
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CY 2024 ESRD PPS Final Rule

ESRD QIP Finalized Proposals

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Objectives

Attendees will be able to:

- Identify statutory and legislative components for the End-Stage Renal Disease Quality Incentive Program (ESRD QIP).
- Understand the finalized proposals in the calendar year (CY) 2024 ESRD Prospective Payment System (PPS) final rule for the ESRD QIP.
- State the rationale for the finalized policies and their impact on the ESRD QIP.
- Access resources for the ESRD QIP.

Guidance

- During today's presentation, the Centers for Medicare & Medicaid Services (CMS) will discuss the finalized updates for the ESRD QIP in the CY 2024 ESRD PPS final rule, published on November 6, 2023.
- The information provided is offered as an informal reference and does not constitute official CMS guidance.
- CMS encourages stakeholders, advocates, and others to refer to the final rule located in the *Federal Register*.
  - In the PDF version, ESRD QIP begins in Section IV, on page 90.

Legislative Drivers

- The ESRD QIP is described in section 1881(h) of the Social Security Act, as added by Section 153(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).
  - The program's intent is to promote patient health by providing a financial incentive for renal dialysis facilities to deliver high-quality patient care.
  - Section 1881(h) authorizes payment reductions of up to 2 percent if a facility does not meet or exceed the minimum Total Performance Score (TPS).
- The Protect Access to Medicare Act of 2014 added section 1881 (h)(2)(A)(iii).
  - The ESRD QIP must include measures specific to the conditions treated with oral-only drugs. These measures are required to be outcome-based, to the extent feasible.

Statutory Overview

MIPPA requires the Health and Human Services Secretary to create an ESRD QIP that will:

- Select measures that address the following:
  - Anemia
  - Dialysis adequacy
  - Patient satisfaction
  - Iron management, bone mineral metabolism, and vascular access
- Establish performance standards.
- Specify the performance period.
- Develop a methodology for calculating TPSs.
- Apply an appropriate payment percentage reduction.
- Publicly report results.

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Policy Goals and Drivers

- CMS works to improve people's lives through advancing public policy to ensure the healthcare system works better for everyone.
- CMS announced the CMS strategic vision and six strategic pillars which are:

Final Rule Summary

Remove Two Measures

Modify Two Measures

Add Three Measures

- Ultrafiltration Rate (UFR) Reporting Measure
- Standardized Fistula Rate (SFR) Clinical Measure

Final Rule Summary

Remove Two Measures

Modify Two Measures

Add Three Measures

- COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Reporting Measure
- Clinical Depression Screening and Follow-Up Reporting Measure

Final Rule Summary

Remove Two Measures

Modify Two Measures

Add Three Measures

- Facility Commitment to Health Equity Reporting Measure
- Screening for Social Drivers of Health (SDOH) Reporting Measure
- Screen Positive Rate for SDOH Reporting Measure

Finalized Proposal to Remove the UFR Reporting Measure Beginning with Program Year (PY) 2026

Rationale

Final Rule Action

UFR Reporting Measure

- There is indication that the UFR reporting measure may not result in the intended patient outcomes
- Documentation of ultrafiltration measurements may not indicate the quality of a patient's treatment and tracking.
- Tracking as a quality indicator may influence decision-making regarding treatment.
- Performance may not accurately reflect the quality of care provided.

Rationale

Final Rule Action

UFR Reporting Measure

Remove the UFR reporting measure from the ESRD QIP measure set under removal factor 2: Performance or improvement on a measure does not result in better or intended patient outcomes.

Finalized Proposal to Remove the SFR Clinical Measure Beginning with PY 2026

Rationale

Final Rule Action

SFR Clinical Measure

- There have been changes in best practices to vascular access due to the following:
  - Improvements in the overall care of ESRD patients
  - Changes in patient demographics
  - Increasing patient longevity.
- A patient-centered approach based on a consideration of patient needs and dialysis access eligibility is preferred.
- Providers should consider what is most appropriate for the patient, including that arteriovenous fistula may not always be most appropriate.

Rationale

Final Rule Action

SFR Clinical Measure

- Remove the SFR clinical measure from the ESRD QIP measure set under removal factor 3: A measure no longer aligns with current clinical guidelines or practice.
- Remove the reference to Vascular Access Type Measure topic and assign the total weight of 12 percent to the Long-Term Catheter Rate clinical measure.

Finalized Proposal to Modify the COVID-19 Vaccination Coverage Among HCP Reporting Measure Beginning with PY 2026

Rationale

Final Rule Action

Resources

COVID-19 Vaccination Coverage Among HCP Reporting Measure

- Response to COVID-19 remains a public health priority.
- Incentivize and track HCP vaccination through quality measurement to protect health care workers, patients, and caregivers.
- Sustain the ability of HCP to continue serving their communities.

Rationale

Final Rule Action

Resources

COVID-19 Vaccination Coverage Among HCP Reporting Measure

- Replace the term “complete vaccination course” with the term “up to date” in the HCP vaccination definition.
- Update the numerator to specify the time frames within which an HCP is considered up to date with recommended COVID-19 vaccines, including booster doses.

Rationale

Final Rule Action

Resources

COVID-19 Vaccination Coverage Among HCP Reporting Measure

- Click here to access the COVID-19 Vaccination Modules: Understanding Key Terms and Up to Date Vaccination document.
- Click here for the CY 2023 ESRD PPS final rule.

Finalized Proposal to Convert the Clinical Depression Screening and Follow-Up Reporting Measure to a Clinical Measure Beginning with PY 2026

Rationale

Final Rule Action

Clinical Depression Screening and Follow-Up Reporting Measure to a Clinical Measure

- Assessing whether a facility screens patients for depression and develops follow-up plans when appropriate is an opportunity to improve patient health.
  - Depression is highly prevalent in patients with ESRD.
- Ensure that the measure scoring is aligned with current clinical guidelines by narrowing the number of conditions on which a facility can earn points.

Clinical Depression Screening and Follow-Up Reporting Measure to a Clinical Measure

Rationale

Finalized Proposal

- Convert the measure from a reporting measure to a clinical measure.
- Move the measure to the Care Coordination Measure domain.
- Adopt a new methodology for scoring. Facilities will only be awarded points if they report one of the conditions below.

Screening for clinical depression is:

- Documented as being positive, and a follow-up plan is documented.
- Documented as positive, and a follow-up plan is not documented, and the facility possesses documentation stating the patient is not eligible.
- Documented as negative, and a follow-up plan is not required.
- **Not** documented, but the facility possesses documentation stating the patient is not eligible.

Finalized Proposal to Adopt the Facility Commitment to Health Equity Reporting Measure Beginning with the PY 2026

Rationale

Measure Overview

Calculation

Data Submission

Public Reporting

Facility Commitment to Health Equity Reporting Measure

- Significant and persistent disparities in healthcare outcomes exist in the United States.
- Belonging to a minority group, living in a rural area, being a person disabilities, or being near or below the poverty level, is often associated with worse health outcomes.
- Studies demonstrate these groups receive lower quality of care and experience more complications and readmissions.
- Inequities in these groups are interrelated and influence a wide range of health, quality-of-life outcomes, and risks.

Rationale

Measure Overview

Calculation

Data Submission

Public Reporting

Facility Commitment to Health Equity Reporting Measure

- Assesses a dialysis facility's commitment to health equity using five attestation domains.
  - Domain 1 – Equity is a Strategic Priority
  - Domain 2 – Data Collection
  - Domain 3 – Data Analysis
  - Domain 4 – Quality Improvement
  - Domain 5 – Leadership Engagement
- Requires an affirmative attestation for elements within each of the five domains.

Facility Commitment to Health Equity Reporting Measure

Domain 1 – Equity is a Strategic Priority

Facility commitment to reducing healthcare disparities is strengthened when equity is a key organizational priority. The facility will attest that they have a strategic plan for advancing health equity and that it includes all the following activities:

(A) Our facility strategic plan identifies priority populations who currently experience health disparities.

(B) Our facility strategic plan identifies health equity goals and discrete action steps to achieving those goals.

(C) Our facility strategic plan outlines specific resources which have been dedicated to achieving our equity goals.

(D) Our facility strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.

Facility Commitment to Health Equity Reporting Measure

Domain 2 – Data Collection

Collecting valid and reliable demographic and social determinant of health data on patients served in a facility is an important step in identifying and eliminating health disparities. The facility will attest that they engage in the following activities:

A) Our facility collects demographic information and/or social determinant of health information on the majority of our patients.

(B) Our facility has training for staff in culturally sensitive collection of demographic and/or social determinant of health information.

(C) Our facility inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using Electronic Health Record (EHR) technology.

Facility Commitment to Health Equity Reporting Measure

Domain 3 – Data Analysis

Effective data analysis can provide insights into which factors contribute to health disparities and how to respond. The facility will attest that they engage in the following activity:

(A) Our facility stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on facility performance dashboards.

Facility Commitment to Health Equity Reporting Measure

Domain 4 – Quality Improvement

Health disparities are evidence that high-quality care has not been delivered equitably to all patients. Engagement in quality improvement activities can improve quality of care for all patients.

(A) Our facility participates in local, regional, or national quality improvement activities focused on reducing health disparities.

Facility Commitment to Health Equity Reporting Measure

Domain 5 – Leadership Engagement

Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. The facility will attest that they engage in the following activities:

(A) Our facility senior leadership, including chief executives and the entire facility board of trustees, annually reviews our strategic plan for achieving health equity.

(B) Our facility senior leadership, such as, but not limited to, chief executives and the entire facility board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.

Rationale

Measure Overview

Calculation

Data Submission

Public Reporting

Facility Commitment to Health Equity Reporting Measure

- Assesses a dialysis facility's commitment to health equity using five attestation domains.
  - Domain 1 – Equity is a Strategic Priority
  - Domain 2 – Data Collection
  - Domain 3 – Data Analysis
  - Domain 4 – Quality Improvement
  - Domain 5 – Leadership Engagement
- Requires an affirmative attestation for elements within each of the five domains.

Rationale

Measure Overview

Calculation

Data Submission

Public Reporting

Facility Commitment to Health Equity Reporting Measure

- Measure consists of five attestation-based questions, worth two points each.
- Facility must engage in all activities under the domain to affirmatively attest “yes” to a domain.
- Denominator is “ten,” with each domain being represented as two points out of the total ten points.
- Numerator is calculated as two points for each “yes” answer the facility reports.

Rationale

Measure Overview

Calculation

Data Submission

Public Reporting

Facility Commitment to Health Equity Reporting Measure

- Requires facilities to attest to each of the five domains
- Submitted annually in the ESRD Quality Reporting System (EQRS) beginning with the CY 2024 performance period for PY 2026
  - Opens for attestation submission starting January 1 of each year and closes at the end of the EQRS December reporting deadline (approximately two months after December)

Facility Commitment to Health Equity Reporting Measure

- Facility-specific results will be displayed on an annual basis on the *Care Compare* website.
- CMS anticipates making the first public report available in January 2026.

Revisions to Measure Domains and Measure Weights Used to Calculate the TPS Beginning with PY 2026

Measure Domains and Weights Used to Calculate TPS

Measure/Measure Topics by Subdomain	Newly Finalized Measure Weight as Percent of TPS PY 2026
Patient and Family Engagement Measure Domain	**15.00**
In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) measure	15.00
Care Coordination Measure Domain	**30.00**
Standardized Hospitalization Ratio (SHR) clinical measure	9.00
Standardized Readmission Ratio (SRR) clinical measure	9.00
Percentage of Prevalent Patient Waitlisted (PPPW) measure	6.00
Clinical Depression Screening and Follow-Up measure	6.00
Clinical Care Measure Domain	**35.00**
Kt/V Dialysis Adequacy Comprehensive measure	11.00
Long-Term Catheter Rate measure	12.00
Standard Transfusion Ratio (STrR) measure	12.00
Safety Measure Domain	**10.00**
National Healthcare Safety Network (NHSN) Blood Stream Infection	10.00
Reporting Measure Domain	**10.00**
Facility Commitment to Health Equity measure	2.00
Hypercalcemia measure	2.00
Medication Reconciliation (MedRec) measure	2.00
NHSN Dialysis Event measure	2.00
COVID-19 HCP Vaccination measure	2.00

PY 2026
Payment Reduction Scale

PY 2026 Payment Reduction Scale

A facility must meet or exceed a minimum Total Performance Score (mTPS) of **53** to avoid a payment reduction.

Estimated Payment Reduction Scale for PY 2026 Based on the Most Recently Available Data	
Total Performance Score	**Reduction (%)**
100–53	0%
52–43	0.5%
42–33	1.0%
32–23	1.5%
22–0	2.0%

Finalized Performance Standards for PY 2026 ESRD QIP Clinical Measures

Measure	Achievement Threshold (15th percentile**)	Median (50th percentile**)	Benchmark (90th percentile**)
Long-Term Catheter Rate	18.35%*	11.04%*	4.69%*
Kt/V Comprehensive	94.33%*	97.61%*	99.42%*
Standardized Readmission Ratio (SRR)	34.27*	26.50	16.19
NHSN Bloodstream Infection	0.734	0.248	0
Standardized Hospitalization Ratio (SHR)	166.60	129.14	87.98
Standardized Transfusion Ratio (STR)	48.29	26.19	8.86
Percentage of Prevalent Patient Waitlisted (PPPW)	8.12%*	16.73%*	33.90%*
Clinical Depression and Follow-Up	87.10%	94.29%	100.00%
ICH CAHPS:			
Nephrologists' Communication and Caring	58.20%*	67.90%*	79.15%*
Quality of Dialysis Center Care and Operations	54.87%	63.22%	72.83%
Providing Information to Patients	74.49%*	81.09%*	87.80%*
Overall Rating of Nephrologists	49.33%*	62.22%*	76.57%*
Overall Rating of Dialysis Center Staff	51.01%	64.86%	78.86%
Overall Rating of the Dialysis Facility	54.58%	69.42%	84.09%

* Values are the same final performance standards for those measures for PY 2025. In accordance with our longstanding policy, we are using those numerical values for those measures for PY 2026 because they are higher standards than the PY 2026 numerical values for those measures.**We are finalizing our proposal to update the Clinical Depression Screening and Follow-Up measure beginning in PY 2026, as discussed in section IV.C.4 as of the CY 2024 ESRD PPS final rule.

Finalized Proposal to Adopt the Screening for SDOH Reporting Measure Beginning with PY 2027

Screening for SDOH Reporting Measure

Rationale

Measure Overview

Calculation

Data Submission

Public Reporting

- Enables facilities to identify patients with health-related social needs (HRSNs)
- Reduces healthcare access barriers, addresses the disproportionate expenditures attributed to populations with greatest risk, and improves the facility's quality of care
- Improves care coordination efforts by helping facilities understand what HRSNs might be contributing to poor patient outcomes

Rationale

Measure Overview

Calculation

Data Submission

Public Reporting

Screening for SDOH Reporting Measure

Assesses the percentage of patients aged 18 and older who are screened for:

- Food insecurity
- Housing instability
- Transportation needs
- Utility difficulties and
- Interpersonal safety

Rationale

Measure Overview

Calculation

Data Submission

Public Reporting

Screening for SDOH Reporting Measure

- Numerator is the number of patients who are 18 years or older during the performance period and are screened for ALL five HRSNs.
- Denominator is the number of patients who are 18 years or older on the first day of the performance period.
  - Exclusions include patients who opt-out of screening and patients who are unable to complete the screening and have no legal guardian or caregiver who can complete the screening on their behalf.

$$\left[\frac{\text{Number of Eligible Patients for Whom a Facility Screened for all Five HSRNs During the Performance Period}}{\text{Total Number of Eligible Patients During the Performance Period}}\right] \times 10$$

Rationale

Measure Overview

Calculation

Data Submission

Public Reporting

Screening for SDOH Reporting Measure

- Facilities must submit measure data annually in EQRS beginning in CY 2025 for PY 2027.
- Deadline for submission will be the end of the EQRS December data reporting month (approximately two months after December).
- Facilities may choose their own screening tool or method to screen patients.
  - Multiple screening tools exist and are publicly available. Facilities can refer to the SIREN website for information about the most widely used HRSN screening tools.

Screening for SDOH Reporting Measure

- Facility-specific results will be displayed on an annual basis on the *Care Compare* website.
- CMS anticipates making the first public report available in January 2027.

Finalized Proposal to Adopt the Screen Positive Rate for SDOH Reporting Measure Beginning with PY 2027

Screen Positive Rate for SDOH Reporting Measure

Rationale

Measure Overview

Calculation

Data Submission

Public Reporting

- Enables facilities to capture the magnitude of HRSNs and estimate the impact on healthcare utilization and quality of care.
- Enables the development of individual patient action plans for those who screen positive.
- Improves patient outcomes by acknowledging patients' non-clinical needs that contribute to adverse clinical outcomes.
- Supports data-informed collaboration with community-based services to connect patients to local resources.

Rationale

Measure Overview

Calculation

Data Submission

Public Reporting

Screen Positive Rate for SDOH Reporting Measure

- Identifies the proportion of patients at the facility who screen positive for each HRSN:
  - Food Insecurity
  - Housing Instability
  - Transportation Needs
  - Utility Difficulties
  - Interpersonal Safety
- Requires facilities to report data as five separate rates

Rationale

Measure Overview

Calculation

Data Submission

Public Reporting

Screen Positive Rate for SDOH Reporting Measure

- Numerator is the number of patients who are 18 years or older during the performance period and are screened for all five HRSNs, and who screened positive for one or more of the HRSNs.
- Denominator is the number of patients who were screened for all five HRSNs during the performance period.
  - Exclusions include patients who opt-out of screening and patients who are unable to complete the screening and have no legal guardian or caregiver who can complete the screening on their behalf.

$$\left[\frac{\text{Number of Eligible Patients for Whom a Facility Reports Screening Results for all Five HSRNs During the Performance Period}}{\text{Total Number of Eligible Patients who were Screened for all five HRSNs During the Performance Period}}\right] \times 10$$

Rationale

Measure Overview

Calculation

Data Submission

Public Reporting

Screen Positive Rate for SDOH Reporting Measure

- This requires facilities to submit measure data annually in EQRS beginning in CY 2025 for PY 2027.
- Deadline for submission will be the end of the EQRS December data reporting month (approximately two months after December).
- This requires facilities to report data as five separate rates for each HRSN.

Rationale

Measure Overview

Calculation

Data Submission

Public Reporting

Screen Positive Rate for SDOH Reporting Measure

- Facility-specific results will be displayed on an annual basis on the *Care Compare* website.
- Facility screen positive rate for each HRSN will be displayed separately.

Finalized Measure Domains and Weights Beginning with PY 2027

Measure Domains and Weights Used to Calculate TPS

Measure/Measure Topics by Subdomain	Newly Proposed Measure Weight as Perfect of TPS PY 2027
Patient and Family Engagement Measure Domain	**15.00**
ICH CAHPS measure	15.00
Care Coordination Measure Domain	**30.00**
SHR clinical measure	7.50
SRR clinical measure	7.50
PPPW measure	7.50
Clinical Depression Screening and Follow-Up measure	7.50
Clinical Care Measure Domain	**35.00**
Kt/V Dialysis Adequacy Comprehensive measure	11.00
Long-Term Catheter Rate clinical measure	12.00
STrR clinical measure	12.00
Safety Measure Domain	**10.00**
NHSN Bloodstream Infection clinical measure	10.00
Reporting Measure Domain	**10.00**
Screening for SDOH measure	1.43
Screen Positive Rate for SDOH reporting measure	1.43
Facility Commitment to Health Equity measure	1.43
Hypercalcemia reporting measure	1.43
MedRec reporting measure	1.43
NHSN Dialysis Event reporting measure	1.43
COVID-19 HCP Vaccination reporting measure	1.43

Questions and Answers

Resources

Resource	Location
General ESRD QIP Information	ESRD QIP Section on CMS.gov ESRD QIP Section on QualityNet
ESRD QIP Measures	Technical Specifications on CMS.gov ESRD QIP Measures on CMS.gov ICH CAHPS on CMS.gov ESRD QIP Measures on QualityNet
ESRD Public Reporting	Dialysis Facility Compare
ESRD Stakeholder Partners	Partners in ESRD Care
ESRD Final Rule	ESRD QIP Final Rule

Contact us via the QualityNet Question & Answer (Q&A) Tool.

Acronyms

CMS	Centers for Medicare & Medicaid Services	**PPS**	Prospective Payment System
CY	Calendar Year	**PY**	Payment Year
EQRS	ESRD Quality Reporting System	**QIP**	Quality Incentive Program
ESRD	End-Stage Renal Disease	**SDOH**	Social Drivers of Health
HCP	healthcare personnel	**SFR**	Standardized Fistula Rate
HRSN	health-related social needs	**SHR**	Standardized Hospitalization Ratio
ICH CAHPS	In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems	**SRR**	Standardized Readmission Ratio
MIPPA	Medicare Improvements for Patients and Providers Act	**STrR**	Standardized Transfusion Ratio
mTPS	Minimum Total Performance Score	**TPS**	Total Performance Score
NHSN	National Healthcare Safety Network	**UFR**	Ultrafiltration Rate
PPPW	Percentage of Prevalent Patient Waitlisted		

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