

ESRD QIP Payment Year 2015 Program Details

The Centers for Medicare & Medicaid Services (CMS) administers the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) to promote high-quality services 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.

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

ESRD QIP Final Rule Governing Payment Year 2015

The final rule governing the ESRD QIP for Payment Year (PY) 2015, published in the [Federal Register on November 9, 2012](#), outlines how CMS will implement the law establishing the program. The rule specifies the following in more detail:

- **Measures selected** – Ten total measures (six clinical and four reporting) for assessing the quality of ESRD care
- **Performance period** – Timeframe during which CMS will collect data to evaluate facility performance
- **Methodology** – The process used to score facility performance
- **Payment reduction scale** – Scale used to determine payment reductions for facilities not meeting established performance standards.

The final rule also addresses public comments to the earlier proposed rule and CMS's responses to those comments.

Measuring Quality

Section 153(c) of the Medicare Improvements for Patients and Providers Act (MIPPA) requires CMS to use certain types of quality measures as part of the ESRD QIP. These include:

- Measures on anemia management that reflect the labeling approved by the Food and Drug Administration (FDA) for administration of erythropoiesis-stimulating agents (ESAs)
- Measures on dialysis adequacy

- Other measures as the Secretary of the Department of Health and Human Services (HHS) may specify on iron management, bone mineral metabolism, vascular access, and patient satisfaction.

For PY 2015, CMS selected ten measures for evaluating each facility, and the resulting scores will be combined to establish its Total Performance Score. Six of these measures are “clinical,” meaning that they evaluate clinical values. The four other measures are related to “reporting,” meaning that they require a facility to either provide data about specific treatments/outcomes or attest that it has taken a designated action. By increasing the number of clinical measures and reporting measures, as well as expanding the scope of the program to include pediatric ESRD patients, the PY 2015 rule illustrates that the ESRD QIP is evolving and becoming more sophisticated in its evaluation of dialysis facilities.

Not all facilities are eligible for a Total Performance Score in 2015. To receive a Total Performance Score, a facility must have enough data for at least one clinical measure and at least one reporting measure. A given measure is not included unless a facility has 11 eligible patients. Reporting measures also may not be included if a facility is new.

Not receiving a Total Performance Score is not an indicator of the quality of care provided by that facility.

Clinical Measures Selected

The six clinical measures are organized into three “measure topics.” One measure relates to anemia management and addresses hemoglobin levels; another relates to the success of dialysis treatment in removing waste products from patients’ blood; and the last measure relates to the type of vascular access used to treat patients. Data to assess performance on these measures will be taken from claims during calendar year (CY) 2013.

For the anemia measure, the smaller the number of patients with hemoglobin outside the range, the better the facility will score. For the dialysis adequacy measures, the larger the number of patients above the threshold, the better the facility will score. The Vascular Access Type score is affected negatively if patients have catheters and positively if patients have fistulae.

Reporting Measures Selected

The reporting measures require facilities to:

1. Report the hemoglobin or hematocrit values and any erythropoiesis-stimulating agents (ESA) dosage on Medicare claims
2. Enroll, complete training, and report data on specific infection-related dialysis events, such as central line-associated blood infections, via the National Healthcare Safety Network (NHSN)
3. Report the serum calcium and serum phosphorus levels of Medicare patients
4. Attest that they have administered the In-Center Hemodialysis Survey Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) survey.

The NHSN dialysis event reporting measure applies to facilities that serve in-center hemodialysis patients.

The ICH-CAHPS patient survey reporting measure applies to facilities that serve adult in-center hemodialysis patients.

ESRD QIP Performance Data

Since measures are developed for specific groups of patients, various facility data are used to calculate ESRD QIP scores. Certain data are excluded, as provided in each measure's technical specifications.

Details on individual measure specifications are available at <http://www.dialysisreports.org/ESRDMeasures.aspx>. Please note that measure specifications are removed from this site once calculations for the applicable payment year have been finalized.

Clinical Measures Exclusions

Claims will be excluded from the anemia management measure calculations for a patient who:

- Is less than 18 years old as of the start date of the claim
- Is in the first 89 days of ESRD as of the start date of the claim
- Has a reported hemoglobin value (or hematocrit value divided by 3) less than 5 g/dL or greater than 20 g/dL
- Is not treated with ESAs according to the claim
- Has missing data
- Is not on chronic dialysis
- Has fewer than 4 months of eligible claims at the facility.

Claims will be excluded from the adult hemodialysis adequacy measure calculations for a patient who:

- Is less than 18 years old as of the start date of the claim
- Is on peritoneal dialysis
- Is in the first 89 days of ESRD as of the start date of the claim
- Has a spKt/V value less than 0.5 or greater than 2.5
- Is treated fewer than three times during the claim month
- Is not on chronic dialysis.

Claims will be excluded from the adult peritoneal dialysis adequacy measure calculations for a patient who:

- Is less than 18 years old as of the start date of the claim
- Is on hemodialysis
- Is in the first 89 days of ESRD as of the start date of the claim
- Has a Kt/V value less than 0.5 or greater than 5.0
- Is not on chronic dialysis.

Claims will be excluded from the pediatric hemodialysis adequacy measure calculations for a patient who:

- Is 18 years or older as of the start date of the claim
- Is on peritoneal dialysis
- Is on home hemodialysis
- Is in the first 89 days of ESRD as of the start date of the claim

- Has a spKt/V value less than 0.5 or greater than 2.5
- Dialyzes fewer than three times per week or more than four times per week
- Is treated fewer than two times during the claim month
- Is not on chronic dialysis.

Claims will be excluded from the VAT fistula measure calculations for a patient who:

- Is less than 18 years old as of the start date of the claim
- Is on peritoneal dialysis according to the claim
- Has both a fistula and a graft according to the claim
- Is not on chronic dialysis
- Has fewer than 4 months of eligible claims at the facility.

Claims will be excluded from the VAT catheter measure calculations for a patient who:

- Is less than 18 years and 90 days old as of the start date of the claim
- Is on peritoneal dialysis according to the claim
- Has both a fistula and a graft according to the claim
- Is not on chronic dialysis
- Does not have four consecutive months of eligible claims at the facility.

Reporting Measures Exclusions

Note: A facility receiving its CMS Certification Number (CCN) after June 30, 2013, need not report for any of these measures. Such a facility will not receive a Total Performance Score or receive a payment reduction.

Claims will be excluded from the anemia management measure calculations for a patient who:

- Has been treated fewer than seven times during the reporting month
- Is on home dialysis.

Facilities will be excluded from the NHSN reporting measure if:

- The facility does not treat in-center hemodialysis patients
- The facility receives its CCN after January 1, 2013.

Claims will be excluded from the mineral metabolism measure calculations for a patient who:

- Has been treated fewer than seven times during the reporting month
- Is on home dialysis.

Facilities will be excluded from the ICH CAHPS reporting measure if:

- The facility does not treat in-center hemodialysis patients
- The facility treats fewer than 11 patients.

Facility Scoring

Period of Performance

The period of performance for PY 2015 is calendar year (CY) 2013. This timeframe was selected to allow enough time for CMS to:

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

Scoring for Clinical Measures

Facility performance will be evaluated against each measure; a facility receives a score based on the higher of its achievement and improvement on a measure. The comparison period for the PY 2015 clinical measures was CY 2011 for achievement and CY 2012 for improvement.

Facilities receive achievement points on a measure based on where they fall on the achievement range. The **achievement range** begins at the achievement threshold, which is defined as the 15th percentile of facilities during the comparison period. It ends at the benchmark, which is defined as the 90th percentile of facilities during the comparison period. A facility will receive an achievement score of 0 if it is below the achievement threshold, 1 – 9 if its performance falls within this range, and 10 points if it is at or above the benchmark.

Facilities receive improvement points on a measure based on where they fall on the improvement range. The **improvement range** begins at the facility's prior performance rate on the measure during the improvement period (facility comparison rate) and ends at the benchmark. A facility will receive an improvement score of 0 if it is below the facility's comparison rate, 0 – 9 if its performance falls within this range, and 10 if it is at or above its benchmark.

Scoring for Reporting Measures

The reporting scores are not calculated using achievement and improvement scores. Instead, facilities receive points based on whether they meet certain reporting requirements.

If the facility reports data for the anemia management, NHSN, and mineral metabolism reporting measures for every patient during each eligible month, then the facility will earn full points (10). Facilities will be able to earn partial points for reporting for a portion of the applicable performance period.

Measure Weighting

The ten measures for the PY 2015 ESRD QIP do not contribute equally to the Total Performance Score. Each facility's score will be calculated according to the following measure weights:

- Clinical measures – 75 percent
- Reporting measures – 25 percent

If a score is not received for a measure topic(s), then the remaining measure topics will be weighted equally to add up to the total weight of the Total Performance Score. For example, if a facility does not have sufficient data to calculate a performance rate for the VAT measure topic, then the Kt/V and anemia management clinical measure topics (for which the facility did receive a score) would be weighted equally at 37.5 percent to add up to the 75 percent applicable to clinical measures.

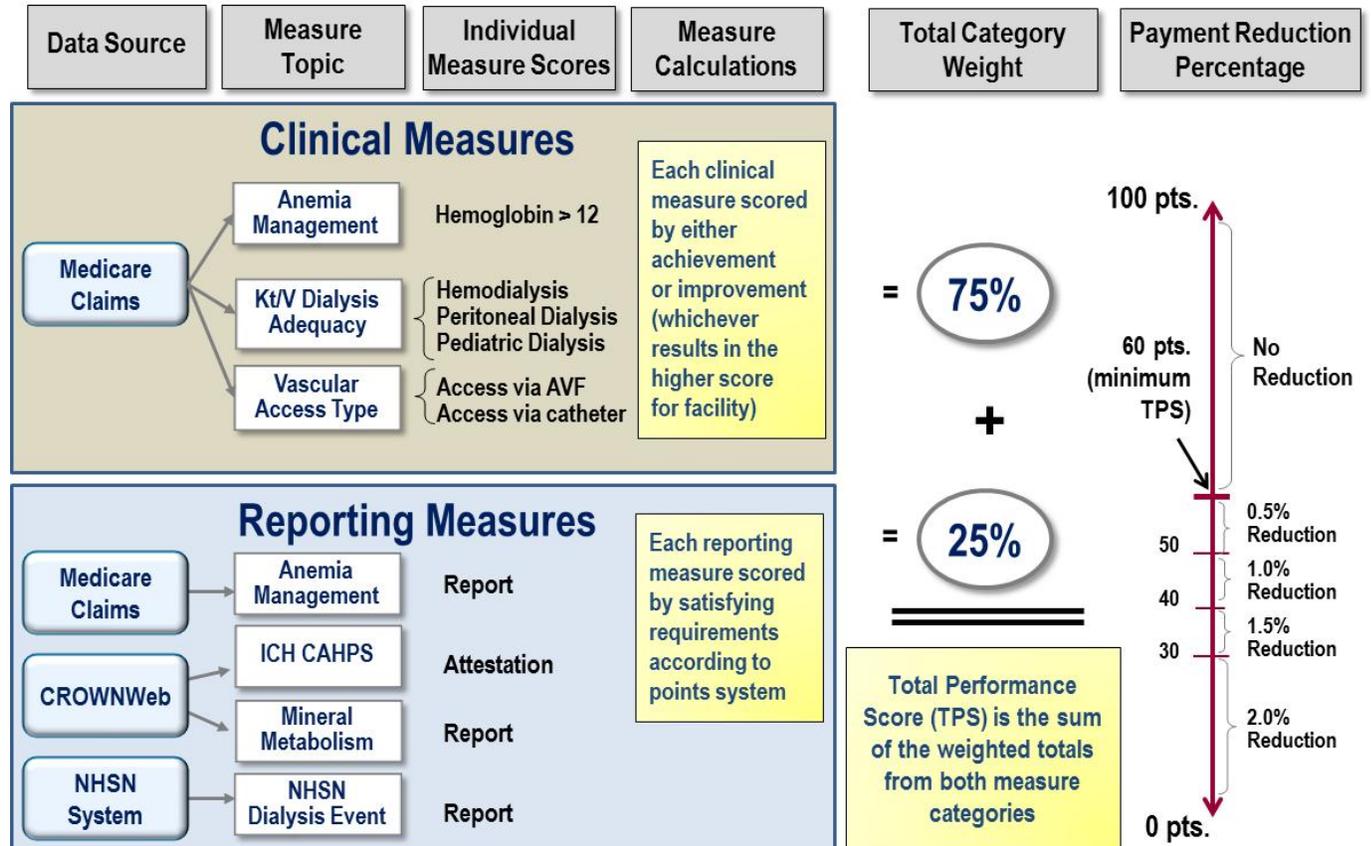
Calculating a Facility's Total Performance Score

A facility's Total Performance Score in PY 2015 is calculated by:

1. Multiplying each measure by its appropriate weight
2. Adding these weighted measures
3. Multiplying the sum by 10.

A facility's Total Performance Score can range from 0 – 100 points.

The following graphic illustrates the methodology that CMS uses for calculating PY 2015 performance scores and payment reductions.



Payment Adjustments

Section 153(c) of MIPPA directs the Secretary of HHS to develop a method to assess the quality of dialysis care provided by facilities and to link this performance to possible payment reductions. To receive full payment for PY 2015, facilities must have a Total Performance Score of at least 60 points. Facilities that fail to meet this standard may receive a payment reduction of up to two percent. This payment reduction will apply to all Medicare payments to that facility in 2015.

Scale for Payment Reductions

PY 2015 payment reductions will apply to a facility according to the following chart:

Total Performance Score	Payment Reduction
60 to 100	No reduction
50 to 59	0.5%
40 to 49	1.0%
30 to 39	1.5%
0 to 29	2.0%

Score Preview Period

Facilities will have the opportunity to preview their scores and any resulting payment reductions prior to public release. The Preview Period will occur in the summer of 2014. During this time, facilities can ask general clarification questions about how their scores were calculated. In addition, each facility can submit one formal inquiry regarding data or scoring-related issues if the facility believes a scoring error has occurred.