ESRD QIP
Frequently Asked Questions

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 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.

This document is intended to provide dialysis facilities and other interested parties with technical details about the ESRD QIP.

Dialysis Facility Compare is an additional CMS resource that allows patients to find detailed information about Medicare-certified dialysis facilities, and to compare the services and the quality of care that facilities provide. The website includes star ratings for each facility, along with details about the facility's hospitalizations, deaths, and use of best treatment practices. CMS encourages beneficiaries and consumers alike to learn more about the ESRD QIP on Medicare's Dialysis Facility Compare website, available online at http://www.medicare.gov/DialysisFacilityCompare/search.html.

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

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General Program Information

Where can I find information from CMS regarding the Medicare program that ties payment to the quality of dialysis care?

Information on value-based purchasing for dialysis facilities, known as the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP), can be found in many different locations, including this ESRD QIP section of the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/.

I have questions about the ESRD QIP. What should I do?

If your question is not addressed in this resource or in any resources linked within this section, please submit it to the ESRD QIP inbox at ESRDQIP@cms.hhs.gov. CMS addresses questions on

a first-come, first-served basis. Our goal is to provide a response within 10 business days, although questions that require additional research may take longer to answer.

What statute provides the legislative authority for the ESRD QIP?

The authority for this program comes from the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Section 153(c) of that act, amending Section 1881(h) of the Social Security Act (SSA), establishes a Quality Incentive Program for renal dialysis facilities.

Where can I find the rules further explaining and outlining the ESRD QIP?

In September 2009, CMS proposed the general framework for the ESRD QIP, along with three performance measures for use in Payment Year (PY) 2012. The agency finalized PY 2012 measures in the *Federal Register* on August 12, 2010. At the same time, CMS proposed the remainder of the ESRD QIP format for PY 2012, including performance standards, performance periods, scoring methodology, and payment reductions. This rule was published in the *Federal Register* on January 5, 2011. On July 8, 2011, CMS published a proposed rule for PY 2013 and PY 2014. The final rule was published on November 10, 2011. On July 2, 2012, CMS published a proposed rule for PY 2015. The final rule was published on November 9, 2012. On July 8, 2013, CMS published a proposed rule for PY 2016. The final rule was published on December 2, 2013. On July 11, 2014, CMS published a proposed rule for PY 2017 and PY 2018. The final rule was published on November 6, 2014.

These final rules can be found at:

- http://edocket.access.gpo.gov/2010/pdf/2010-18466.pdf
  (PY 2012 PPS final rule finalizing measures)
- http://edocket.access.gpo.gov/2011/pdf/2010-33143.pdf
  (PY 2012 ESRD QIP final rule)
- http://www.gpo.gov/fdsys/pkg/FR-2011-11-10/pdf/2011-28606.pdf
  (Calendar Year [CY] 2011 ESRD PPS final rule; includes PY 2013 and PY 2014 final rule)
- http://www.gpo.gov/fdsys/pkg/FR-2012-11-09/pdf/2012-26903.pdf
  (CY 2013 ESRD PPS final rule; includes PY 2015 final rule)
- http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28451.pdf
  (CY 2014 ESRD PPS final rule; includes PY 2016 final rule)
- http://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26182.pdf
  (CY 2015 ESRD PPS final rule; includes PY 2017 and PY 2018 final rule)

Why is the performance period so much earlier than the year that this performance affects payment?

Facility performance data for the ESRD QIP is based primarily on claims data that dialysis facilities submit to CMS as part of their billing process. CMS requires six months after the end of the performance period to finalize these claims and to allow for corrections, appeals, and adjudication.

After all claims for services rendered during the performance period receive final adjudication, CMS analyzes the claims and calculates facility performance scores for the ESRD QIP. CMS then provides facilities with an opportunity to preview their scores and address any issues and

concerns with CMS through a Preview Period. Upon completion of the Preview Period, CMS makes final adjustments to applicable payment reductions prior to the start of the payment year.

This entire process requires approximately one year from the end of the performance period to the time that payments are adjusted. As a result, the performance period must end at least a year before the beginning of the payment year.

How is a facility's performance in the ESRD QIP communicated to the facility and the public?

Facilities are able to preview their ESRD QIP measure scores and Total Performance Scores after the close of the performance period and prior to the implementation of payment reductions and public reporting. This Preview Period typically occurs in the July – August timeframe. Once scores are finalized, the scores are provided to facilities and are made available to the general public.

Facility performance in the ESRD QIP is publicly reported through three mechanisms. CMS produces a Performance Score Certificate (PSC) summarizing a facility's performance, which facilities are required to display in a public area. A section of Medicare's publicly available website, Dialysis Facility Compare (DFC), also provides searchable information about individual facilities. CMS also releases detailed facility information each year in a file titled "ESRD QIP Dialysis Facility Performance Information." It is posted on a CMS-approved website.

What are the inclusion criteria for the ESRD QIP?

For details on the claim, patient, and facility-level inclusion criteria for the ESRD QIP, please refer to the "Inclusion Criteria" section of the guide for each payment year. This document is posted along with the Preview Performance Score Report (PSR) at the beginning of the Preview Period.

Performance Score Report and the Preview Period

What is the Performance Score Report?

The Performance Score Report (PSR) is a document intended to inform a dialysis facility about its performance on quality measures during the Performance Period, its Total Performance Score (TPS), how its score was calculated, and how Medicare payments will be affected as a result. CMS issues a Preview PSR for each facility at the beginning of the Preview Period, and a Final PSR in December.

What is the Preview Period?

The Preview Period is a 30-day timeframe (normally occurring in late summer each year) during which a facility has the opportunity to review the preliminary performance scores calculated by CMS. During that time, a facility may submit one or more clarification questions and/or a single formal inquiry in the event that it believes an error in calculating its scores has been made.

As a facility, what do I do if the provider numbers listed in my Preview PSR are wrong?

If any facility identification information on your PSR is incorrect, please submit a correction either as an ESRD QIP comment or as part of your formal inquiry. Please note that only one formal inquiry will be permitted per facility, but that inquiry may include as many questions as necessary.

CMS strongly encourages facilities to review their scores early and submit any clarification questions roughly by the midpoint of the Preview Period to ensure that a response from CMS is

received prior to the close of the Preview Period. Facilities may submit clarification questions after that midpoint, but CMS may not be able to resolve all questions prior to the close of the Preview Period.

Formal inquiries and questions will not be accepted after the end of the Preview Period.

What do I do if the data in my Preview PSR do not match the data I submitted?

For an explanation of the inclusion criteria applied to claims and patients, please review the "Inclusion Criteria" section of the applicable *Guide to the ESRD QIP*. If you suspect that the inclusion criteria were not appropriately applied to data submitted by your facility, or you would like additional clarification on how the process was applied to your facility, then you may submit an ESRD QIP comment or formal inquiry. Please note that only one formal inquiry will be permitted per facility.

What is the difference between a clarification question (or comment) and a formal inquiry?

Throughout the Preview Period, facilities will be able to submit clarification questions and comments. A clarification question is any question about methodology or how scores are calculated. This includes a request for a patient list. The purpose of a clarification question is to allow a facility to obtain more information about its score calculation.

If a facility believes it has identified an error in its score, it may submit a single formal inquiry requesting CMS review. A formal inquiry is an explanation from a facility about policy or methods and/or a request to change a measure score based on evidence (typically a review of patient-level data). Facilities must indicate approval of the Medical Director/Facility Administrator when they submit their formal inquiry. CMS will respond to all formal inquiries submitted during the Preview Period (although CMS may send the response after the Preview Period ends).

Although each facility is permitted to submit only one formal inquiry, facilities are not limited in the number of clarification questions and comments they submit. If clarification questions are submitted after the midpoint of the Preview Period, however, then CMS may not be able to resolve all of the facility's questions with sufficient time for the facility to submit a formal inquiry, if desired.

Formal inquiries and questions will not be accepted after the end of the Preview Period.

Who can submit a clarification question about a facility's Preview PSR?

Only one user per facility has access to submit a clarification question. Please contact your facility Master Account Holder to find out who has the ability to submit a clarification question. CMS strongly encourages facilities to review their scores early and submit any clarification questions no later than the midpoint of the Preview Period to ensure that a response from CMS is received prior to the close of the Preview Period.

Formal inquiries and questions will not be accepted after the end of the Preview Period.

Who can submit a formal inquiry about the Total Performance Score on a facility's Preview PSR?

Only one user per facility has access to submit a formal inquiry to CMS, and each facility is only allowed to submit **one** formal inquiry. The Medical Director/Facility Administrator of your facility must approve this inquiry before it is submitted. Please contact your facility Master Account Holder to find out who has the ability to submit a formal inquiry.

Formal inquiries and questions will not be accepted after the end of the Preview Period.

When does the Preview Period end?

The Preview Period typically lasts for 30 days.

How do the ESRD QIP measures differ from the measures reported in the Dialysis Facility Compare Report?

Although the information contained in these two projects may be similar, the projects usually differ in substantive ways. For instance, the two measures used in the ESRD QIP during PY 2013 are also reported in the Dialysis Facility Compare (DFC) Report. When these measures are calculated for the ESRD QIP, however, pediatric patients are excluded from the calculation.

Why was a Total Performance Score not calculated for my facility?

A facility may not receive a score for a payment year for any of several reasons (e.g., not receiving a CMS Certification Number by a specified time, not receiving scores on enough individual measures in a given year). Not receiving a Total Performance Score is not an indication of the quality of care a facility provides.

Performance Score Certificate

What is the Performance Score Certificate?

The Performance Score Certificate (PSC) is a document informing patients and their families about how a dialysis facility performed in the ESRD QIP. It is available in English and Spanish. Facilities must post both versions in an area easily visible to patients and their families.

What does the PSC mean to patients?

The purpose of the ESRD QIP is to improve the quality of dialysis care and produce better outcomes for beneficiaries. The PSC provides a picture of how well the facility performed on specific measures, and may help inform the decisions patients make about their care. CMS encourages patients to discuss these results with their physicians and other medical staff at the facility.

When will facilities receive their PSC?

CMS will electronically notify facilities that the PSCs are available for downloading in December of each year. Each facility is responsible for printing the PSC and posting it in a prominent location where patients and caregivers can view it.

When should facilities begin displaying the PSC?

The requirements for displaying the PSC have changed as the ESRD QIP has evolved. For PY 2014, facilities are required to post their PSCs within five business days after the certificates are made available. For PY 2015, facilities will be required to post their PSCs on or before the first business day after January 1, 2015. For PY 2016, facilities are required to post their PSCs within 15 days after the certificates were made available for downloading on December 17, 2014.

How long does a facility need to display the PSC?

The English and Spanish versions of a facility's PSC will be replaced annually, and must be displayed for the entire year. For example, PY 2015 PSCs must be displayed for the duration of Calendar Year 2015.

Are there any special instructions about displaying the PSC?

Facilities are prohibited from altering the size or content of the PSC in any way (including changing the font size). It must be printed on plain white or light-colored paper of at least 8 ½ by 11 inches. All pages of the document must be displayed together.

What should a facility do if its PSC is lost or destroyed?

If a PSC is lost, removed, destroyed, or defaced, the facility is responsible for replacing the certificate with a new copy as soon as possible and reprinting it. The certificate can be requested by sending an email to ESRDQIP@cms.hhs.gov.

Will the PSCs be available to patients and the public through other sources?

Starting in January 2013, data that appears in the PSC will also appear on the CMS DFC website at http://www.medicare.gov/DialysisFacilityCompare/search.html. CMS intends to release that data by mid-January of each payment year. Nevertheless, facilities will need to download and print their certificates from Dialysis Facility Reports directly.

Do the PSCs indicate the quality of care that a facility provides?

The ESRD QIP doesn't capture every aspect of care provided by a facility, so the results should be considered along with all other available information. Patients should talk with their treatment team about any concerns they may have.

PY 2012

What was the scoring methodology for PY 2012?

CMS scored facility performance on two standards: (1) the facility's own performance in 2007 (the "special rule") or (2) the national performance rate in 2008. Whichever standard yielded the better score was applied. If a facility met or exceeded the standard in question, it earned a score of 10 points on the measure. For each percentage point the facility fell short of the applicable performance standard, CMS subtracted 2 points from the measure score.

One measure (Hgb < 10g/dL) was weighted at 50 percent of the Total Performance Score; each of the remaining two measures (Hgb > 12 and URR) were weighted at 25 percent of the Total Performance Score. The Total Performance Score ranged from 0 – 30 points.

CMS reduced payments in PY 2012 for all facilities that did not receive a Total Performance Score of at least 26 points. Payment reductions ranged from 0.5 percent to 2 percent, depending on how far below this threshold a facility performed.

Why did the special rule remain in PY 2012?

CMS used calendar year 2010 as the performance period for PY 2012. Because CMS was finalizing performance standards after the beginning of the performance period, CMS had to adhere to the "special rule," as described earlier and in Section 1881(h)(4)(E) of the Social Security Act (SSA) for PY 2012. The special rule no longer applied starting in PY 2014, as measures and standards for PY 2014 and future payment years were finalized prior to the start of the performance period. For more information regarding the special rule and its use in previous Payment Years of the ESRD QIP, please see the CY 2011 ESRD PPS Final Rule (76 Fed. Reg. 629).

PY 2013

What was the scoring methodology for PY 2013?

CMS scored facility performance on two standards: (1) their own performance in 2007 (the "special rule") or (2) the national performance rate in 2009. Whichever standard yielded the better score was applied. The measure scores were calculated on a scale of 0–10. For each percentage point the facility fell short of the applicable performance standard (the lesser of the national rate in 2009 or the facility's rate in 2007), CMS subtracted 2 points from 10 (the maximum score a facility can receive on the measure).

Each of the two measures (Hgb > 12 and URR) were weighted at 50 percent of the Total Performance Score. The weighted score was multiplied by 1.5 to achieve the Total Performance Score, which ranged from 0 – 30.

To further incentivize improvement in the second year of the ESRD QIP, CMS reduced payments in PY 2013 for all facilities that did not receive a Total Performance Score of 30 points (the highest possible score). Payment reductions ranged from 1 percent to 2 percent—compared with 0.5 percent to 2 percent in PY 2012—depending on how far below this threshold a facility performed.

Technical specifications for both PY 2013 ESRD QIP measures are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html.

Why did the special rule remain in PY 2013?

CMS used calendar year 2011 as the performance period for PY 2013. Because CMS was finalizing performance standards after the beginning of the performance period, CMS had to adhere to the "special rule," as described earlier and in Section 1881(h)(4)(E) of the Social Security Act (SSA) for PY 2013. The special rule no longer applied starting in PY 2014, as measures and standards for PY 2014 and future payment years were finalized prior to the start of the performance period.

PY 2014 – Eligibility

Are home hemodialysis-only facilities included in the PY 2014 ESRD QIP?

Starting on January 1, 2012, outpatient home hemodialysis facilities were included for the first time in the ESRD QIP. Not every measure applies to this type of facility, however.

Adult **home hemodialysis-only facilities** are evaluated based on three measures:

- The Hemoglobin Greater Than 12 g/dl measure
- The Vascular Access Type (VAT) measure
- The Mineral Metabolism reporting measure.

For the PY 2014 ESRD QIP, home hemodialysis-only facilities are not required to enroll, train, and report via the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). Additionally, home hemodialysis facilities were not required to conduct the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CHAPS) survey or to fulfill the requirements for the Urea Reduction Ratio (URR) clinical measure.

Are peritoneal dialysis-only facilities included in the PY 2014 ESRD QIP?

The ESRD QIP applies to outpatient peritoneal-only facilities as of January 1, 2012, which is the start of the performance period with potential payment implications during 2014. Not every measure applies to this type of facility, however.

Adult **peritoneal dialysis-only** facilities are evaluated on two measures:

- The Hemoglobin Greater Than 12 g/dL measure
- The Mineral Metabolism reporting measure.

For the PY 2014 ESRD QIP, peritoneal-only facilities are not required to enroll, train, and report via the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). Additionally, peritoneal-only facilities were not required to conduct the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CHAPS) survey or to fulfill the requirements for the Urea Reduction Ratio (URR) and Vascular Access Type (VAT) clinical measures.

Are pediatric-only facilities included in the PY 2014 ESRD QIP?

The ESRD QIP will apply to **pediatric outpatient dialysis facilities** as of January 1, 2012, which is the start of the performance period with potential payment implications during 2014.

To receive full points for the program, all pediatric facilities, including those caring only for patients less than age 18, must comply with the reporting requirements for the mineral metabolism reporting measure. Additionally, pediatric facilities providing in-center hemodialysis must comply with the requirements for the NHSN reporting measure.

Pediatric facilities that also care for patients age 18 or older may be eligible for additional measures.

For purposes of the program, on what date are facilities considered "new"?

To determine whether a facility is "new" for the PY 2014 ESRD QIP, CMS uses the date of the CMS Certification Number (CCN) from the certification date.

PY 2014 – Clinical Measures Scoring

Where can I find specifications for the PY 2014 clinical measures?

Technical specifications for all PY 2014 ESRD QIP clinical measures are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html.

Are frequent dialyzers included in the Hemodialysis Adequacy measure?

Patients on hemodialysis one, two, or three times a week are included in the denominator of the urea reduction ratio (URR) measure (assuming all other requirements are met). Patients that dialyze four or more times a week are excluded from the denominator of the URR measure.

How is the final VAT measure calculated?

The Vascular Access Type (VAT) measure is comprised of two submeasures: the fistula submeasure and the catheter submeasure. To calculate the score of the VAT measure, CMS first individually scores the submeasures. This means that CMS uses the PY 2014 scoring methodology as if each of the submeasures were its own measure. Each submeasure is awarded

the higher of its achievement or improvement score. The submeasure scores are then averaged to reach the final VAT measure score.

For purposes of VAT scoring, how is the "duration of catheter use" determined?

For purposes of the ESRD QIP, duration of catheter use is based on how long a patient is receiving dialysis through a catheter. CMS does not use the life of the catheter for this calculation.

Where can I find the values for the performance standards for PY 2014 clinical measures?

The final rule finalized the PY 2014 clinical performance standards. Due to data limitations related to the claims verification process, however, CMS was unable to publish in the final rule the numerical values for the achievement thresholds and benchmarks for the clinical measures. Instead, the final rule *estimated* achievement thresholds and benchmarks based on data from July 1, 2010, through March 30, 2011. Later, the values for the clinical performance standards based on the full 12 months of data were finalized and published separately. They are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/UpdatedBaseline-2014-FR.pdf.

PY 2014 – NHSN Reporting

Do I have to register for all three components of National Healthcare Safety Network (NHSN), or just the one regarding patient safety?

During enrollment, only the Patient Safety Component needs to be activated for a facility to participate in Dialysis Event surveillance. To find additional information on the enrollment process, please visit http://www.cdc.gov/nhsn/dialysis/cms-dialysis-enroll-steps.html.

My outpatient dialysis facility is a part of a hospital that is already registered with NHSN. Do I need to re-enroll?

Yes, dialysis clinics must be enrolled in NHSN individually as an "AMB-HEMO – Hemodialysis Center" facility type to report data to CMS, even if the dialysis clinic is hospital-affiliated.

Although the dialysis facility will need to enroll separately from the hospital, multiple facilities (e.g., outpatient dialysis, inpatient acute care) can be enrolled using a single digital certificate. See the instructions at Enrolling Multiple Outpatient Dialysis Clinics in NHSN.

How must I submit my NHSN data to CDC? Can I submit it to CMS instead?

Please submit your data to the CDC using NHSN. NHSN dialysis event data will not be accepted if it is sent directly to CMS. Please note that CMS requires at least one staff member at the facility be trained in and knowledgeable of how to report dialysis event data to the NHSN.

In addition, Clinical Document Architecture (CDA) is currently under development as an import option within NHSN for dialysis event data. Using CDA will allow facilities to import their data (numerators and denominators) electronically into NHSN, instead of manually entering patient information. A facility-based NHSN user is expected to review the data in NHSN on an ongoing basis to verify that data reported via CDA are complete, accurate, and correct. For additional information, please visit the Tracking Infections in Outpatient Dialysis Facilities section and click on FAQs about NHSN reporting with CDA – General and dialysis event reporting.

Where can I go to find more information on enrolling in and submitting data to NHSN?

To find additional information on NHSN enrollment, set-up, and reporting, please visit the Tracking Infections in Outpatient Dialysis Facilities section. Here you will find the required trainings, form instructions, and corresponding materials.

CDC provides instructions for enrollment in the NHSN at http://www.cdc.gov/nhsn/dialysis/cms-dialysis-enroll-steps.html.

How many months of data must my facility report to NHSN to receive full credit for the NHSN Dialysis Event reporting measure?

To receive the maximum 10 points and comply with the CMS ESRD QIP rule, facilities are required to:

- Complete the required training and enroll the facility in NHSN during or prior to 2012 (5 points)
- Report at least 3 consecutive months of CY 2012 data (5 points; refer to the NHSN Dialysis Event Protocol for reporting instructions).

Additionally, this data must have been submitted to NHSN by April 30, 2013, to receive credit for PY 2014.

PY 2014 – ICH CAHPS Survey Reporting

What is "successful administration" of the ICH CAHPS survey?

"Successful administration" of the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) survey is defined in the rule as following the specifications established by the Agency for Healthcare Research and Quality (AHRQ). These specifications can be found at http://www.cahps.ahrq.gov/hemodialysis/fieldingich.pdf.

Can the facility administer the survey itself? Can it provide for patients to drop off their survey results at the facility?

In accordance with the specifications, the ICH CAHPS survey must be administered by a third party in order for the administration to be considered successful under the ESRD QIP. According to the online guidance referenced in the previous question, this third-party administration may be done through mail with telephone follow-up, or by telephone only. Facilities may not collect the surveys at their individual facilities.

To whom must the ICH CAHPS survey be administered?

The rule states that the ICH CAHPS survey must be administered in accordance with AHRQ specifications. Eligibility of the population is defined within these specifications. The specifications state that "[a]ll currently *dialyzing in-center* hemodialysis patients with *at least 3 months of experience* on hemodialysis *at their current facility* are eligible for the survey. This survey is designed for *adults only* (18 and older)." Therefore, the measure does not apply to pediatric patients, patients not receiving in-center hemodialysis for at least three months, and patients who have not had three months of experience *at that facility*.

What if not all of my patients respond to the survey?

Although AHRQ specifications aim for a 40 percent response rate, rates may be higher or lower in individual facilities, and such variation is acceptable.

Who is responsible for submitting attestation of the use of the ICH CAHPS survey to CROWNWeb? Is a vendor able to submit that information on behalf of dialysis-facility clients, or is the dialysis facility required to submit that information on its own?

For purposes of the PY 2014 ESRD QIP, only facilities are able to submit the attestation regarding compliance with the ICH CAHPS survey. Note that *no information* from the surveys need be submitted to CMS for the PY 2014 program. The facility need only make an attestation via CROWNWeb that it successfully completed the survey's specifications as provided by AHRQ.

What is the attestation submission process for CROWNWeb?

CROWNWeb will provide facilities with a specific form for the attestation. The form is brief and is submitted electronically.

Do I submit my ICH CAHPS data to CMS?

As stated in the rule, a facility need only attest to successful administration of the survey to receive full points on the measure; no data submission is required for the PY 2014 program. Although not required by the ESRD QIP, CMS expects facilities to review their own results to see how they can improve care.

If a home hemodialysis and peritoneal program is part of an ICH (same provider number), does it have to administer the ICH CAHPS to its patients?

The ICH CAHPS survey only applies to those patients who receive in-center hemodialysis. If a facility only provides home hemodialysis and/or peritoneal dialysis, then it need not administer the ICH CAHPS survey. If a facility provides home hemodialysis and/or peritoneal dialysis *and* in-center hemodialysis, then the facility need only administer the ICH CAHPS survey to the patients receiving in-center hemodialysis.

If the facility provides home hemodialysis and/or peritoneal dialysis *and* in-center hemodialysis, then it must attest that it administered the survey successfully to receive points for this measure. "Successful administration" means that it administered the survey to its in-center hemodialysis patients in accordance with the specifications.

Can the ICH CAHPS survey be customized for individual facility use?

Yes, a facility may include additional questions in the ICH CAHPS survey; note, however, that these questions must immediately precede the "About You" section and appear after question number 41 in the core survey.

PY 2014 – Mineral Metabolism Reporting

What if my patient dies or is transient? Do I still need to measure his/her calcium and phosphorus measures once per month?

CMS does not expect facilities to measure levels for patients who do not consider the dialysis facility their "home" facility (i.e., for those patients for whom the facility would not be monitoring bone mineral metabolism trends). As the measure specifications cited in the rule state, an in-center Medicare patient need only be included if he/she has been treated at the facility at least seven times during the claims month.

For purposes of complying with the Mineral Metabolism reporting measure, can my facility include results of lab work performed by another provider (e.g., a hospital) or laboratory during the reporting period?

Yes, if a patient is treated elsewhere during the claim month, then the facility may include results of lab work performed by another healthcare provider as part of the facility's compliance with this reporting measure. The source and the lab values should be documented in the patient's dialysis record. CMS believes that eliminating redundant lab tests helps to reduce costs while ensuring continuity of care.

CMS notes that the facility itself is not required to draw blood from the patient. If, for example, a patient is hospitalized or transient during the claim month, then the facility may report the hemoglobin or hematocrit readings for the patient for a month if a patient has labs drawn in an accredited laboratory (e.g., Joint Commission, College of American Pathologists, American Association of Bioanalysts, or other state and federal agencies) and the facility reviews the hemoglobin or hematocrit readings from these labs.

What is the attestation submission process for CROWNWeb? Is there a particular form or format?

CROWNWeb will provide facilities with a specific form for the attestation. The form is brief and is submitted electronically.

How do I submit my mineral metabolism data to CMS?

Facilities need not report this data to CMS as part of the PY 2014 ESRD QIP. For purposes of the PY 2014 ESRD QIP, facilities need only attest to measuring the calcium and serum levels of each Medicare patient at least once per month.

PY 2014 – Total Performance Score

What is the scoring methodology for PY 2014?

CMS introduced a new scoring methodology for ESRD QIP PY 2014 in which facilities have two opportunities to earn points, and the higher of the two scores is awarded. Under the new methodology, CMS assesses performance on achievement and improvement for each clinical measure. For the achievement score, facilities are compared to national performance during the baseline period; for the improvement score, a facility's performance during the performance period is compared to its performance in the baseline period. The clinical measure score is the higher of the improvement and achievement scores. The clinical measure scores for which a facility is eligible will be weighted equally, and will combine to comprise 90 percent of the facility's Total Performance Score.

The reporting measures assess whether the facility completed the data collection and reporting for that measure as specified. The reporting measures for which a facility is eligible will be weighted equally to comprise the remaining 10 percent of the facility's Total Performance Score.

If a facility is only eligible for one type of measure, that type will comprise 100 percent of the score.

The Total Performance Score, which will range from 0 – 100, will then be translated into a payment-reduction percentage for facilities failing to meet the minimum Total Performance Score. The minimum Total Performance Score for PY 2014 is 53.

For the ESRD QIP in PY 2014, the baseline period is July 1, 2010 – June 30, 2011. The performance period for PY 2014 is Calendar Year (CY) 2012.

Where can I find the final numerical values for the minimum Total Performance Score, performance standards, achievement thresholds, and benchmarks?

CMS posted the numerical values for the minimum Total Performance Score, performance standards, achievement thresholds, and benchmarks on December 30, 2011, to http://www.dialysisreports.org/ESRDMeasures.aspx. (The documentation is now available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html.) CMS also informed the ESRD community about the availability of this data through emails and via the CMS ESRD website.

PY 2015 – Eligibility

What modalities of treatment are covered under the ESRD QIP?

One or more ESRD QIP measures may apply to facilities treating adult hemodialysis patients, adult peritoneal dialysis patients, and pediatric hemodialysis patients.

What are the facility eligibility requirements for the ESRD QIP?

A facility must qualify for at least one clinical measure and one reporting measure for the ESRD QIP to apply in PY 2015. If a facility does not qualify for at least one measure in both categories, then the ESRD QIP does not apply, and the facility will receive neither a Total Performance Score nor a payment reduction.

What are the case minimums for the clinical and reporting measures?

For a clinical or reporting measure to apply to a facility in PY 2015, a facility must have at least 11 cases, over the course of the entire performance period, meeting the requirements outlined in each measure's specifications. For clinical measures, CMS will use claims data to determine how many eligible cases a facility has. If the facility has 11 – 25 cases, then a scoring adjustment for "low-volume facilities" may apply (see PY 2015 – Clinical Measures). For reporting measures, if a facility does not complete a short attestation via CROWNWeb that it does not meet the 11-case minimum, it will be scored accordingly.

How does CMS determine the date on which operations (and thus eligibility for the ESRD QIP) begin?

CMS relies upon the CMS Certification Number (CCN) to determine the date on which a facility's operations begin. If the CCN remains the same for a facility after a change in ownership, CMS will treat it as the same facility for purposes of the ESRD QIP, and all prior rates, scores, and payment reductions (if any) will continue to apply. If it receives a new CCN as a result of a change in ownership, then CMS will treat it as a new facility as of the date of certification.

For PY 2015, a facility that receives a CCN after June 30, 2013, will not be eligible for any reporting measures—and therefore will not be eligible for the ESRD QIP. (Please see PY 2015 – Reporting Measures for more detail about how the CCN date affects eligibility for each reporting measure.)

PY 2015 – Clinical Measures

Where can I find specifications for the PY 2015 clinical measures?

Technical specifications for all PY 2015 ESRD QIP clinical measures are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html.

Can CMS provide my individual facility's performance rates during the comparison period or the performance period?

CMS currently does not have the capability to generate performance rates while the performance period is ongoing. We will take this suggestion into consideration for development in future payment years. CMS encourages facilities to track and calculate their own comparison rates using their individual facility's data.

How will measure topic scores be combined into a single calculation for purposes of determining an overall clinical score for a facility?

In PY 2015, two measure topics—Kt/V Dialysis Adequacy and Vascular Access Type—are made up of more than one measure. Each measure will be calculated individually to determine its specific performance rate and score.

For purposes of calculating the facility's Total Performance Score, all eligible measures within the measure topic will be combined into a single score. An individual measure score's weight in a measure topic is determined by comparing the number of patients included in that measure to the total number of patients included in all of the measures in the measure topic.

The final rule describes this methodology in detail, using examples calculating the Kt/V measure topic score.

What is the scoring adjustment for "low-volume facilities" for PY 2015?

If a facility has 11 – 25 eligible cases for a clinical measure, then the small sample size puts it at risk for having one or two challenging patients dramatically alter its measure rates and ESRD QIP performance scores.

The ESRD QIP therefore applies a favorable adjustment to measure rates for facilities with 11 – 25 cases, effectively giving these facilities the "benefit of the doubt" that low-volume facilities would have scored that much higher if they treated 26 or more patients.

CMS believes that this approach balances the need to treat each facility fairly with the desire to include as many facilities as possible in the ESRD QIP.

Detailed descriptions of the method for calculating the adjuster can be found in the final rule.

PY 2015 – Reporting Measures

Where can I find specifications for the PY 2015 reporting measures?

Technical specifications for all PY 2015 reporting measures are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html.

What steps should a facility take if it does not have 11 eligible cases for a reporting measure?

A facility that does not meet the case-minimum requirement for a reporting measure should attest to that fact in CROWNWeb. If a facility does not make the appropriate attestation, then it will be scored accordingly.

How does a facility attest in CROWNWeb that a reporting measure does not apply?

CROWNWeb will provide facilities with a specific form for each attestation. The form is brief and is submitted electronically.

How do the PY 2015 reporting measures apply to facilities that begin operations during 2013 (the performance period)?

CMS relies upon the CMS Certification Number (CCN) to determine the date on which a facility's operations begin.

- The National Healthcare Safety Network (NHSN) reporting measure does not apply to a facility that receives its CCN after December 31, 2012.
- For the remaining reporting measures (Anemia Management, Mineral Metabolism, and the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems [ICH CAHPS] survey): If the facility receives its CCN between January 1 and June 30, 2013, reporting requirements begin on the first day after the month in which the facility receives its CCN. For example, reporting requirements apply starting April 1, 2013, for a facility that receives its CCN during March 2013.
- If the facility receives its CCN after June 30, 2013, then it will not be eligible for any reporting measures, and therefore not eligible for the ESRD QIP.

For purposes of complying with the Anemia Management and Mineral Metabolism reporting measures, can a facility include results of lab work performed by another provider (e.g., a hospital) or laboratory during the reporting period?

Yes, if a patient is treated elsewhere during the claim month, then the facility may include results of lab work performed by another healthcare provider as part of the facility's compliance with this reporting measure. The source and the lab values should be documented in the patient's dialysis record. CMS believes that eliminating redundant lab tests helps to reduce costs while ensuring continuity of care.

CMS notes that the facility itself is not required to draw blood from the patient. If, for example, a patient is hospitalized or transient during the claim month, then the facility may report the hemoglobin or hematocrit readings for the patient for a month if a patient has labs drawn in an accredited laboratory (e.g., Joint Commission, College of American Pathologists, American Association of Bioanalysts, or other state and federal agencies) and the facility reviews the hemoglobin or hematocrit readings from these labs.

How must NHSN data be submitted?

The Centers for Disease Control and Prevention (CDC) administers the NHSN. Please submit your data to the CDC using NHSN. NHSN dialysis event data will not be accepted if it is sent directly to CMS. Please note that CMS requires at least one staff member at the facility be trained in and knowledgeable of how to report dialysis event data to the NHSN.

The CDC provides instructions for enrollment in the NHSN at http://www.cdc.gov/nhsn/dialysis/cms-dialysis-enroll-steps.html.

What is "successful administration" of the ICH CAHPS survey?

"Successfully" is defined in the rule as following the specifications established by the Agency for Healthcare Research and Quality (AHRQ). Please see http://www.cahps.ahrq.gov/hemodialysis/fieldingich.pdf for detailed survey information.

Can a facility administer the ICH CAHPS survey? Can it provide for patients to drop off their survey results at the facility?

In accordance with the specifications, the ICH CAHPS survey must be administered by a third party in order for the administration to be considered successful under the ESRD QIP. According to the online guidance referenced in the previous question, this third-party administration may be done through mail with telephone follow-up, or by telephone only. Facilities may not collect the surveys at their individual facilities.

What happens if not all of a facility's patients respond to the ICH CAHPS survey?

Although AHRQ specifications aim for a 40 percent response rate, rates may be higher or lower in individual facilities, and such variation is acceptable.

Who is responsible for submitting attestation of the use of the ICH CAHPS survey to CROWNWeb? Is a vendor able to submit that information on behalf of dialysis-facility clients, or is the dialysis facility required to submit that information on its own?

For purposes of the PY 2015 ESRD QIP, only facilities are able to submit the attestation. Note that no information from the surveys need be submitted to CMS for the PY 2015 program. The facility need only make an attestation via CROWNWeb that it successfully completed the survey's specifications as provided by AHRQ.

How does a facility submit ICH CAHPS data to CMS?

As stated in the rule, a facility need only attest to successful administration to receive full points on the measure; no data submission is required for the PY 2015 program. Although not required by the ESRD QIP, CMS expects facilities to review their own results to see how they can improve care.

Does the ICH CAHPS reporting measure apply to a facility that provides hemodialysis to pediatric patients?

The ICH CAHPS survey only applies to adult patients who receive in-center hemodialysis. If a facility treats only pediatric patients, then it need not administer the ICH CAHPS survey. If a facility treats pediatric patients and provides in-center hemodialysis to adults, then the facility need only administer the ICH CAHPS survey to the adult patients receiving in-center hemodialysis.

If a home hemodialysis and peritoneal program is part of an ICH (same provider number), does the program have to administer the ICH CAHPS to these patients?

The ICH CAHPS survey only applies to adult patients who receive in-center hemodialysis. If a facility only provides home hemodialysis and/or peritoneal dialysis (or if it serves 10 or fewer adult in-center hemodialysis patients), then it need not administer the ICH CAHPS survey. If a facility provides home hemodialysis and/or peritoneal dialysis and provides in-center hemodialysis, then the facility need only administer the ICH CAHPS survey to the adult patients receiving in-center hemodialysis.

If the facility provides in-center hemodialysis to 11 or more adult patients, then it must attest that it administered the survey successfully to receive points for this measure. "Successful administration" means that it administered the survey to its adult in-center hemodialysis patients in accordance with the specifications.

Can the ICH CAHPS survey be customized for individual facility use?

Yes, a facility may include additional questions in the ICH CAHPS survey; note, however, that these questions must immediately precede the "About You" section and appear after question number 41 in the core survey.

PY 2015 – Measure Scoring and Payment Reductions

What is the scoring methodology for PY 2015?

The performance period for PY 2015 is Calendar Year 2013.

CMS retained the general approach for scoring clinical measures used in PY 2014. CMS assesses performance on achievement and improvement for each clinical measure. For the achievement score, facilities are compared to national performance during 2011; for the improvement score, a facility's performance during the performance period is compared to its performance during 2012. The clinical measure score is the higher of the improvement and achievement scores. The clinical measure scores for which a facility is eligible will be weighted equally, and will combine to comprise 75 percent of the facility's Total Performance Score.

The reporting measures assess whether the facility completed the data collection and reporting for that measure as specified. If a facility reports data according to the guidelines for each eligible month, then the facility will earn 10 points on the measure. If the facility reports data according to the guidelines for a portion of its eligible months, CMS will apply a ratio to calculate the points earned. The reporting measures for which a facility is eligible will be weighted equally to comprise the remaining 25 percent of the facility's Total Performance Score.

If a facility is not eligible for at least one clinical measure and one reporting measure, then it is not eligible to participate in the PY 2015 ESRD QIP and will not receive a Total Performance Score. No payment reduction will apply to such facility.

The Total Performance Score, which will range from 0 – 100, will then be translated into a payment reduction percentage for facilities failing to meet the minimum Total Performance Score. The minimum Total Performance Score for PY 2015 is 60.

How does the scoring methodology for PY 2015 differ from that used in PY 2014?

The approach to scoring in PY 2015 differs from PY 2014 in three major ways.

- The calculation of a facility's Total Performance Score weights clinical measure scores at 75 percent and reporting measure scores at 25 percent. CMS chose to weight the reporting measures more heavily to reflect that the reporting measures require submission of treatment data, which will be critical information in developing future clinical measures. (In PY 2014, the Total Performance Score was a 90 percent clinical/10 percent reporting weight, and the reporting measures featured attestations only.)
- For similar reasons, scores for reporting measures are included in the calculation of the minimum Total Performance Score, as detailed in the next question. (In PY 2014, the minimum Total Performance Score factored only clinical measure scores.)

- To be eligible for the PY 2015 ESRD QIP, facilities must qualify for at least one clinical measure and one reporting measure. (In PY 2014, facilities could be eligible for the ESRD QIP if they qualified for a measure in either category.)

How was the minimum Total Performance Score calculated?

CMS calculated the minimum Total Performance Score by scoring a hypothetical facility as if it reached the performance standard—the 50th percentile nationally—for each clinical measure, and scored half of the available points on each eligible reporting measure. Clinical measure scores combined to comprise 75 percent of the minimum Total Performance Score, and reporting measure scores combined to comprise 25 percent of the minimum Total Performance Score. The minimum Total Performance Score to avoid a payment reduction for PY 2015 is 60.

What is the payment reduction range for PY 2015?

For every 10 points that a facility's Total Performance Score falls below the minimum Total Performance Score of 60 points, 0.5 percent payment reduction is assessed, up to a maximum reduction of 2 percent. The following chart illustrates the application of the payment reduction.

Total Performance Score	Payment Reduction Percentage
100 – 60 points	0%
59 – 50 points	0.5%
49 – 40 points	1.0%
39 – 30 points	1.5%
29 – 0 points	2.0%

PY 2016 – Eligibility

What modalities of treatment are covered under the ESRD QIP?

PY 2016 is the most comprehensive year of the ESRD QIP to date. It includes more areas of clinical practice, more sources of data, and a larger population of ESRD patients. One or more ESRD QIP measures may apply to facilities treating adult hemodialysis patients, adult peritoneal dialysis patients, and pediatric hemodialysis patients.

What are the facility eligibility requirements for the ESRD QIP?

A facility must qualify for at least one clinical measure and one reporting measure for the ESRD QIP to apply in PY 2016. If a facility does not qualify for one or more measure in both categories, then the facility will receive a Total Performance Score of "No Score" and will not receive a payment reduction.

What are the case minimums for the clinical and reporting measures?

For a clinical measure to apply to a facility in PY 2016, a facility must have at least 11 cases, over the course of the entire performance period, meeting the requirements outlined in each measure's specifications. For clinical measures, CMS will use claims and CROWNWeb data to determine how many eligible cases a facility has. If the facility has 11 – 25 cases, then a scoring adjustment for "low-volume facilities" may apply (see PY 2016 – Clinical Measures).

For reporting measures, the case minimums vary. The Anemia Management and Mineral Metabolism reporting measures automatically apply if a case minimum of two patients is met; the

In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Patient Satisfaction Survey reporting measure automatically applies if a case minimum of 30 patients is met. If a facility does not complete a short attestation via CROWNWeb that it does not meet the applicable case minimums, it will be scored accordingly.

How does CMS determine the date on which operations (and thus eligibility for the ESRD QIP) begin?

CMS relies upon the CMS Certification Number (CCN) to determine the date on which a facility's operations begin. If the CCN remains the same for a facility after a change in ownership, CMS will treat it as the same facility for the purposes of the ESRD QIP, and all prior rates, scores, and payment reductions (if any) will continue to apply. If it receives a new CCN as a result of a change in ownership, then CMS will treat it as a new facility as of the date of certification.

PY 2016 – Clinical Measures

Where can I find specifications for the PY 2016 clinical measures?

Technical specifications for all PY 2016 ESRD QIP clinical measures are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html.

How do the clinical measures in the PY 2016 final rule differ from the measures in the PY 2015 ESRD QIP?

The PY 2016 final rule includes eight clinical measures. Five measures are captured in two clinical measure "topics" or categories (Kt/V Dialysis Adequacy and Vascular Access Type). The National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Outpatients and Hypercalcemia measures are new; the Kt/V Dialysis Adequacy measure topic, Vascular Access Type measure topic, and the Anemia Management: Hemoglobin Greater Than 12 g/dL measure remain unchanged from PY 2015.

Can CMS provide my individual facility's performance rates during the comparison period or the performance period?

CMS currently does not have the capability to generate performance rates while the performance period is ongoing. We will take this suggestion into consideration for development in future payment years. CMS encourages facilities to track and calculate their own comparison rates using their individual facility's data.

How will measure topic scores be combined into a single calculation for purposes of determining an overall clinical score for a facility?

In PY 2016, two measure topics—Kt/V Dialysis Adequacy and Vascular Access Type—are made up of more than one measure. Each measure will be calculated individually to determine its specific performance rate and score.

For purposes of calculating the facility's Total Performance Score, all eligible measures within the measure topic will be combined into a single score. An individual measure score's weight in a measure topic is determined by comparing the number of patients included in that measure to the total number of patients included in all of the measures in the measure topic.

What is the scoring adjustment for "low-volume facilities" for PY 2016?

If a facility has 11 – 25 eligible cases for a clinical measure, then the small sample size puts it at risk for having one or two challenging patients dramatically alter its measure rates and ESRD QIP performance scores. The ESRD QIP therefore applies a favorable adjustment to measure rates for facilities with 11 – 25 cases. CMS believes that this approach balances the need to treat each facility fairly with the desire to include as many facilities as possible in the ESRD QIP.

Detailed descriptions of the method for calculating the adjuster can be found in the final rule.

PY 2016 – Reporting Measures

Where can I find specifications for the PY 2016 reporting measures?

Technical specifications for all PY 2016 reporting measures are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html.

How do the reporting measures in the PY 2016 final rule differ from the measures in the PY 2015 ESRD QIP?

The final rule modifies three reporting measures that were part of the PY 2015 program: Anemia Management, Mineral Metabolism, and the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Patient Satisfaction Survey. CMS revised the Anemia Management and Mineral Metabolism measures to include home peritoneal dialysis patients and expanded the ICH CAHPS measure to include submitting the results of the survey.

Further, because the final rule includes the new NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure, the NHSN Dialysis Event reporting measure in PY 2015 will not apply in PY 2016. Similarly, the Mineral Metabolism reporting measure will no longer include serum calcium, as facilities are required to report serum calcium values as part of the new Hypercalcemia clinical measure.

What steps should a facility take if it does not have enough eligible cases for a reporting measure?

A facility that does not meet the case-minimum requirement for a reporting measure should attest to that fact on CROWNWeb. If it does not make the appropriate attestation, then it will be scored accordingly.

How does a facility attest in CROWNWeb that a reporting measure does not apply?

CROWNWeb will provide facilities with a specific form for each attestation. The form is brief and is submitted electronically.

For purposes of complying with the Anemia Management and Mineral Metabolism reporting measures, can a facility include results of lab work performed by another provider (e.g., a hospital) or laboratory during the reporting period?

Yes, if a patient is treated elsewhere during the claim month, then the facility may include results of lab work performed by another healthcare provider as part of the facility's compliance with this reporting measure. The source and the lab values should be documented in the patient's dialysis record. CMS believes that eliminating redundant lab tests helps to reduce costs while ensuring continuity of care.

CMS notes that the facility itself is not required to draw blood from the patient. If, for example, a patient is hospitalized or transient during the claim month, then the facility may report the

hemoglobin or hematocrit readings for the patient for a month if a patient has labs drawn in an accredited laboratory (e.g., Joint Commission, College of American Pathologists, American Association of Bioanalysts, or other state and federal agencies) and the facility reviews the hemoglobin or hematocrit readings from these labs.

What is "successful administration" of the ICH CAHPS survey?

"Successfully" is defined in the rule as following the specifications established by CMS and reporting the survey results to CMS. Please see https://ichcahps.org/SurveyandProtocols/SurveyMaterials.aspx#catid2 for detailed survey information.

Can a facility administer the ICH CAHPS survey? Can it provide for patients to drop off their survey results at the facility?

The ICH CAHPS survey must be administered by a third party in order for the administration to be considered successful under the ESRD QIP. According to the online guidance referenced in the previous question, this third-party administration may be done through mail with telephone follow-up, or by telephone only. Facilities may not collect the surveys at their individual facilities.

Who is responsible for submitting results of the ICH CAHPS survey to CROWNWeb?

The facility's third-party vendor submits the survey data on behalf of the facility.

Does the ICH CAHPS reporting measure apply to a facility that provides hemodialysis to pediatric patients?

The ICH CAHPS survey only applies to adult patients who receive in-center hemodialysis. If a facility treats only pediatric patients, then it need not administer the ICH CAHPS survey. If a facility treats pediatric patients and provides in-center hemodialysis to adults, then the facility need only administer the ICH CAHPS survey to the adult patients receiving in-center hemodialysis.

If a home hemodialysis and peritoneal program is part of an ICH (same provider number), does the program have to administer the ICH CAHPS to these patients?

The ICH CAHPS survey only applies to adult patients who receive in-center hemodialysis. If a facility only provides home hemodialysis and/or peritoneal dialysis (or if it serves 29 or fewer adult in-center hemodialysis patients), then it need not administer the ICH CAHPS survey. If a facility provides home hemodialysis and/or peritoneal dialysis and provides in-center hemodialysis, then the facility need only administer the ICH CAHPS survey to the adult patients receiving in-center hemodialysis.

If the facility provides in-center hemodialysis to 30 or more adult patients, then it must arrange to have its third-party vendor submit the survey results to CMS. "Successful administration" means that it administered the survey to its adult in-center hemodialysis patients in accordance with the specifications and reporting the survey results to CMS.

Can the ICH CAHPS survey be customized for individual facility use?

Yes, a facility may include additional questions in the ICH CAHPS survey; note, however, that these questions must immediately precede the "About You" section and appear after question number 41 in the core survey.

PY 2016 – Measure Scoring and Payment Reductions

What is the scoring methodology for PY 2016?

The performance period for PY 2016 is Calendar Year 2014.

CMS retained the general approach for scoring clinical measures used in PY 2015. Generally, CMS assesses performance on achievement and improvement for each clinical measure (with two exceptions, as detailed in this paragraph). For the achievement score, facilities are compared to national performance during 2012; for the improvement score, a facility's performance during the performance period is compared to its performance during 2013. The clinical measure score is the higher of the improvement and achievement scores. The NHSN Bloodstream Infections in Hemodialysis Outpatients clinical measure will not be scored via the improvement method, and CY 2014 will serve as both the performance period and the achievement comparison period for this measure. The Hypercalcemia achievement comparison period will be from May 1 – November 30, 2012. The clinical measure scores for which a facility is eligible will be weighted equally (with the exception that the Hypercalcemia clinical measure will have two-thirds the weight of the other clinical measures), and will be combined to comprise 75 percent of the facility's Total Performance Score.

The reporting measures assess whether the facility completed the data collection and reporting for that measure as specified. If a facility reports data according to the guidelines for each eligible month for the Anemia Management and Mineral Metabolism reporting measures, then the facility will earn 10 points on the measure. If the facility reports data according to the guidelines for a portion of its eligible months, a ratio (where applicable) will be applied to calculate the points earned for these two measures. The reporting measures for which a facility is eligible will be weighted equally to comprise the remaining 25 percent of the facility's Total Performance Score.

If a facility is not eligible for at least one clinical measure and one reporting measure, then it is not eligible to participate in the ESRD QIP and will not receive a Total Performance Score. No payment reduction will apply to such facility.

The Total Performance Score, which will range from 0 – 100, will then be translated into a payment reduction percentage for facilities failing to meet the minimum Total Performance Score. The minimum Total Performance Score for PY 2016 is 54.

How was the minimum Total Performance Score calculated?

CMS calculated the minimum TPS by scoring a hypothetical facility as if it:

- Scored zero points for the NHSN Bloodstream Infection clinical measure;
- Met the national performance standard for 2012 for each remaining clinical measure; and
- Scored half the total possible points for each reporting measure.

Clinical measure scores combined to comprise 75 percent of the minimum Total Performance Score, and reporting measure scores combined to comprise 25 percent of the minimum Total Performance Score. The minimum TPS required to avoid a payment reduction in PY 2016 is 54.

What is the payment reduction range for PY 2016?

For every 10 points that a facility's Total Performance Score falls below the minimum Total Performance Score of 54 points, 0.5 percent payment reduction is assessed, up to a maximum reduction of 2 percent. The following chart illustrates the application of the payment reduction.

Total Performance Score	Payment Reduction Percentage
100 – 54 points	0%
53 – 44 points	0.5%
43 – 34 points	1.0%
33 – 24 points	1.5%
23 – 0 points	2.0%

PY 2017 – Eligibility

What modalities of treatment are covered under the ESRD QIP?

PY 2017 is the most comprehensive year of the ESRD QIP to date. It includes more areas of clinical practice, more sources of data, and a larger population of ESRD patients. One or more ESRD QIP measures may apply to facilities treating adult hemodialysis patients, adult peritoneal dialysis patients, and pediatric hemodialysis patients.

What are the facility eligibility requirements for the ESRD QIP?

A facility must qualify for at least one clinical measure and one reporting measure for the ESRD QIP to apply in PY 2017. If a facility does not qualify for one or more measure in both categories, then the ESRD QIP does not apply, and the facility will receive neither a Total Performance Score nor a payment reduction.

What are the case minimums for the clinical and reporting measures?

For a clinical measure to apply to a facility in PY 2017, a facility must have at least 11 cases (or experience 11 index discharges, in the case of the Standardized Readmission Ratio [SRR] measure), over the course of the entire performance period, meeting the requirements outlined in each measure's specifications. For clinical measures, CMS will use Medicare claims, CROWNWeb data, and other federal databases to determine how many eligible cases a facility has. If the facility has 11 – 25 cases, then a scoring adjustment for "low-volume facilities" may apply (see PY 2017 – Clinical Measures).

For reporting measures, the case minimums vary. The Anemia Management and Mineral Metabolism reporting measures have a case minimum of 11 patients; the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Patient Satisfaction Survey reporting measure automatically applies if the facility treats a minimum of 30 survey-eligible patients during the eligibility period (CY 2014) and obtains at least 30 completed surveys during the performance period.

How does CMS determine the date on which operations (and thus eligibility for the ESRD QIP) begin?

CMS relies upon the CMS Certification Number (CCN) to determine the date on which a facility's operations begin. If the CCN remains the same for a facility after a change in ownership, then CMS will treat it as the same facility for the purposes of the ESRD QIP, and all prior rates, scores, and payment reductions (if any) will continue to apply. If it receives a new CCN as a result of a change in ownership, then CMS will treat it as a new facility as of the date of certification.

PY 2017 – Clinical Measures

Where can I find specifications for the PY 2017 clinical measures?

Technical specifications for all PY 2017 ESRD QIP clinical measures are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html.

How do the clinical measures in the PY 2017 final rule differ from the measures in the PY 2016 ESRD QIP?

The PY 2017 final rule includes eight clinical measures. Five measures are captured in two clinical measure "topics" or categories (Kt/V Dialysis Adequacy and Vascular Access Type). The SRR clinical measure is new. The National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Outpatients measure, Hypercalcemia measure, Kt/V Dialysis Adequacy measure topic, and Vascular Access Type measure topic are unchanged. The Anemia Management: Hemoglobin Greater Than 12 g/dL clinical measure has been retired.

Can CMS provide my individual facility's performance rates during the comparison period or the performance period?

CMS currently does not have the capability to generate performance rates while the performance period is ongoing. We will take this suggestion into consideration for development in future payment years. CMS encourages facilities to track and calculate their own comparison rates using their individual facility's data.

How will measure topic scores be combined into a single calculation for purposes of determining an overall clinical score for a facility?

In PY 2017, two measure topics—Kt/V Dialysis Adequacy and Vascular Access Type—are made up of more than one measure. Each measure will be calculated individually to determine its specific performance rate and score.

For purposes of calculating the facility's Total Performance Score, all eligible measures within the measure topic will be combined into a single score. An individual measure score's weight in a measure topic is determined by comparing the number of patients included in that measure to the total number of patients included in all of the measures in the measure topic.

What is the scoring adjustment for "low-volume facilities" for PY 2017?

If a facility has 11 – 25 eligible cases for a clinical measure, then the small sample size puts it at risk for having one or two challenging patients dramatically alter its measure rates and ESRD QIP performance scores. The ESRD QIP therefore applies a favorable adjustment to measure rates for facilities with 11 – 25 cases. CMS believes that this approach balances the need to treat each facility fairly with the desire to include as many facilities as possible in the ESRD QIP.

PY 2017 – Reporting Measures

Where can I find specifications for the PY 2017 reporting measures?

Technical specifications for all PY 2017 reporting measures are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html.

How do the reporting measures in the PY 2017 final rule differ from the measures in the PY 2016 ESRD QIP?

The final rule modifies three reporting measures that were part of the PY 2016 program: Anemia Management, Mineral Metabolism, and the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Patient Satisfaction Survey. CMS revised the Anemia Management and Mineral Metabolism measures to apply an 11-case minimum for a facility to be eligible for the measure. CMS also altered the ICH CAHPS measure to apply a minimum of 30 patients treated during the eligibility period (CY 2014) and 30 surveys completed during the performance period for a facility to be eligible for the measure.

The PY 2017 program also removed the attestation process in CROWNWeb for a facility to record that it does not meet the case minimum of a reporting measure. CMS will use its data sources to establish eligibility for these measures.

For purposes of complying with the Anemia Management and Mineral Metabolism reporting measures, can a facility include results of lab work performed by another provider (e.g., a hospital) or laboratory during the reporting period?

Yes, if a patient is treated elsewhere during the claim month, then the facility may include results of lab work performed by another healthcare provider as part of the facility's compliance with this reporting measure. The source and the lab values should be documented in the patient's dialysis record. CMS believes that eliminating redundant lab tests helps to reduce costs while ensuring continuity of care.

CMS notes that the facility itself is not required to draw blood from the patient. If, for example, a patient is hospitalized or transient during the claim month, then the facility may report the hemoglobin or hematocrit readings for the patient for a month if a patient has labs drawn in an accredited laboratory (e.g., Joint Commission, College of American Pathologists, American Association of Bioanalysts, or other state and federal agencies) and the facility reviews the hemoglobin or hematocrit readings from these labs.

What is "successful administration" of the ICH CAHPS survey?

"Successfully" is defined in the rule as following the specifications established by CMS and reporting the survey results to CMS. Please see https://ichcahps.org/SurveyandProtocols/SurveyMaterials.aspx#catid2 for detailed survey information.

Can a facility administer the ICH CAHPS survey? Can it provide for patients to drop off their survey results at the facility?

The ICH CAHPS survey must be administered by a third party in order for the administration to be considered successful under the ESRD QIP. According to the online guidance referenced in the previous question, this third-party administration may be done through mail with telephone follow-up, or by telephone only. Facilities may not collect the surveys at their individual facilities.

Who is responsible for submitting results of the ICH CAHPS survey to CROWNWeb?

The facility's third-party vendor submits the survey data on behalf of the facility.

Does the ICH CAHPS reporting measure apply to a facility that provides hemodialysis to pediatric patients?

The ICH CAHPS survey only applies to adult patients who receive in-center hemodialysis. If a facility treats only pediatric patients, then it need not administer the ICH CAHPS survey. If a

facility treats pediatric patients but also provides in-center hemodialysis to 30 or more adults, then the facility need only administer the ICH CAHPS survey to the adult patients receiving in-center hemodialysis.

If a home hemodialysis and peritoneal program is part of an ICH (same provider number), does the program have to administer the ICH CAHPS to these patients?

The ICH CAHPS survey only applies to adult patients who receive in-center hemodialysis. If a facility only provides home hemodialysis and/or peritoneal dialysis (or if it serves 29 or fewer adult in-center hemodialysis patients), then it need not administer the ICH CAHPS survey. If a facility provides home hemodialysis and/or peritoneal dialysis and provides in-center hemodialysis, then the facility need only administer the ICH CAHPS survey to the adult patients receiving in-center hemodialysis.

If the facility provides in-center hemodialysis to 30 or more adult patients, then it must arrange to have its third-party vendor submit the survey results to CMS. "Successful administration" means that it administered the survey to its adult in-center hemodialysis patients in accordance with the specifications and reporting the survey results to CMS.

Can the ICH CAHPS survey be customized for individual facility use?

Yes, a facility may include additional questions in the ICH CAHPS survey; note, however, that these questions must immediately precede the "About You" section and appear after question number 41 in the core survey.

PY 2017 – Measure Scoring and Payment Reductions

What is the scoring methodology for PY 2017?

The performance period for PY 2017 is Calendar Year 2015.

CMS retained the general approach for scoring clinical measures used in PY 2016. Generally, CMS assesses performance on achievement and improvement for each clinical measure (with one exception, as detailed in this paragraph). For the achievement score, facilities are compared to national performance during 2013; for the improvement score, a facility's performance during the performance period is compared to its performance during 2014. The clinical measure score is the higher of the improvement and achievement scores. The NHSN Bloodstream Infections in Hemodialysis Outpatients clinical measure will use CY 2015 will serve as the performance period for the achievement and improvement methods alike. In addition, a facility with a CMS Certification Number (CCN) open date after January 1, 2015, will not be eligible for this measure.

The clinical measure scores for which a facility is eligible will be weighted equally (with the exception that the Hypercalcemia clinical measure will have two-thirds the weight of the other clinical measures), and will be combined to comprise 75 percent of the facility's Total Performance Score.

The reporting measures assess whether the facility completed the data collection and reporting for that measure as specified. If a facility reports data according to the guidelines for each eligible month for the Anemia Management and Mineral Metabolism reporting measures, then the facility will earn 10 points on the measure. If the facility reports data according to the guidelines for a portion of its eligible months, a ratio (where applicable) will be applied to calculate the points

earned for these two measures. If a facility satisfies the performance requirements of the ICH CAHPS reporting measure, then it will earn 10 points on the measure.

The reporting measures for which a facility is eligible will be weighted equally to comprise the remaining 25 percent of the facility's Total Performance Score.

If a facility is not eligible for at least one clinical measure and one reporting measure, then it is not eligible to participate in the ESRD QIP and will not receive a Total Performance Score. No payment reduction will apply to such facility.

The Total Performance Score, which will range from 0 – 100, will then be translated into a payment reduction percentage for facilities failing to meet the minimum Total Performance Score. The minimum Total Performance Score for PY 2017 is 60.

How was the minimum Total Performance Score calculated?

CMS calculated the minimum TPS by scoring a hypothetical facility as if it:

- Scored zero points for each clinical measure that does not have an associated numerical value for a performance standard published prior to January 1, 2015;
- Met the national performance standard for 2013 for each remaining clinical measure; and
- Scored 10 points (the 50th percentile of facility performance on PY 2015 reporting measures) for each reporting measure.

Clinical measure scores combined to comprise 75 percent of the minimum Total Performance Score, and reporting measure scores combined to comprise 25 percent of the minimum Total Performance Score. The minimum TPS required to avoid a payment reduction in PY 2017 is 60.

What is the payment reduction range for PY 2017?

For every 10 points that a facility's Total Performance Score falls below the minimum Total Performance Score of 60 points, 0.5 percent payment reduction is assessed, up to a maximum reduction of 2 percent. The following chart illustrates the application of the payment reduction.

Total Performance Score	Payment Reduction Percentage
100 – 60 points	0%
59 – 50 points	0.5%
49 – 40 points	1.0%
39 – 30 points	1.5%
29 – 0 points	2.0%

ESRD QIP Online Resources

What reference websites are available to find out more information about the ESRD QIP?

A number of online resources are available to facilities, beneficiaries, their families, community stakeholders, and other interested parties.

- The ESRD QIP section of CMS's website provides information about the ESRD QIP, including downloads to National Provider Calls and Open Door Forums, technical

specifications for measures, fact sheets, and other relevant information: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/index.html

- The Dialysis Facility Compare section of Medicare's website provides beneficiaries and consumers with information about chronic kidney disease, as well as an opportunity to learn more about facilities in their area, to help patients and family members make decisions about dialysis care: http://www.medicare.gov/DialysisFacilityCompare/search.html

Where can I find rules and regulations online?

- **Medicare Improvements for Patients and Providers Act (MIPPA) of 2008** (Public Law 100-275) – This act, in part, modernized the Medicare payment system for dialysis services and required the implementation of a quality incentive program for providers of ESRD services. http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf

- **ESRD PPS 2011 Final Rule** (August 12, 2010) – This final rule establishes the quality measures for the ESRD QIP for PY 2012. http://edocket.access.gpo.gov/2010/pdf/2010-18466.pdf

- **ESRD QIP PY 2012 Final Rule** (January 5, 2011) – This final rule sets forth requirements for the ESRD QIP for PY 2012. http://www.gpo.gov/fdsys/pkg/FR-2011-01-05/pdf/2010-33143.pdf

- **CY 2011 ESRD PPS Final Rule** (November 10, 2011) – This final rule sets forth requirements for the ESRD QIP for PYs 2013 and 2014. http://www.gpo.gov/fdsys/pkg/FR-2011-11-10/pdf/2011-28606.pdf

- **CY 2013 ESRD PPS Final Rule** (November 9, 2012) – This final rule sets forth requirements for the ESRD QIP for PY 2015. http://www.gpo.gov/fdsys/pkg/FR-2012-11-09/pdf/2012-26903.pdf

- **CY 2014 ESRD PPS Final Rule** (December 2, 2013) – This final rule sets forth requirements for the ESRD QIP for PY 2016. http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28451.pdf

- **CY 2015 ESRD PPS Final Rule** (November 6, 2014) – This final rule sets forth requirements for the ESRD QIP for PY 2017 and PY 2018. http://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26182.pdf

Monitoring & Evaluation

How does CMS monitor the impact of the ESRD QIP and the ESRD PPS on patients?

Changes in reimbursement and emphasis on patient outcomes (rather than sheer volume of services) could create unintentional consequences for Medicare beneficiaries, facilities may undertreat patients in order to maximize profits and minimize costs. Congress established the ESRD QIP to ensure that facilities continue to provide high-quality care to patients with ESRD.

For example, the ESRD QIP includes a measure to help ensure that dialysis treatments adequately clean a beneficiary's blood, thus guarding against the possibility that facilities might "cut corners" and not provide enough quality of care.

CMS is committed to improving the quality of care delivered to beneficiaries, as well as ensuring that access to care is not impeded—especially to racial and ethnic minorities and other medically underserved populations. CMS closely monitors practice patterns as well as patient outcomes; if it discovers issues with regard to access, cost, or quality of care, then the facility involved will be thoroughly investigated, followed by appropriate and timely corrective action.