms, Medicare hospice claims, Enrollment Data Base (EDB), and other CMS ESRD administrative databases.

Clinical Care Measure Domain

Measures in the Clinical Care Measure Domain changed for PY 2025. This domain still includes four clinical measures. However, starting in PY 2025, the Hypercalcemia and Ultrafiltration Rate (UFR) measure is part of the Reporting Measure Domain. Additionally, starting in PY 2025, the STrR measure changed from a reporting measure to a clinical measure, expressed as a rate. The Clinical Care Measure Domain reflects quality measurement based on the CMS Meaningful Measures 2.0 framework and represents 35 percent of a facility's TPS. The Clinical Care Domain requires facilities to submit:

1. **Kt/V Dialysis Adequacy: Comprehensive** – This evaluates the success of achieving the delivered dose of dialysis. (The greater the number of patients above the Kt/V threshold, the better the facility will score towards the TPS.)
2. **Vascular Access Type: Hemodialysis Vascular Access** – This evaluates the vascular access type used to deliver hemodialysis.
    - **Standardized Fistula Rate (SFR)** – The higher the SFR, the better the facility will score towards the TPS.
    - **Long-Term Catheter Rate** – The lower the Long-Term Catheter Rate, the better the facility will score towards the TPS.
3. **Standardized Transfusion Ratio (STrR)** – This evaluates the number of red blood cell transfusion events. (The lower the STrR rate, the better the facility will score towards the TPS.)***

Data to assess performance on these measures are taken from EQRS, Medicare claims, EDB, Long Term Care Minimum Data Set, and other CMS ESRD administrative databases.

*The SRR measure is expressed as a rate. The SRR is expressed as a risk-standardized rate by multiplying the facility SRR by the national average readmission rate. The SRR measure has a covariate adjustment applied for patient history of COVID-19.
**The SHR measure is expressed as a rate. The SHR is expressed as a risk-standardized rate by multiplying the facility SHR by the national average hospitalization rate. The SHR measure has a covariate adjustment applied for patient history of COVID-19.
***STrR is expressed as a risk-standardized rate by multiplying the facility STrR by the national average transfusion rate.

Patient & Family Engagement Measure Domain

The Patient & Family Engagement Measure Domain for PY 2025 remains unchanged and includes one clinical measure. The ICH CAHPS Survey measure represents this domain. The ICH CAHPS Survey measure assesses patients' self-reported experience of care. The higher the ICH CAHPS Survey scores, the better the facility will score towards the TPS. This domain represents 15 percent of a facility's TPS.

Data to assess performance on this measure will be taken from the ICH CAHPS Survey, EQRS, and other CMS ESRD administrative databases.

Performance on this measure is calculated using information on the ICH CAHPS Survey administered by the facility, the reporting of facility survey administration in EQRS, and validation against other CMS ESRD administrative databases.

Safety Measure Domain

For PY 2025, the Safety Measure Domain now contains one clinical measure and represents 10 percent of the facility's TPS. Also, starting in PY 2025, the NHSN Dialysis Event Reporting and Medication Reconciliation (MedRec) measure is in the Reporting Measure Domain. The Safety Measure Domain requires facilities to submit the NHSN Bloodstream Infection (BSI) in Hemodialysis Patients measure. This evaluates the number of BSIs incurred by in-center hemodialysis patients. (The lower the BSI ratio, the better the facility will score towards the TPS.)

Data to assess performance on this measure will be taken from NHSN, EQRS, EDB, Medicare claims, and other CMS ESRD administrative data.

The NHSN BSI in Hemodialysis Patients measure requires facilities to enter data according to the Centers for Disease Control and Prevention (CDC) *Dialysis Event Surveillance Protocol*. Facilities that do not submit 12 months of data in accordance with the *Dialysis Event Surveillance Protocol* will receive 0 points for this measure. Quarterly reporting in NHSN (as specified by the CDC's NHSN and ESRD QIP web page) is required. A facility will receive maximum points by meeting the CDC deadlines and by having a lower number of BSIs. For more information on how to report and submit data to NHSN, visit the *CDC NHSN Training* web page.

Reporting Measure Domain

The Reporting Measure Domain is a new domain for PY 2025. This domain includes six reporting measures: Four existing reporting measures, the Hypercalcemia measure (now a reporting measure in PY 2025) and the new COVID-19 Healthcare Personnel (HCP) Vaccination reporting measure. This domain represents 10 percent of the facility's TPS. The Reporting Measure Domain requires facilities to submit the following information:

1. **Clinical Depression Screening and Follow-up** examines the percentage of eligible patients for which a facility reports in EQRS whether a clinical depression screening and/or follow-up plan was performed. (A higher Clinical Depression Screening and Follow-Up percentage will result in a better facility TPS score.)
2. **Hypercalcemia** examines the percentage of patient-months of uncorrected calcium values reported by the facility. (The more patient-months with calcium data reported the better the facility will score towards the TPS.)
3. **Ultrafiltration Rate (UFR)** examines facility reporting of the data elements used to calculate UFR during the week of the monthly Kt/V laboratory draw and is scored based on the number of

eligible patient-months. (The more patient-months with required UFR data elements reported the better the facility will score towards the TPS.

4. **NHSN Dialysis Event Reporting Measure** examines the percentage of months of Dialysis Event Reporting data reported in NHSN by the facility. (The greater number of months for which the facility reports NHSN Dialysis Event Data, the better the facility will score towards the TPS). Quarterly reporting to NHSN (as specified by the CDC's NHSN and ESRD QIP web page) is required, and a facility will receive maximum points by meeting the CDC deadlines for quarterly data submissions.*
5. **Medication Reconciliation (MedRec)** examines facility reporting of the percentage of MedRec measures performed and documented by an eligible professional. This measure is scored based on the number of eligible facility-months. (The higher percentage of MedRec measures performed and reported, the better the facility will score towards the TPS.)
6. **COVID-19 Healthcare Personnel (HCP) Vaccination** examines the percentage of months of COVID-19 HCP vaccination data reported in NHSN by the facility. (The greater the number of months for which the facility reports COVID-19 HCP data, the better the facility will score towards the TPS). Reporting for at least one week per month (as specified in the *NHSN HCP COVID-19 Vaccination Protocol*) is required and the facility will receive maximum points by meeting the CDC data submission deadlines and reporting requirements.

Data to assess performance on these measures will be taken from EQRS, EDB, facility medical records, Medicare claims, NHSN, and other CMS ESRD administrative data.

Facility Scoring

Period of Performance

The period of performance for PY 2025 is CY 2023. This allows enough time for CMS to:

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

Per the CY 2023 ESRD PPS Final Rule, for PY 2025, CY 2019 data would be used as the baseline period for the seven measures (SHR, SRR, ICH CAHPS, SFR, Long-term Catheter Rate, PPPW and Kt/V) suppressed in PY 2023. All remaining non-suppressed measures would use CY 2021 as the baseline period. For additional scoring policies pertaining to PY 2025, refer to the PY 2023 ESRD PPS Final Rule document, published in the *Federal Register* on November 7, 2022.

Scoring for Clinical Measures

CMS will evaluate facility performance against each measure; a facility receives a score based on the higher of its achievement or improvement on a measure.

The performance period for the PY 2025 clinical measures will be CY 2023. CY 2021 and CY 2019 will be the baseline period for establishing the achievement threshold and benchmark. (CY 2019 will be used for the six suppressed measures in PY 2023 due to the COVID-19 public health emergency.) CY 2022 will be the baseline period for establishing the improvement threshold. 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 baseline period. A facility will receive an achievement score of 0 points if its performance on that measure falls below the achievement threshold, 1 to 9 points if the facility's 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 points if its performance falls below the facility's comparison rate, 1 to 9 points if its performance falls within this range, and 10 points if it is at or above the benchmark.

Scoring for Reporting Measures

Facilities are scored on the reporting measures based on whether they submit certain reporting data and meet the reporting requirements for those data. For the Clinical Depression Screening and Follow-Up, Hypercalcemia, NHSN Dialysis Event Reporting, UFR, MedRec, and COVID-19 HCP Vaccination reporting measures, facilities may be able to earn partial points for satisfying some of the reporting requirements. For more information, please refer to the *CMS ESRD QIP CY 2023 Measure Technical Specifications* and the *CMS ESRD Measures Manual for the 2023 Performance Period*.

Measure Weighting

The 15 measures for PY 2025 do not contribute equally to the TPS. Each facility's score will be calculated according to the following domain weights:

- Clinical Care Measure Domain – 35 percent
- Care Coordination Measure Domain – 30 percent
- Patient & Family Engagement Measure Domain – 15 percent
- Safety Measure Domain – 10 percent
- Reporting Measure Domain (added in PY 2025) – 10 percent

In CY 2019, the ESRD PPS final rule finalized a policy to assign weights to individual measures and to allow weight redistribution for unscored measures. If a facility does not meet the eligibility requirements for a measure, the facility is not scored on the measure. If a facility is not scored on any measures (or measure topics) in a domain, then that domain's weight is redistributed evenly across the remaining domains and then evenly across the eligible measures within those domains. The table on the following page is an example of the measure weights as a percent of the TPS.

Measure Weights as a Percent of TPS		
Measure Topics by Domain	**Measure Weight as a Percent of Domain**	**Measure Weight as a Percent of TPS**
Care Coordination Measure Domain		
SRR measure	40.00%	12.00%
SHR measure	40.00%	12.00%
PPPW measure	20.0%	6.00%
		30% of TPS
Clinical Care Measure Domain		
Kt/V Dialysis Adequacy - Comprehensive measure	31.43%	11.00%
Vascular Access Type: Hemodialysis Vascular Access (SFR and Long-term Catheter Rate) measure	34.29%	12.00%
STrR measure	34.29%	12.00%
		35% of TPS
Patient & Family Engagement Measure Domain		
ICH CAHPS Survey measure	100.00%	15.00%
		15% of TPS
Safety Measure Domain		
NHSN BSI in Hemodialysis Patients measure	100.00%	10.00%
		10% of TPS
Reporting Measure Domain		
Clinical Depression and Follow-Up measure	16.67%	1.67%
Hypercalcemia measure	16.67%	1.67%
UFR measure	16.67%	1.67%
MedRec measure	16.67%	1.67%
NHSN Dialysis Event Reporting measure	16.67%	1.67%
COVID-19 HCP Vaccination measure	16.67%	1.67%
		10% of TPS

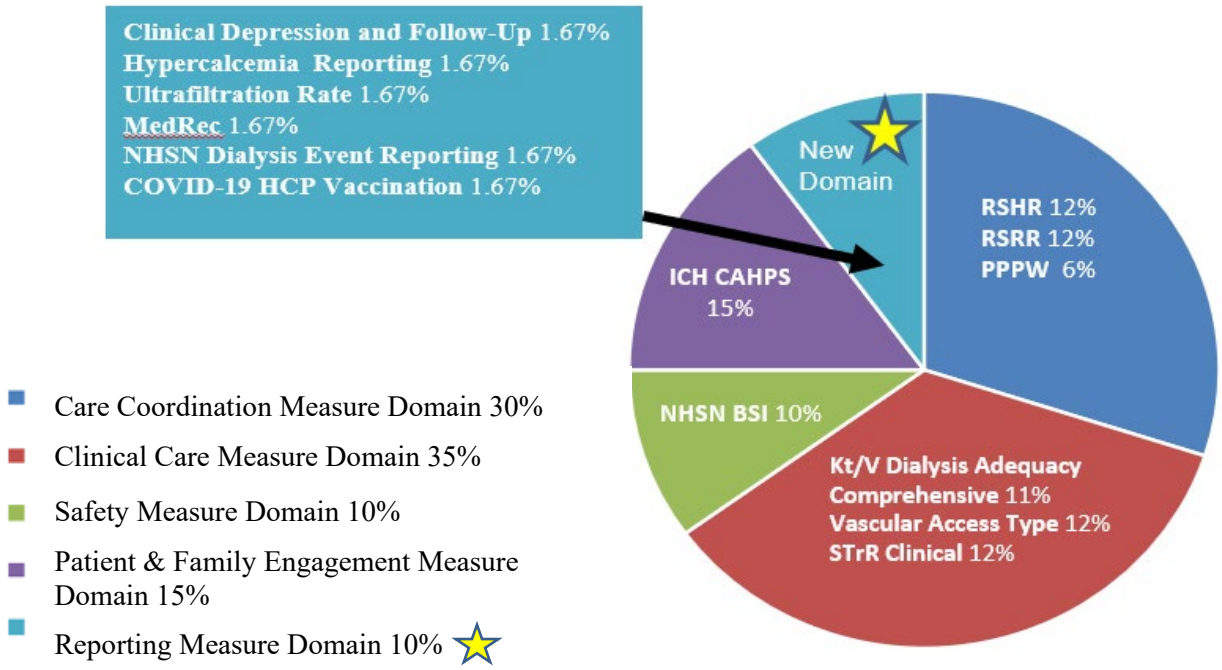
Calculating a Facility's Total Performance Score

A facility's TPS in PY 2025 is calculated by the following steps:

1. Multiply each measure score by its appropriate weight.
2. Add these weighted measure scores.
3. Multiply the sum of the weighted measure scores by 10.

A facility's TPS can range from 0–100 points.

The following graphic illustrates the methodology that CMS uses for calculating PY 2025 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 2025, facilities must have a TPS of at least 55 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 2025.

Scale for Payment Reductions

PY 2025 payment reductions will apply to a facility according to the following chart.

Total Performance Score	Payment Reduction
100–55	No reduction
54–45	0.5%
44–35	1.0%
34–25	1.5%
24–0	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 approximately 30 days and is scheduled to occur in the summer of 2024. During this time, facilities may ask an unlimited number of inquiries about how the system calculates measure results. If a facility believes an error has been made regarding the calculations or data used for a facility's results, the facility can also submit inquiries on this topic during the preview period via the EQRS QIP user interface.