Outpatient Quality Program Systems and Stakeholder Support Team

CY 2024 ESRD PPS Final Rule

Question and Answer Summary Document

Moderator:
Danielle Leffler, MS
Outpatient Quality Program Systems and Stakeholder Support Team

Speaker(s):
Delia Houseal, PhD, MPH
End-Stage Renal Disease Quality Incentive Program (ESRD QIP) Program Lead
Division of Value, Incentives & Quality Reporting (DVIQR)
Centers for Medicare & Medicaid Services (CMS)

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Subject-matter experts researched and answered the following questions during the live webinar. The questions may have been edited for grammar.

General Webinar Question

Question 1: How can I obtain the slides from the January 11, 2024, final rule webinar?

The Calendar Year (CY) 2024 End Stage Renal Disease Prospective Payment System (ESRD PPS) Final Rule webinar event materials are available on the Educational Resources page on CMS.gov.

End Stage Renal Disease (ESRD) Data Submission Deadlines Question

Question 2: Where can I find data submission deadline dates for ESRD data?

The ESRD Quality Reporting System (EQRS) and National Healthcare Safety Network (NHSN) data submission deadlines are listed on www.MyCROWNWeb.org. They can be accessed on the Home page under the "Important Links" section.

To view EQRS data submission deadlines by CY, click 2023 or 2024. To view NHSN data submission deadlines, click 2023 or 2024.

Note: If your facility batch submits data or uses Health Information Exchange/Electronic Data Interchange methods for data submission, please follow the guidance provided by your organization.

ESRD Quality Incentive Program (QIP) Questions

Question 3: Where can I go to find information on how to comply with the ESRD QIP guidelines and improve our ESRD QIP scores?

For detailed information on the ESRD QIP measures (including measure descriptions, measure type, numerator and denominator statements, exclusion criteria, minimum data requirements, data sources, and additional information) please refer to the ESRD QIP Technical Measures Specifications available on the CMS.gov website.

For detailed information on ESRD QIP measure calculations, please refer to the ESRD Measures Manual available on the CMS.gov website.

For information on how to report data in EQRS, please visit www.MyCROWNWeb.org. For information on how to report data in NHSN, please visit the Dialysis Component section of the NHSN website.

Question 4: Where can I find the final CY 2024 ESRD QIP Technical Measure Specifications?

The ESRD QIP Technical Measure Specifications document contains information on the ESRD QIP measures. This document includes measure descriptions, measure type, numerator and denominator statements, exclusion criteria, minimum data requirements, data sources, and additional information.

The CY 2024 Technical Measure Specifications are currently available on the CMS.gov website.

Question 5: Which calendar year of data will be used for payment year (PY) 2026 ESRD QIP score calculations?

PY 2026 score calculations will use data from the 2024 performance period, which is CY 2024 data. For clinical measures, the Improvement Score calculations will use CY 2023 data. CY 2022 will be the baseline period for establishing the achievement thresholds and benchmarks.

Facility Commitment to Health Equity Reporting Measure Questions

Question 6: How should facilities address health disparities and health equity for the Facility Commitment to Health Equity measure?

The facility must determine how to best satisfy the competencies aimed at achieving health equity.

The Facility Commitment to Health Equity reporting measure assesses a facility's commitment to health equity using equity-focused competencies aimed at achieving health equity for all populations including (but not limited to) racial and ethnic minority groups, people with disabilities, members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, individuals with limited English proficiency, rural populations, religious minorities, and people living near or below the poverty level.

Beginning CY 2024, facilities will be required to submit data annually via an attestation submission in EQRS for the Facility Commitment to Health Equity measure. Facilities will be required to attest to five domains, each representing a competency aimed at achieving health equity. Each domain is worth two points, with a total of 10 possible points. To receive a full 10 points for this measure, facilities must complete and attest to engaging in all activities in each domain.

For additional information on the Facility Commitment to Health Equity measure, including facility and patient exclusions, please refer to the CY 2024 Technical Measure Specifications available on the CMS.gov website.

Question 7: When are the attestations for the Facility Commitment to Health Equity reporting measure due in EQRS?

Dialysis facilities are required to submit the Commitment to Health Equity attestation **annually** by the EQRS December data reporting deadline, or approximately two months after December. Starting on January 1, 2024, facilities can begin to submit, view, and edit their CY 2024 Commitment to Health Equity attestation data. Facilities have until February 28, 2025, at 11:59 p.m. Pacific Time to complete CY 2024 attestation data submission in EQRS.

For additional information on the Facility Commitment to Health Equity measure, including facility and patient exclusions, please refer to the CY 2024 Technical Measure Specifications available on the CMS.gov website.

Note: If your facility batch submits data or uses Health Information Exchange/Electronic Data Interchange methods for data submission, please follow the guidance provided by your organization.

Screening for Social Drivers of Health (SDOH) Reporting Measure Questions

Question 8: Is there an existing screening tool that facilities can use to screen patients for the Screening for SDOH reporting measure?

CMS allows facilities flexibility to select their own screening tool or method to screen patients for SDOH (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety). Multiple screening tools exist and are publicly available. Facilities can refer to the Social Interventions Research and Evaluation Network (SIREN) website.

Question 9: When will facilities be required to submit data for the SDOH reporting measures (Screening for SDOH and Screen Positive Rate for SDOH)?

Beginning in CY 2025 reporting period for PY 2027, dialysis facilities will be required to submit data for the Screening for SDOH and the Screen Positive Rate for SDOH reporting measures data **annually** in EQRS by the EQRS December data reporting deadline, or approximately two months after December. For instance, facilities must submit the CY 2025 Screening for SDOH and Screen Positive Rate for SDOH reporting in EQRS by March 2, 2026, at 11:59 pm Pacific Time (PT).

For additional information on the Screening for SDOH reporting measure and the Screen Positive Rate for SDOH reporting measure, including facility and patient exclusions, please refer to the CY 2024 Technical Measure Specifications available on the CMS.gov website.

Note: If your facility batch submits data or uses Health Information Exchange/Electronic Data Interchange methods for data submission, please follow the guidance provided by your organization.

Clinical Depression Screening and Follow Up Clinical Measure Questions

Question 10: What is the deadline for submitting the Clinical Depression Screening and Follow Up assessments in EQRS?

The Clinical Depression Screening and Follow Up assessments must be entered in EQRS by the close of the EQRS December data reporting month for the applicable performance period, or approximately two months after December. For instance, facilities must submit the CY 2023 Clinical Depression Screening and Follow Up assessment reporting in EQRS by February 29, 2024, at 11:59 pm PT. Additionally, facilities must submit the CY 2024 assessments in EQRS by February 28, 2025, at 11:59 pm PT.

Question 11: Are facilities required to provide evidence that action was taken for a patient that screened positive for depression?

CMS is committed to verifying the accuracy of information submitted. Therefore, CMS will monitor the accuracy of data submitted through the EQRS validation efforts. Additionally, justification for or against a positive screening should be documented in the medical record. Validation information and guidance can be found on the EQRS Data Validation page of the QualityNet website.

Question 12: What are the reporting guidelines for the Clinical Depression Screening and Follow Up assessments?

A patient must be admitted to a facility for 90 days or more in any CY to be counted in the measure, regardless of admission date. Additionally, facilities are responsible for screening all eligible patients at least once during the CY. Therefore, if the patient receives treatment for **90 days or greater in a single calendar year** and is discharged without having been screened in that facility, then the facility will not get credit for this patient for that calendar year.

Per the ESRD Measures Manual for the 2024 Performance Period, a patient is excluded from a facility's measure calculation if they were treated for fewer than 90 days (days do not have to be consecutive) during the performance period (calendar year) at that facility.

Facilities must screen all eligible patients at least once during the calendar year and must report this information by the EQRS December reporting deadline (approximately two months after December) in EQRS. For instance, facilities must enter the CY 2023 Clinical Depression Screening and Follow-up assessments in EQRS by February 29, 2024, at 11:59 pm PT. This deadline is for all assessments completed in CY 2023.

Facilities must enter the CY 2024 Clinical Depression Screening and Follow-up assessments in EQRS by February 28, 2024, at 11:59 pm PT. This deadline is for all assessments completed in CY 2023.

COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Reporting Measure Questions

Question 13: How is the COVID-19 Vaccination Coverage Among HCP reporting measure calculated?

The COVID-19 Vaccination Coverage Among Healthcare Personnel reporting measure calculates the percentage of months for which the facility successfully reports NHSN COVID-19 vaccination data for eligible healthcare personnel (HCP) in the Centers for Disease Control and Prevention's NHSN system.

Facilities should submit COVID-19 vaccination data via the Weekly COVID-19 Vaccination Module for at least one week per month to fulfill CMS reporting requirements. For facilities that report more than one week per month, the last week of the reporting month will be shared with CMS. If a facility reports data for a week that begins in one month and ends in the following month, the data will be applied to the month that the week ends. NHSN guidance and definitions for

reporting weekly HCP COVID-19 vaccination data can be found in the NHSN HCP COVID-19 Vaccination Protocol.

Question 14: Are facilities scored on the number of vaccinated staff?

The ESRD QIP scoring for the COVID-19 Vaccination Coverage among HCP measure is a reporting measure and does not score facilities based on the number of staff vaccinated. Instead, facilities will be scored on the completeness of the data that are reported to the NHSN system for their facility. Scoring will be based on whether the facility submits the required reporting data by the reporting deadlines for those data. More specifically, the scoring for the COVID-19 Vaccination Coverage among HCP measure evaluates the percentage of months that the facility reports data to NHSN. Facilities can receive maximum points for this measure by meeting the data submission deadlines and reporting requirements. Therefore, the greater the number of months the facility reports data, the better the facility will score towards the measure. Additionally, facilities can earn partial points for satisfying some of the reporting requirements for this measure.

Long-term Catheter Rate Clinical Measure Question

Question 15: Is there a QIP payment adjustment for facilities that have a high patient volume with complex comorbid conditions?

Currently there are no payment adjustments for catheters in the ESRD QIP. However, CMS does evaluate QIP scoring for each measure every year. Additionally, per the CY 2024 Technical Measure Specifications, the Long-term Catheter measure currently has various patient exclusions for patients with a limited life expectancy:

- Patients under hospice care in the current reporting month.
- Patients with metastatic cancer in the past 12 months.
- Patients with end stage liver disease in the past 12 months.
- Patients with coma or anoxic brain injury in the past 12 months.

Ultrafiltration Rate (UFR) Reporting Measure Question

Question 16: Are facilities still required to enter UFR data into EQRS?

No, facilities are not required to enter UFR data into EQRS. However, given the importance of fluid management to ESRD treatment, CMS encourages facilities to continue reporting UFR data in EQRS.

Pediatric Patient Questions

Question 17: How will pediatric facilities be scored on the Long-term Catheter Rate clinical measure?

Pediatric patients are excluded from the long-term catheter measure. If the facility only treats patients under the age of 18 years, then No Score will be assigned for that measure and the facility will not be penalized.

For additional information on the Long-term Catheter Rate clinical measure, including facility and patient exclusions, please refer to the CY 2024 Technical Measure Specifications available on the CMS.gov website.

Question 18: Where can I find which measures do not apply to pediatric patients?

The CY 2024 Technical Measure Specifications indicate the exclusions for each measure. Please review the patient exclusions for each measure to determine whether pediatric patients are excluded from a specific measure.

Standardized Transfusion Ratio (STrR) Clinical Measure Question

Question 19: How is the STrR clinical measure calculated?

STrR is the ratio of the number of eligible red blood cell transfusion events observed in patients dialyzing at a facility to the number of eligible transfusion events that would be expected under a national norm, after accounting for the patient characteristics within each facility. Eligible transfusions are those that do not have any claims related to the comorbidities identified for exclusion in the one-year look back period before each observation window. STrR is expressed as a risk-standardized rate by multiplying the facility STrR by the national average transfusion rate. For more information on the measure calculation, refer to the CMS ESRD Measures Manual for the 2024 Performance Period.

NHSN Bloodstream Infection (BSI) in Hemodialysis Patients Clinical Measure Question

Question 20: Are facilities still required to report contaminated blood cultures for calculating the Standardized Infection Ratio (SIR) for the BSI in Hemodialysis Patients measure?

Yes. Per the NHSN Dialysis Event Surveillance Protocol, positive blood cultures are considered a dialysis event and must be reported in NHSN. The BSI in Hemodialysis Patients measure calculates the SIR of BSIs among outpatient hemodialysis (HD) patients. According to the Measures Manual, the numerator is the number of new positive blood culture events based on blood cultures drawn as an outpatient or within one calendar day (24 hours) after a hospital admission. A positive blood culture is considered a new event and counted only if it occurred 21 days or more after a previous blood culture in the same patient. For more information on the measure calculation, refer to the CMS ESRD Measures Manual for the 2024 Performance Period.

Peritonitis Infections Module Question

Question 21: Where can I find information on reporting peritonitis infections in EQRS?

The CMS Infection Event Data Submission Requirements document provides information about reporting peritonitis infection data in EQRS and is available on the Education page on www.MyCROWNWeb.org. Additionally, please refer to the June Town Hall event materials (slides and recording) for training on how to enter peritonitis infections in EQRS. These training materials are available from the Events page on www.MyCROWNWeb.org. Additional questions can be submitted to the QualityNet Question & Answer Tool.