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National Provider Call - Transcript

Centers for Medicare & Medicaid Services
ESRD Quality Incentive Program:
Notice of Proposed Rulemaking for PY 2017 and 2018
National Provider Call
Moderator: Aryeh Langer
July 23, 2014
2:00 p.m. ET

Contents

Operator: At this time, I'd like to welcome everyone to today's MLN Connects National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Aryeh Langer. Please go ahead.

Announcements and Introduction

Aryeh Langer: Thank you, Holley. This is Aryeh Langer from the Provider Communications Group here at CMS, and as today's moderator, I'd like to welcome everyone to this MLN Connects National Provider Call on ESRD QIP, the End-Stage Renal Disease Quality Incentive Program. MLN Connects Calls are part of the Medicare Learning Network. This MLN Connects Call focuses on the upcoming ESRD Prospective Payment System, or PPS, proposed rule with 30-day comment period, which includes rules for operationalizing the ESRD QIP in Payment Year 2017 and 2018. After the presentation, participants will have an opportunity to ask questions of CMS subject-matter experts.

Before we get started, there are a few items I would like to quickly cover. You should have received the link to the slide presentation for today's call in an email earlier today. If you have not yet seen the email, you can find today's presentation on the Call Details web page on the CMS website, which can be found by visiting www.cms.gov/npc. Again, that URL is www.cms.gov/npc. On the left side of that page, select National Provider Calls and Events, then select today's call by date from the list below. The slide presentation is located there in the Call Materials section.

I'll also note that this call is being recorded and transcribed. An audio recording and written transcript will be posted to the CMS Call Details webpage within 2 weeks of this call, and an announcement will be placed in the MLN Connects Provider eNews.

At this time, I would like to begin the formal part of the presentation by turning the call over to Jim Poyer, Director of the Division of Value, Incentives, and Quality Reporting here at CMS. Jim?

Presentation

Introduction

James Poyer: Thank you. Payment Year 2017 and 2018 represent the 6th and the 7th payment years for the End-Stage Renal Disease Quality Incentive Program, or ESRD QIP. These proposals represent a key vantage point in the development of the program. They build upon earlier measures and approaches in a wide variety of ways, as we'll discuss. But how does the program fit into CMS's overall goal for improving quality?

The VBP programs, or Value-Based Purchasing programs, incentivize better care across settings. Beneficiaries expect cost-effective, quality care. VBP is an avenue to assist us in achieving this goal.

VBP promotes CMS's three-part aim of better care for individuals, better care for populations and communities, and lower cost for improvement. And the ESRD QIP was CMS's first pay-for-performance program. And rather than paying dialysis facilities based on how many services they provide patients, Medicare now pays dialysis facilities based on how well those services help patients – keep these patients feel – safe and healthy.

And the ESRD QIP uses the Government's purchasing power through Medicare to incentivize improvements to the treatment of patients with ESRD. And these incentives drive care throughout the health care sector, not just Medicare patients.

And we're going to walk through an overview of the proposed rule, before I hand it over to the speakers today, for Payment Year 2017 and '18. And we're going to discuss why the proposed rule and the comment period are important to you, and then what steps you need to take to participate. We're providing a lot of information over the next 90 minutes, and I think we will be able to provide you with a good understanding of how facilities will be impacted by the proposals and how to participate in the comment period.

And we'll go over our prepared presentation for you and then open up the discussion for questions. And I want to emphasize that Federal regulations prevent us from answering any specific questions or address your opinions about the proposed rule which was published in the *Federal Register* earlier this month. And we encourage you to please share your ideas and questions on the proposed rule itself by participating in the formal comment period that is now ongoing. And we must – and we're obligated to respond to all these formal comments that are submitted to the *Federal Register* by the deadline, and that would be documented and posted in the *Federal Register* final rule.

Many of you will want additional information that we won't be able to cover today, so I invite you to review the online resources listed in the slide deck. Questions that remain can be sent to our mailbox, esrdqip@cms.hhs.gov.

And with that, I'm happy to turn over the presentation to Anita Segar, our ESRD Program Lead. Anita?

ESRD QIP Overview

Anita Segar: Thank you, Jim. In this section, as Jim referenced, we'll share some information about the legislative nature of ESRD QIP generally, before delving into the composition of the Payment Year 2017 and Payment Year 2018 proposals and the comment period itself.

Slide 10. MIPPA amended the Social Security Act to mandate the creation of the ESRD QIP. The ESRD QIP is intended to promote patient health by encouraging renal

dialysis facilities to deliver high-quality patient care. And MIPPA provides the mechanism for establishing standards of care, and it authorizes payment reductions for facilities failing to meet these standards. MIPPA also gives CMS the authority to establish standards by which ESRD facilities will be evaluated. The ESRD QIP is required to include measures of anemia management and dialysis adequacy. The Secretary may specify that the program measures also cover patient satisfaction, iron management, bone mineral metabolism, and vascular access.

ESRD QIP also sets down the way individual measures are used to create an overall score, and CMS will impose a payment reduction of up to 2 percent if the facility's score does not meet a minimum Total Performance Score.

Information about the facility's performance in ESRD QIP is contained in the Performance Score Report, or PSR. Public reporting of the results is a key component because it allows beneficiaries to select facilities based on quality of care provided, and it provides a mechanism by which facilities may judge their performance compared to the performance of others.

The Performance Score Certificate, or the PSC, is the prime vehicle for communicating the facility's performance under the ESRD QIP to its patients, and facilities are required to display this document every year.

Dialysis Facility Compare, or DFC, also provides information about facility performance to the public. And CMS releases detailed facility performance information in a large spreadsheet as well, and posts it on the web. So, with the structure of the program in mind, we turn now to how it evolves from year to year through the rulemaking process.

Slide 12. By issuing a proposed rule, CMS sets out the clinical and reporting measures as well as the scoring mechanisms it wants to include in a payment year. Then the public has a 60-day opportunity to comment on the proposal and suggest approaches it would like to see in the program. In this way, facilities and the general public have an opportunity to influence the shape the rule governing each payment year.

These comments that we receive from the public are taken very seriously by CMS. In the past, comments have led to the postponement of implementing measures, and those measures are stronger when they are implemented in future years. So it's very important that stakeholders participate in the comment period and share their thoughts on how the ESRD QIP can best serve the needs of patients with ESRD.

So with that, I want to turn the presentation over to Joel to begin our discussion of the Payment Year 2017 proposals. Joel?

PY 2017 Proposed Clinical Measures and Scoring

Joel Andress: Thank you, Anita. To start off, I want to point out something that many of you may have already – may have already noticed, which is that, divergent from our

rulemaking efforts in the previous 2 years, we have proposed – we have proposed changes for both Payment Year 2017 and Payment Year 2018 in this year's rule.

This is part of a deliberate effort on CMS's attempt to expand the window between the finalization of rule – of a rule and the beginning of the performance period for the measures proposed in that rule. It's our belief that – that providers will benefit from having this extended period of time and that CMS itself will benefit as well in ensuring that the appropriate infrastructure is in place to support measure submission.

In future years, we intend to take up – take up once again the pattern of proposing a single year at a time, so that next year's rule-writing cycle will address Payment Year 2019, and the year after that will address Payment Year 2020. So we hope to retain the 14-year window until we see a reason – until we see any particularly good reason to – to change it.

I also want to call your attention to the disclaimer at the bottom of slide 13, which also appears at the beginning of each section that delves into the proposal. It's important to note that these elements are not finalized, and so material is subject to change, as Anita has just noted. In fact, the very purpose of this process is so that it *can* change in response to feedback that we receive from the public.

So now we'll get started at looking at the proposed measures for Payment Year 2017. On slide 14 you'll see a representation of the proposed clinical and reporting measures for 2017. We are proposing a total of eight clinical measures that will provide five distinct scores that comprise 75 percent of a facility's Total Performance Score. The remaining reporting measures will comprise – will comprise the remaining 25 percent of the TPS. Please note that the new Payment Year 2017 clinical measure, the Standardized Readmission Ratio, is indicated by a gold star. This icon will appear when we talk about all the new measures in the proposals for both payment years.

On slide 15 we compare Payment Year 2017 measures to those of the previous payment year. In accordance with our measure retirement policy to remove topped-out measures, we are proposing to remove the Hemoglobin Greater Than 12 Grams per Deciliter measure. Additionally, we are proposing the implementation of the Standardized Readmission Ratio, an all-cause readmission measure risk-adjusted for patient case mix and other factors. Greater detail on risk adjustments and the overall measure methodology is available by a methodological report posted on the QIP page of cms.gov. A link is provided at the end of this presentation that will allow you to review this material at your leisure.

You may also note that the NHSN Bloodstream Infection measure does not appear on this summary slide (that would be slide 15). That's because the proposed rule modifies this measure effective for Payment Year 2016, and we'll get to those modifications a little later in the presentation.

The technical specifications for each of the measures in the proposed rule, which include definitions and exclusions, are available on the CMS website. Again, we provided a URL to that page at the end of the presentation.

On slide 16 you'll see a chart that should be familiar to most of you that represents the directionality of measures in the proposed rule. Directionality matters for the – for how performance in individual measures is accounted in the measure scoring. However, nothing has really changed about how we incorporate different directionality in – from the prior rules, and so this should be – this should be familiar ground for most of you.

Likewise, on page – on slide 17, I should say, we provide some key scoring terms for clinical measures. Again, these have not changed substantially since previous rules, so we'll not belabor the point, but we will note that there are some exceptions that apply and are listed on slide 19 later in the presentation.

Please note that the performance standard as calculated is not used in scoring in the individual measure, but is critical in determining whether a facility will be subject to a payment reduction because it is used to calculate the minimum TPS.

On slide 18 you will see a graphic representation of the general approach for scoring clinical measures. In the past, we have provided a slide with much greater detail. However, the substance of measure scoring has not changed in several payment years now. And as such, we have chosen to provide this broad overview. Again, as you will be familiar with, the achievement – I should say, measures, are assessed through both achievement and improvement scoring methods, with the better score of the two applied in calculating a TPS.

The achievement method compares the facility's calendar year 2015 performance to the performance of all facilities during calendar year 2013. The improvement method, by comparison, assesses facilities – a facility's calendar year 2015 performance to its own performance during calendar year 2014. In this way, a facility can increase its score if it shows an improvement over its previous performance, while it strives to reach a national average of performance on a measure. CMS does favor achievement over improvement, which is why a facility can score a maximum of 10 points using that method, while it is limited to a maximum score of 9 for improvement.

On slide 19 we provide the exceptions to measure score – to measure assessment for the NHSN Bloodstream Infection clinical measure in terms of how it departs from the – from those presented on slide 17. It uses performance in 2014 as the comparison period for both the achievement and improvement scoring methods. Additionally, facilities with a CCN open date after the 1st of January 2015 will not be scored on this measure.

On slide 20, we provide a chart with the projected achievement thresholds, benchmarks, and performance standards for the clinical measures proposed for Payment Year 2017. These values will be finalized at a later date after all data for the 2013 national

performance have been calculated. The exception, as noted, is the values for the NHSN Bloodstream Infection measure, which will be based on 2014 national performance data.

Now we've examined the clinical measures proposed for the payment year, I will hand the discussion back over to Anita for a look at the reporting measures.

PY 2017 Proposed Reporting Measures and Scoring

Anita Segar: Thank you, Joel. In this section we'll examine the three proposed reporting measures for Payment Year 2017, and we will consider the measure requirements as well as the way that they are scored.

On slide 22: Because all three reporting measures for Payment Year 2017 were already in place for Payment Year 2016, it's easy to describe Payment Year 2017 by comparing the measures to how they were established for the previous payment year. The global modification for Payment Year 2017 lies in doing away with the CROWNWeb attestation about whether the facility is eligible for a given measure based on the number of patients treated. So starting with Payment Year 2017, we propose to use claims, CROWNWeb, and other administrative data in CMS databases to determine ineligibility.

The other eligibility modification applies only to the ICH CAHPS measure. We're proposing that in order to be eligible for this measure in Payment Year 2017, the facility must treat at least 30 patients in calendar year 2014, and that the facility must receive at least 30 completed surveys during calendar year 2015.

Moving on to slide 23: So scoring for the reporting measures remains the same for these three measures as it was in Payment Year 2016. The scoring formula applies for Mineral Metabolism and Anemia Management, comparing the number of months with appropriate reporting to the total number of months of eligibility. So this formula has been in place since Payment Year 2015. And the ICH CAHPS reporting measure remains an all-or-nothing endeavor. So the facility will either score 10 points for meeting the requirements or zero points for failing to meet the requirements.

PY 2017 Proposed Methods for Calculating the TPS and Determining Payment Reductions

Anita Segar: Now that we've discussed how clinical and reporting measures will be scored, we'll talk about the methods used to create the TPS and the structure by which any payment reductions will be applied. The approach closely resembles the process used in Payment Year 2016.

Slide 25. So once again, the TPS will range from zero to 100 points. Just as in Payment Year 2016, clinical measures will count for 75 percent, and Hypercalcemia will have two-thirds of the weight applied to each of the other eligible clinical measures.

So, for example, if a facility is eligible for all of the Payment Year 2017 clinical measures, then each clinical measure and measure topic except Hypercalcemia would be worth 16.1 percent of the facility's TPS, and Hypercalcemia would be worth 10.7 percent

of the facility's TPS. The reporting measures will continue to be rated equally to make up the remaining 25 percent of the TPS.

Slide 26. Establishing the minimum TPS for Payment Year 2017, which is currently estimated to be 58 points, also follows a familiar process, with one departure. For the purposes of calculating the minimum TPS, we factor that a facility receives zero points for every measure for which the value of the performance standard is not published before the beginning of the performance period. So for Payment Year 2017, the NHSN Bloodstream Infection measure fits this description.

Now, in contrast with how the minimum TPS was constructed in Payment Year 2015, beginning in Payment Year 2017, we are factoring that a facility scores 10 points on each of the proposed reporting measures. We introduced this change because 10 points was the 50th percentile of facility performance on all of the reporting measures in Payment Year 2015, and we certainly do not wish to incentivize facilities to provide below-average care. The minimum TPS will be included in the calendar year 2015 ESRD Prospective Payment System Final Rule this November.

On slide 27 you'll see a chart demonstrating the ranges for payment reductions based on a facility's TPS. The minimum TPS is yet to be finalized, so this chart presents the ranges of potential payment reductions which have been used since Payment Year 2014, when the ESRD QIP first established the 100-point scale.

The slide on page 29 provides a summary graph of how facilities will be scored, how those scores will translate into its TPS, and whether a payment reduction will be applied. It identifies the measures, category weights, and the scale for the payment reduction, if applicable.

Now that we've reviewed the make-up and calculation of the proposed Payment Year 2017 program, I'd like to turn the presentation back over to Aryeh for an important announcement before we continue on with Payment Year 2018.

Keypad Polling

Aryeh Langer: Thank you, Anita. Before we move into our next section of the presentation, we'll pause for a moment to complete keypad polling so CMS has an accurate account of the number of participants on the line with us today. Please note, there will silence on the line while we tabulate the results.

Holley, we're ready to start polling, please.

Operator: CMS greatly appreciates that you minimize the Government's teleconference expense by listening to these calls together in your office using one phone line.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are

between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Once again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Thank you. I'll turn the call back over to Aryeh.

Aryeh Langer: Thank you very much, and I'm going to turn the call over to Joel for the next portion of the presentation.

Presentation (continued)

PY 2018 Proposed Clinical Measures and Scoring

Joel Andress: Thanks, Aryeh. We now turn to the clinical measures and scoring for the Payment Year 2018 proposals.

Slide 30. We provide a listing of the clinical and reporting measures proposed for Payment Year 2018. As should be apparent, the ESRD QIP structure has changed with the proposed rule. We have retained the measure topic structure for Vascular Access and Dialysis Adequacy, but instead of each clinical measure having equal weight—except, of course, for Hypercalcemia—the clinical measures are grouped into subdomains with their own distinct weights. The subdomains reflect CMS's desire to more closely align the ESRD QIP with other Value-Based Purchasing programs that measure quality by grouping measures based on the National Quality Strategy Goals.

Once again, the new measures are indicated by the gold star—six overall, with three new clinical measures and three new reporting measures. For clinical measures, we're proposing to extend ICH CAHPS from its prior reporting measure status, and we are including the Standardized Transfusion Ratio measure and the Pediatric Peritoneal Dialysis Adequacy measure. For reporting measures, we're proposing to add Pain Assessment and Follow-Up, Clinical Depression Screening and Follow-Up, and the NHSN Healthcare Personnel Influenza Vaccination measure.

On slide 31 we compare the proposed Payment Year 2018 program to the proposals for Payment Year 2017 to illustrate the changes in the new approach. The proposals for Payment Year 2018 include 11 clinical measures, three of which will be new.

The ICH CAHPS measure expands from the prior reporting measure, while the Pediatric Peritoneal Dialysis Adequacy measure is added to the Kt/V Dialysis Adequacy topic.

Finally, the Standardized Transfusion Ratio is a risk-adjusted measure of red blood cell transfusions that occur in the ESRD dialysis population. As mentioned before, the technical specifications for each clinical measure are available in the ESRD QIP section of cms.gov, for which we will provide a link at the end of this presentation.

This next slide, on 32, may look familiar to some of you. Again, we are addressing directionality for the additional measures proposed in Payment Year 2018.

On slide 33 we are, again, providing the key scoring terms. These have not changed from Payment Year 2017 and require no discussion.

On slide 34, we provide the graph – the same graphic confirmation that the – some graphic confirmation that the general approach for scoring the individual clinical measures remains unchanged. These achievements and improvement scoring methods will continue under this proposal as they have in prior years and will under Payment Year 2017.

Also unchanged, though not displayed here, is the manner in which the Kt/V Dialysis Adequacy measures and the Vascular Access Type measures are combined to establish the respective measure topic scores.

Again, you may want to review the Payment Year 2016 Final Rule National Provider Call presentation from earlier this year on the QIP page on cms.gov. We have provided a link for this as well at the end of the presentation.

As with Payment Year 2017, one clinical measure does not follow the general approach for scoring of individual measures—in this case, the ICH CAHPS Survey measure. It uses performance in calendar year 2015 as the comparison period for both the achievement and improvement scoring methods. Furthermore, the measure is made up of three composite measures and three global ratings to reflect the NQF-endorsed measure specifications. Each of these six elements will be scored according to the achievement and improvement methodologies, with the better result applied. Then the six scores will be averaged together to determine the overall score of measure.

So now that we have identified the 11 clinical measures, Anita will take over here to talk about the five reporting measures in the proposal for Payment Year 2018. Anita?

PY 2018 Proposed Reporting Measures and Scoring

Anita Segar: Thanks, Joel. That's quite a lot of information to digest. So before we discuss significant changes in the methodology for calculating the TPS in the proposed Payment Year 2018 program, let's just take a moment to look at the reporting measures.

On slide 37: As mentioned earlier, the ICH CAHPS reporting measure from previous payment years is proposed to be expanded into a clinical measure for Payment Year 2018. Anemia Management is unchanged, and Mineral Metabolism is modified to accept either serum phosphorus or plasma phosphorus to comply with the measure requirements.

The proposal also adds the three new reporting measures Joel mentioned earlier and that are listed here as well. All three of these measures represent an enhanced focus on patient

well-being and of the health of the medical professionals employed by the facility to treat patients.

Slide 38. As in previous years, Mineral Metabolism and Anemia Management are scored according to the formula presented here. Conversely, the three new measures are all-or-nothing propositions, just as the ICH CAHPS reporting measure had been. So that means the facility will receive 10 points for satisfying all of the performance requirements, or zero points if they do not.

Now, although the process of scoring individual clinical and reporting measures has not changed at all, the way in which the measure scores are used to create the total performance score is totally new in the proposed Payment Year 2018 program, and we'll explore this change in the following section.

PY 2018 Proposed Methods for Calculating the TPS and Determining Payment Reductions

Anita Segar: Slide 40. So in previous payment years, including the proposed Payment Year 2017 program, CMS calculates the total performance score by assigning a portion of the score to the clinical measures (75 percent, for example) and the remainder to the reporting measures (20 – 25 percent).

Now, instead of calculating a TPS based on the weighting of clinical and reporting measures, CMS proposes to assign measure scores on the basis of two domains, the clinical measure domain and the reporting measure domain.

The reporting measures will be added to calculate the reporting measure domain score, which will then be used to derive the reporting measure adjuster that we will talk about in a later slide. The reporting measure adjuster is then subtracted from the clinical measure domain score to arrive at the Total Performance Score for the facility. With this approach, CMS continues to reinforce the importance of both categories of measures, but in a different manner than before.

Clinical care remains the primary focus of ESRD QIP, as it reflects the quality of care provided. But CMS also places an emphasis on facility compliance with reporting regulations, as that information is crucial to the development of future clinical measures. And compliance with reporting requirements, again, will result in a better TPS by minimizing the reduction in the clinical measure domain score.

So we're going to demonstrate each of these calculations in turn. On slide 41 and over the next few slides, we will use hypothetical facility scores on the proposed Payment Year 2018 measures to illustrate how these scores are used to create the clinical measure domain score, the reporting measure domain score, and ultimately, the Total Performance Score.

So on the left-hand side of this slide is a list of each measure or measure topic score in Payment Year 2018, along with the hypothetical Facility A's scores. On the right-hand

side of the slide we have the formulas for each of the three subdomains: the safety subdomain, patient and family engagement/care coordination subdomain, and the clinical care subdomain. We have that along with the weight for each measure represented as its portion of the subdomain score.

So in this example, the facility qualifies for a score on each of the measures. The arrows illustrate where each clinical measure score will be used in the formula. The proposed weight of the subdomains and the weight of individual measures within those subdomains were selected according to three criteria: 1 of them being the number of measures in each subdomain, 2 is facility experience with the measures, and 3 being how closely the measures aligned with CMS priorities for quality improvement.

Moving on to slide 42. So here on this slide, we see each score populated in the three subdomain formulas, and the results of each calculation. So safety subdomain formula has a total of 80; patient and family engagement/care coordination, a total of 90; and clinical care subdomain formula is 96.4.

Following that, on the next slide, we take each subdomain score and apply the relative weight to each, as described earlier.

For the clinical measure domain, clinical measures and measure topics will be divided into three subdomains, which were described earlier. The safety subdomain will represent 20 percent of the clinical measure domain score. The patient and family engagement/care coordination subdomain accounts for 30 percent of the clinical measure domain score, and the clinical care subdomain makes up the remaining 50 percent of the clinical measure domain score.

So these weighted results, as you can see on slide 43, are added to calculate the clinical measure domain score, which in this example is 91.2, which is quite a respectable result for Facility A.

Now that we have a clinical measure domain score, we will examine on slide 44 how the reporting measure scores influence the facility's TPS.

So CMS will subtract the sum of a facility's eligible reporting measure scores from the total possible reporting measure points for which the – for which the facility is eligible, then multiply that total by a coefficient that translates the value of a reporting measure point to its proportional value in the overall TPS. The result of that calculation, as illustrated by the formula on this slide, will be the reporting measure adjustment, or the adjuster.

Now, in the Payment Year 2016 program and as proposed for the Payment Year 2017 program, the relative value of a reporting measure point was five-sixths of an overall TPS point. So that is the coefficient proposed for Payment Year 2018 calculation, and because the reporting measure adjuster is used to reduce the clinical measure domain score, lower

reporting measure scores result in a larger reporting measure adjuster, or RMA, and that's a larger reduction in the clinical measure domain score.

So let's take a look at this calculation in action, using our hypothetical Facility A scores once more. So on slide 45 we see Facility A's scores again, with the arrows showing where each score fits in the overall formula for the reporting measure domain score. So here Facility A earned 46 points of a possible or maximum total of 50 points, once again making a strong showing in the ESRD QIP.

So with the reporting measure domain score in hand, we can now calculate the reporting measure adjuster. So on slide 46 we see that the reporting measure adjuster, or the RMA, is 3.3, and this will result in a relatively small reduction in the facility's performance on the clinical measures, as we will see on the next slide.

So slide 47: The clinical domain score – the clinical measure domain score is 91.2. You have an RMA of 3.3. So subtracting 3.3 from 91.2, Facility A's TPS of 87.9 is now rounded to a result of 88.

Slide 48. The proposed method for calculating the minimum TPS for Payment Year 2018 is similar to the approach we're proposing to use in Payment Year 2017 program, with the dates changed, of course, to account for the applicable comparison and performance period.

Now, because Payment Year 2018 performance standards are based on facility performance throughout calendar year 2014, we're not able to calculate the minimum TPS at this time, but the applicable performance standards, the achievement thresholds, the benchmarks will all be published in the next – in next year's round of rulemaking, which is the proposed rule next year for calendar year 2019, along with the minimum TPS for the payment year. So these details will be included in next year's rule.

Slide 49. Although we cannot calculate or even estimate the TPS for Payment Year 2018 at this time, we propose that the payment reduction structure remain constant. So this table here on slide 49 shows the ranges for each reduction percentage category.

Slide 50. Just as we did for Payment Year 2017, this slide provides a summary graph of how facilities will be scored, how those scores will translate into its TPS, and whether a payment reduction will be applied as part of the proposed rule for Payment Year 2018. This slide also includes the measures, the clinical measure subdomain, the subdomain weights, all of the relevant calculations, and the payment reduction scale where applicable. And as we have done throughout the presentation, proposed new measures on this slide are identified, again, with a gold star.

Slide 51. So, as mentioned, the proposed rule addresses issues beyond the scope of either Payment Year 2017 or Payment Year 2018, and some of these issues are administrative in nature and will become effective shortly after publishing the final rule. So, as mentioned, the proposed rule modifies the NHSN Bloodstream Infection clinical measure

effective for measuring calendar year 2014 performance. The scoring methodology is revised to use the adjusted ranking metric, and this move accounts for differential volumes of exposure at large and small facilities, and will better differentiate facility performance on the measure. The proposed rule also identifies how CMS will determine whether a measure is topped out. We identify and provide information on the progress of the data validation project and our efforts to monitor beneficiary access to treatment and, of course, policies clarifying how extraordinary circumstances will impact facility scores on the ESRD QIP.

And with that, I'd like to turn this presentation over to Brenda Gentles for a discussion about the comment period. Brenda?

Participating in the Comment Period

Brenda Gentles: Great. Thanks so much, Anita. And we will share some guidance of recommendations for participating in the comment period for the proposed rule, but we'll begin with an overview of the program from a timeline perspective.

On slide 53, to start with, let's take a look at the overarching timeline of the program. This graphic illustrates what's going on with the program as we speak.

So right now, we're in the midst of payment implications for Payment Year 2014 programs. The 60-day comment period for the proposed Payment Year 2017 and '18 program is ongoing, of course. Additionally, the 30-day preview period for Payment Year 2015 has begun. And finally, we have the performance period underway for Payment Year 2016. In this way, the ESRD QIP can be seen as a series of multiple-year programs.

The process of creating and implementing Federal regulations includes the period in which the public may provide input on the proposed rules. In past years the comments that CMS received helped shape the final rule, and they sometimes reflected significant differences from the proposed rules as a result of those comments.

As an example, in Payment Year 2015 the proposed rule included Hypercalcemia as a clinical measure, but CMS changed course in the final rule due to feedback it received as part of the comment process, which was finalized at a later date. Therefore, your participation in the process is essential in creating the best possible program for measuring facilities' performance and providing quality of care to the ESRD population.

And just note that the comment period will end at 11:59 p.m. on September the 2nd. And please also note that CMS does take your comments seriously, and therefore, please submit your comments.

On slide 55, the next two slides, we have provided charts to help you find your way around of the proposal to get to specific data and for the detail to the proposal more easily. This is offered to you to assist you in reviewing, commenting – and commenting on the rule.

So on to slide number 57. Perhaps the most convenient way to submit a comment is online through regulations.gov. Here's a screenshot of that home page. You can use the search box to navigate to the rule and the comment portion. You're able to use several search terms that will successfully return the proposed rule as a result—for example, the file number, as pictured above, and the calendar year 2015 ESRD PPS, which is actually part of the proposed rule's formal title.

So here on slide 58 we see another screenshot of the search results. Use the Comment Now function to submit your comments. This slide also identifies some resources for additional help in using the system. Please note the help desk phone number and the hours of operations.

Now, on slide 59 you can upload files as part of your comment. On this comment form, your state, ZIP code, country, and your category (whether you're submitting as an individual, a health care professional, or like – or the like) are now required fields. You must also disclose whether you are submitting the comment on behalf of a third party, as well as that organization's name.

It is important to note that you do not have to use the online interface to submit comments. This slide on – slide number 60 identifies methods to deliver your comments in hard copy format if you prefer. Please be sure, however, to allow time for transit and delivery to prevent any delays. More information can be found at the very beginning of the proposed rule.

Slide 61. To recap today's presentation, the proposed rule for Payment Year 2017—it shares a lot of structure with Payment Year 2016, but includes some new measures as well. The proposed rule for Payment Year 2018, in contrast, represents an evolution in the program's approach to TPS, and it covers five of the six domains in the National Quality Strategy.

Resources and Next Steps

Brenda Gentles: On slide 62, here's a list of some useful content about the program that's available online, and, as Anita has presented and Joel has presented, they have mentioned these, so please take note of slide number 62. We have online available resources, which includes the MIPPA, the ESRD QIP section of cms.gov, the ESRD Network's National Coordinating Center, the Dialysis Facility Compare, and so forth. So please take note of that.

Finally, there are a few actions that we recommend you take in the remainder of 2014. Comment on the Payment Year 2017/Payment Year 2018 proposed rule; review Payment Year 2015; preview Performance Score Report, the PSR; and submit any clarification, questions, or a formal inquiry. Read Payment Year 2017/Payment Year 2018 final rule when it's posted in early November, and review Payment Year 2015 final PSR when available, which should be in mid-December. Post your Payment Year 2015 PSCs in both English and Spanish, when also available in mid-December. OK.

OK. We would like to, certainly, thank you for your attention this afternoon. Please utilize the ESRD QIP mailbox for any questions about this particular presentation. And at this time, I would like to hand the presentation back over to Aryeh, and we will proceed to our questions-and-answer portion of the presentation.

Question-and-Answer Session

Aryeh Langer: Thank you, Brenda. Our subject-matter experts will now take your questions. Because this call is being recorded and transcribed, please state your name and the name of your organization before asking your question. In an effort to hear from as many callers as possible, we ask that you limit yourself to one question at a time. If you have more than one question, please press star 1 after your first question is answered to get back in the queue, and we'll address additional questions as time permits.

Holley, we're ready to start our first question, please.

Operator: To ask a question, please press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q and A roster.

And your first question will come from the line of Glenda Payne.

Glenda Payne: Thank you very much and I appreciate this information. I have a question about slide 31 and slide 35. This is about the ICH CAHPS Survey. On slide 31, it says the "percentage of patient responses to multiple testing tools" as though it's simply the number of patients that respond, while slide 35 says – lists three measures and three global ratings and says there will be achievement and improvement scores.

So I'm wondering if the measure specifications online will clarify whether the actual scores are going to be somehow rated, or are the scores on those measures that individual patients submit and are aggravated by facility, or is this simply the number of patients who actually report scores on those measures? Thank you.

Aryeh Langer: Can you give us one moment, please?

Glenda Payne: Sure.

Anita Segar: Hi, Glenda, this is Anita. Thank you for that question. So the – the way that we score it for Payment Year 2018 is we're looking at the percentage of top box responses, but the detailed specifications are in the rule as well as the ichcahps.org website.

Glenda Payne: OK.

Anita Segar: But I recommend that you actually take a look there because we've provided all of the specifics and details.

Glenda Payne: Thank you.

Anita Segar: Thank you.

Operator: And your next question will come from the line of Joan Simard.

Joan Simard: Good afternoon. Thank you very much for this information. I started to look at the proposals, and I basically have a question of confusion. We are a dialysis facility, but yet we're going to be reporting on pain assessment and depression? Those are not within our scope of care per se, but usually patients are followed at other locations. Where – how are we going to be collecting the data on that?

Anita Segar: Hi, Joan, this is Anita. So are you asking if – how you're going to report the data for those measures?

Joan Simard: Well, I'm not sure, when they say a Pain Assessment and Follow-Up Plan, we don't – we can't – it's not covered in the bundling for us to do prescription – or – a prescriptive workup for something other than their kidney failure. And the same thing with depression—I mean, I'm not trained to go in and do depression screening and counseling with patients. That's usually when they go to another doctor, another resource, or they go to a pain clinic. But we're being – we're going to be called to the – we're going to be monitored to make sure that we're following up on this, when it doesn't – it's not part of our – our bundle-type thing. I'm not – that's where I'm confused.

Anita Segar: Oh, OK. So I hear what you're saying. Now, because this is a comment on the rationale underlying element of the proposed rule, I would ask that you use the comment period we described in this presentation to formally share your opinion that way.

Joan Simard: Why will we . . . ?

Anita Segar: So we can consider it in creating the final rule, and we can provide a response in the text of the regulation itself.

Joan Simard: But I was just wondering: What is their intent at this point? I mean, what are – what are they thinking we're going to be doing, to help me understand if I'm jumping through a hoop beforehand or not. I'm trying to figure out what they're looking for from us.

I mean, are we supposed to be developing a plan of management if a patient has pain, chronic pain? If a patient is depressed, are we supposed to be, you know, following

through and working with – with psychotherapies with them? Like I said, I'm confused as to what this is supposed to help us incorporate into our practice.

Anita Segar: So, Joan, the – I don't know if this will help, but for pain assessment, it is a standardized tool, and for the depression screening, it is a screening to see if the patient has depression. So both of these now, for their specifics about, you know, the description of the measure and which patients are excluded, and there are some additional information about, you know, which conditions need to be reported for every eligible patient—all of that information is on the measure's spec, so that might . . .

Joan Simard: I understand that, but what my question is, we identify these things but are we supposed – are we going to be expected to enact them? Because we're not a pain clinic, you know; we're not – we're not a psychotherapist's office. We can identify these things, but then what do we do with that information? Refer patients? I mean, is this what they're trying to help us work through, or are we supposed – are we going to be expected to *manage* these issues once they've been identified?

Joel Andress: Excuse me, this is Joel Andress. So – so the point of these – of these measures, looking – if you look at the specifications, is for screening only. There is no prescription or requirement in here for you to conduct the actual pain management or . . .

Joan Simard: OK.

Joel Andress: . . . or therapy in the event that there is – they identified the presence of depression.

Joan Simard: OK.

Joel Andress: So the function is that having identified that there is an issue, that you can speak to the – that you can speak to your patients about the issue and direct them toward resources that will allow . . .

Joan Simard: OK, all right, all right. And that makes – that makes sense but if, you know, if we're going to be expected to do the other pieces, there's no chance of that.

Joel Andress: Right, there is – there is no intent here in the . . .

Joan Simard: OK.

Joel Andress: . . . here, as proposed, to expand the scope of practice.

Joan Simard: OK, thank you.

Aryeh Langer: And I'd just like to let all the callers know, if there's a brief pause between your question and when our subject-matter experts answer your question, it's

because we're discussing in the room to give you the most appropriate, correct answer. Thank you.

Operator: Your next question will come from the line of Deborah Halinski.

Deborah Halinski: Hi, I'm from a hospital-based facility, and this is in regards to slide 30, the reporting measure for NHSN Healthcare Personnel Influenza Vaccination. Our employee health department currently tracks influenza vaccines for employees and reports that to NHSN. So wouldn't this be considered double reporting, because it's already being reported for our dialysis facilities through the hospital, and then, you know, adding an extra burden into the dialysis provider?

Anita Segar: Hi, Deborah, this is Anita.

Deborah Halinski: Hi.

Anita Segar: So I would categorize that as a comment on the proposal itself, and I would encourage you to share that comment in the – during the comment period.

Deborah Halinski: OK, thank you.

Anita Segar: Thank you.

Operator: And your next question will come from the line of Cindy McGee.

Cindy McGee: Hi, I'm from Genesis Medical Center in Davenport, Iowa, and I just wanted a clarification. On slide 37, it is – after 36, which is the Payment Year 2018 proposed reporting, but on 37 it says proposed Payment Year 2017, so I'm wondering if it's '17 or '18.

Joel Andress: Yes, this is – this is Joel. Just to clarify, the – the slide 37 is describing the measures proposed in Payment Year 2018 in relation to those proposed in Payment Year 2017. So we apologize for the – for any confusion, but that is – that is what we were intending to say.

Cindy McGee: Thank you.

Operator: Your next question will come from the line of Vlad Ladik.

Vlad Ladik: Hi, this is Vlad Ladik, DCI. My question is: For Kt/V measure in 2015, '16 and it appears that in '17 and '18, the exclusion is that patient should – patient will be excluded only if patient has one treatment in the reporting months. It means that if patient has two more treatments, the patient will be included in this measure. This by itself would basically include a lot of transient patients in the measure for which clinics don't really provide regular service.

It's already affecting clinics now, and it appears that it will affect in the future. And in general—I understand, I will put it in the comment—but in general, my question is, should CMS think about some kind of criteria to identify patient as belonging to the clinic? For example – I don't know – like, Vascular Access has 4-months criteria; that you have to have four claims, then you count the patient.

Kt/V has absolutely different criteria. For Hypoglycemia, you have criteria that a patient should have a result in CROWNWeb. It's all kind of different things, and I think it would be beneficial if you would think about the patient set first—to say, here's the 50 patients in this clinic, and those are patients that would go into CROWN, and then for this patient he would look at the results and the CROWN, the score.

Joel Andress: So, Vlad, this is – this is Joel Andress again. So I think – I think the most direct question that you asked there was, should we think about different ways to attribute patients to facilities for the various measures and seek for alignment? So I think, you know, that's probably not something I can answer in the constraints of this meeting. I think it's certainly something that we have thought about and that we continue to consider as we perform maintenance on the measures.

If you have particular recommendations in terms of how we might be able to define those – or define patient attribution for some – for – specifically, for Kt/V or any other measures, that should certainly be submitted in the form of a – in the form of public comments, so we can look at it, consider it, and get back to you with a – with a written response. But I will certainly say that – that I agree in broad that that is something that we should consider carefully in the measures we implement.

Vlad Ladik: Thank you.

Operator: Your next question will come from the line of Adrienne Adkins.

Adrienne Adkins: Hi, this is Adrienne Adkins from Fresenius Medical Care. I have a question regarding slides 22 and 23. I thought I heard you say that for the Payment Year 2017 that we were removing the attestations. Is that attestations altogether? And then the second part of that question is, I thought I heard you say that with Mineral Metabolism and Anemia Management reporting, that it was an all-or-nothing sort of a score for the reporting measure. Is that correct?

Anita Segar: Hi, Adrienne, this is Anita. Yes, you're right; on slide 22, for the CAHPS, we do not have an attestation for CAHPS in Payment Year 2017. But the second part of your question, as it pertains to Anemia Management and Mineral Metabolism, that is not going to be an all or nothing. We will calculate the score based on that formula that we – that we're using, which is on slide 23: for Mineral Metabolism, Anemia Management, the number of month successfully reporting data divided by the number of eligible months into 12, then minus 2. So that's the formula we would use for those two measures.

Adrienne Adkins: OK, thank you, Anita. I must have misunderstood what was said. So thank you for clarifying that.

Anita Segar: You're welcome.

Operator: Your next question comes from the line of Susan Senich.

Susan Senich: Hello, Susan Senich, North Central PA Dialysis. What's the purpose of the reporting measures adjuster (slide 46)? In the example, what's – yes, what's the purpose of the reporting measure adjuster? In the example, if this facility got a 91, why should they have a deduct to take them to 88?

Aryeh Langer: We're just conferring here in the room. Please give us one moment.

Anita Segar: Hi, Susan, this is Anita. That's a – that's a great question. So the reporting measure adjuster is intended to be an index of facility compliance with the reporting requirements that we have. So if you have a low reporting measure adjuster, that just indicates that you have a high compliance with your reporting measures and vice versa. So if you had a high reporting measure adjuster, that means the compliance with reporting requirements is low.

Now, we end up subtracting it. As you see in this case, there's a total of – the facility, the hypothetical facility received a score of 46 points on the reporting measures; they could have received 50 points. So they did well but not perfectly well, and that's why they end up losing, in the final calculation, 3.3 from the – from the clinical measure, the clinical TPS.

Now, the purpose or the intention behind this has been to incentivize reporting for facilities as well as, you know, give the clinical measures the importance that they deserve and the significance that they deserve.

With this particular methodology, the reporting measures are – can be increased in number, and it would still not affect the weighting. In the previous methodology, you would have 75 percent for clinical measures—say, 25 percent or 10 percent at one point of time that we had. What happens is when you continue to keep adding reporting measures to that sort of a methodology, you end up having a lot more reporting measures for a small percentage weight, and then you're effectively diluting the weight of each of these reporting measures. So in a sense, we're sending this message across that perhaps the reporting measures are not that important because maybe now, depending on the number of reporting measures that we've added, they're all only going to be weighted at 3 percent or 4 percent.

So this methodology, it works around the constraints of the previous methodology and uses the subtraction from the final in a way that actually incentivizes the dialysis facility to not only pay attention to the clinical measures, but also the reporting measures.

Susan Senich: So if they do more poorly on the clinical measures and better on the reporting measures, they're score is better?

Anita Segar: That's not – no, no. The score is not better, because if they do not very well on the clinical measures, they already start off with a lower score, and then if they did well on the reporting measures, we subtract very little. You know, they'll probably have a point or two if they didn't do perfectly on the reporting measures that will be subtracted. So a low – so in that situation that you just described you have a facility with a not very good clinical measure score, but they did well on the reporting measures, so the subtraction is not going to be very much, so you sort of know pretty much where they are going to stand. The clinical measures are still going to account for the bulk of the score.

Susan Senich: OK, thank you.

Operator: And your next question will come from the line of Gloria Weeden.

Gloria Weeden: Hello, this is Gloria Weeden from Central Coast Kidney Center in Santa Maria, California. My question is regarding the data on the bloodstream infection. My understanding is the information is gathered strictly from reporting on NHSN. Is that accurate?

Anita Segar: That is correct.

Gloria Weeden: Oh, OK. So there is no other source that the data is gathered from.

Anita Segar: That is correct. It is only on NHSN.

Gloria Weeden: OK. So if the information or the score comes up where it is actually high but in all the reporting it doesn't appear high, who would I contact, or how would I reconcile this data? Is it through NHSN?

Anita Segar: So, a couple of things: If you have issues with the website itself and the reporting tools, the module that's available on NHSN on the website, you would need to contact the NHSN help desk. But if you are talking about errors maybe, or some questions about calculation of the NHSN score as it pertains to your QIP score, then we would recommend that you raise that as a clarification question during the preview period.

Gloria Weeden: Oh, OK, during the preview period. OK, I appreciate that. Thank you so much.

Aryeh Langer: Thank you.

Operator: Your next question will come from the line of Philip Calderone.

Philip Calderone: Yes, this is Dr. Calderone, CRRT at Water's Edge. This goes back to the same question I proposed last year. Basically, we are in a nursing home. We have a very low volume situation, with patients with an awful lot of comorbidities, so it is almost impossible to make the clinical screens. I've been affiliated with a lot of units for a lot of years, and I can see how things can be done, but when you're dealing with a patient population of a 36 or 40 patients, you can almost never make these screens.

Now, last year we talked about having an elderly population with a lot of comorbidities, and we were told that the comorbidities come from the 2728s, and they're only corrected within the first 30 days of when the patient initiated dialysis. Now, has anything been done? I think, Joel, we definitely discussed that with you last year. I don't know if you remember that. And has anything been done – has anything been done to sort of modify how we can be graded in this situation?

Joel Andress: Dr. Calderone, yes, I do recall our conversation very well and, in fact, I just received a report from my measure developing contractor at the University of Michigan regarding Vascular Access measures as well as a number of others. So to state shortly, we looked at some potential quick fixes, to what could be applied to the Vascular Access measures to try to address some of the issues that you had discussed at a measure development level. But we concluded that – that in order to address the issues we were looking at, we were going to need to do something a little more – a little broader. So we are expecting in the fall that we will be announcing – announcing for a measure development – a measure development TEP for the Vascular Access measures, to address some of the issues that – that I think you've raised in the past, and they'll be taken up there. So you should expect an announcement calling for nominations for expert input in the next couple of months.

With regard to – to its impact on the QIP, however, I think that this is a – that this is something that falls within the domain of public comments. So, again, I would encourage you to submit a written comment so that we can respond to it within that context, and then if you have any questions, I think, regarding the development of measures for these areas, you can contact me directly, and we can discuss it.

Philip Calderone: OK, so this potentially for 2017 and '18, depending on what the findings may be, may not affect our reimbursement rate?

Joel Andress: So, to clarify, the measure development efforts that we'll be undertaking will not impact Payment Year 2017 or 2018. It would have to – we would have to go through – any – any new measure development or measure changes would have to go through the pre-rulemaking process and then rulemaking before we can consider implementation in QIP, I believe.

Philip Calderone: So – so we'd be looking at 2019 before getting any relief, potentially?

Joel Andress: I'm sorry, I didn't catch that. Can you repeat?

Philip Calderone: That means we would be looking at 2019 before we could potentially get any relief relative to the situations we spoke about, as far as reimbursement?

Anita Segar: Dr. Calderone, this is Anita. So, I mean, we've, I think, stated at previous presentations, and I would strongly recommend as it regards this issue and any other issues that's out there that folks might have. The public comment period, the value of it cannot be understated. The importance of comments, I think that, as you can see in previous rules, we've had direction of policy change, you know, which is based on public comments that we received. So I would urge you and others on the call to present some of these issues and to provide comments during the comment period, and we will be happy to take a look at that.

Philip Calderone: We will definitely do that. Thank you very much.

Aryeh Langer: Same to you.

Operator: Your next question will come from the line to Twyla Nordquist.

Twyla Nordquist: Hi, this is Twyla from Sanford Dialysis in Sioux Falls, South Dakota. And my question is about slide 22, with the ICH CAHPS again. With that 30-patient minimum, I want to just make sure that if we fall into that—or below that, we're a smaller unit and would not have that many patients in a year, so we're not – we don't have to participate, but would we still be required to have a patient satisfaction survey of some sort, as per the previous conditions of coverage?

Aryeh Langer: One moment, please.

Anita Segar: Hi, Twyla. This is Anita. So it sounds like, if I'm understanding your question correctly, you are asking if you don't qualify, based on the criteria that we've provided here on slide 22, for the CAHPS survey. You're asking if you should still go ahead and do any other the patient experience of care surveys as regulated by the CfCs?

Twyla Nordquist: Yes. Are we still required to have a patient satisfaction survey done?

Anita Segar: OK, so, yes, that sounds like it may deal with CfC-related issues, which is beyond the scope of the QIP and our discussion today, so I would have to ask you to check back with the appropriate CMS personnel.

Twyla Nordquist: OK, thank you. Can I ask one more question?

Anita Segar: Sure, go ahead.

Twyla Nordquist: So for the pediatric PD with the Kt/Vs, is that – is there a minimum number of patients in – to be included in the program for that?

Joel Andress: So to clarify, the minimum case number for the Kt/V measure is the same for – as for the other Kt/V measures. The minimum is 11.

Twyla Nordquist: It's 11? OK. Thank you.

Operator: Your next question will come from the line of Joan Simard.

Joan Simard: Yes, thank you, and I'm from Salt Lake City Intermountain Healthcare. Some of my other questions have been answered, but I was also going to look – ask about the transfusion – documentation. Again, we don't transfuse in our facility anymore; our patients go elsewhere. So are we going to be required to indicate those admissions that are not done through our facilities?

Joel Andress: So the data for – the data required for the Standardized Transfusion Ratio are already collected by CMS, so they do not impose an additional collection burden. If you want, and I think – does that – does that answer your question?

Joan Simard: Yes, so then – so then there's really nothing that we have to do with submitting anything?

Joel Andress: No, there is no additional data submission requirement. We use administrative data already accessible to us.

Joan Simard: OK, all right, thank you. Thank you very much.

Operator: Your next question will come from the line of Glenda Payne.

Glenda Payne: Hello, again. I work with Nephrology Clinical Solutions, which is a consulting company, and I'm glad you clarified the minimum number that are eligible. So if you have a pediatric facility—and I have a few "adult" patients in that patients have not yet transitioned to adult units, and they are over 18—is there a minimum number of those patients in those pediatric facilities that would have to be met in order for them to be required to report and/or be counted in the scores or the adult measures in this group of measures that are being proposed?

Joel Andress: So this – this is Joel Andress, again. So we don't have any means to distinguish a patient who is in a facility who is – who is in a pediatric facility but is getting ready to shift into an adult facility. I think that's what you're – that seems to be what you're asking.

Glenda Payne: No, I am asking if they are 18. If they are over 18.

Joel Andress: Right, so we currently divide our Kt/V measures by modalities, so hemodialysis or peritoneal dialysis.

Glenda Payne: Right.

Joel Andress: And by age group, either pediatric or adult.

Glenda Payne: OK.

Joel Andress: The minimum case for each of those four measures is 11. So if you have an adult patient – so if you have a patient who is over the age of 18 but is – but you don't treat more than 11 – 11 or more adult patients, then you would fall under the minimum for the Adult Hemodialysis or Peritoneal Dialysis measures, as they are assessed on the QIP.

Glenda Payne: Right, thank you very much.

Operator: And your next question will come from the line of Vlad Ladik.

Vlad Ladik: My question is about Bloodstream Infection Rate. It is – it's reported through NHSL, and right now there is no ability to tell how well clinics report bloodstream infections. We did some initiatives and we saw clinics under-reporting, especially under-reporting blood cultures that were done outside of the clinic. So if patient goes to the hospital and has blood culture in the hospital, it's often not getting reported in our system, and it's often not getting reported in NHSL. Is there going to be any initiative to actually verify data that clinics report in NHSL? For example, cross-reference with some hospital billing to see if any cultures for that hospital bill are not reported by clinics.

Joel Andress: This is Joel Andress again, Vlad. So the short answer for that, I think, is that that's a public comment, particularly with regard to the – to any issues you think where data are being insufficiently – I think your concern is that infections are not being sufficiently reported, and so I think anything along those lines would need to be assessed on public comments.

Vlad Ladik: Yes, and the people who don't report infections sufficiently would benefit with a high score. So there is also incentive to close your eyes and don't be diligent to try to find everything possible about patient.

Joel Andress: [Sneezes] (Excuse me.) So, Vlad, I think the other thing to keep in mind is that this is why we're – this is one of the reasons we're proposing – and I apologize for not mentioning it in my initial response, because it's a little bit outside of my personal bailiwick – but we are proposing for – proposing to undertake validation of the NHSN data. I think we agree with that validation is certainly an important thing to address. Nevertheless, we certainly welcome any concerns or experiences you have that might relate to that that would allow us to ensure that that validation is – is more effective.

Vlad Ladik: OK, thank you.

Joel Andress: Thank you.

Operator: Your next question will come from the line of Adrienne Adkins.

Adrienne Adkins: Hi, this is Adrienne again. Part of my question was regarding Standardized Transfusion Ratio, and you answered part of my question. I had two parts to my question. The second part of the question that was unanswered is, is there some type of report that will be available, like for the dry run for the readmission ratio, that'll be released for us to look at, to see what kind of data is already collected on this measure?

Joel Andress: Right. This Joel again. So for the Transfusion Ratio, we have already been reporting this measure on Dialysis Facility Compare, so we have no plans at this time to conduct a dry run. Typically, we conduct the dry run – a dry run prior to implementation of the measure, and we simply hadn't planned one for transfusions before we implemented on DFC. So the short answer is no. There is no expectation of a specific dry run.

On the other hand, the results of the dry run are – or not the dry run, of reporting on Dialysis Facility Compare are available through the Dialysis Facility Compare preview reports. They are published quarterly and through the – through the downloadable database, which is also accessible via data.medicare.gov.

Adrienne Adkins: OK, thanks.

A Message from the Provider Communications Group

Aryeh Langer: And unfortunately, that's all the time we have for questions today. On slide 66, you'll find information on how to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary, and we hope you'll take a few moments to evaluate your MLN Connects Call experience. Again, my name is Aryeh Langer from the Provider Communications Group here at CMS, and I'd like to thank our subject-matter experts and all the participants who joined us for today's MLN Connects Call. Have a great day everybody.

Operator: This concludes today's call. Presenters, please hold.

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