



**MLN Connects®**

**National Provider Call Transcript**



**Centers for Medicare & Medicaid Services  
ESRD QIP: Proposed Rule for Payment Year 2019  
MLN Connects National Provider Call  
Moderator: Aryeh Langer  
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**Operator:** At this time, I would 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 very much. And as you just heard, my name is Aryeh Langer from the Provider Communications Group here at CMS, and I am your moderator for today's call. I would like to welcome you to this MLN Connects National Provider Call on the End-Stage Renal Disease Quality Incentive Program, or ESRD QIP. MLN Connects Calls are part of the Medicare Learning Network®.

During today's call — call, excuse me — CMS subject matter experts will provide information on the upcoming ESRD Prospective Payment System proposed rule, which would operationalize ESRD QIP in Payment Year 2019. A question-and-answer session follows today's presentation.

A few brief announcements. You should have received a link to today's slide presentation in an email earlier today. If you have not already done so, you may view or download the presentation from the following URL, [www.cms.gov/npc](http://www.cms.gov/npc). Again, that URL is [www.cms.gov/npc](http://www.cms.gov/npc), as in National Provider Call. At the left side of the web page, select National Provider Calls and Events, then select the date of today's call from the list below.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the [MLN Connects Call](http://www.cms.gov/npc) website within approximately 2 weeks. Registrants will receive an email when these materials become available.

At this time, I would like to turn the call over to Jim Poyer, the Director of the Division of Value, Incentives, and Quality Reporting here at CMS. Jim?

## Presentation

Jim Poyer: Thank you. Payment year 2019 represents the eighth payment year for the End-Stage Renal Disease Quality Incentive Program, or ESRD QIP, and it's expanded dramatically over that time. The proposed payment year 2019 program builds upon earlier program measures and presents some vital programmatic changes as well.

But how does the ESRD QIP fit into CMS's overall goal for improving quality? In slide 6, we walk through the objectives for Value-Based Purchasing. The Value-Based Purchasing, or VBP, Programs incentivize better care across healthcare settings.

Beneficiaries expect cost-effective, high-quality care. VBP is an avenue to assist us in achieving this goal. VBP promotes CMS's three-part aim of:

- Better healthcare for individuals,
- Better care for populations and communities, and
- Lower cost through improvement.

The ESRD QIP was first — was CMS's first pay-for-performance program in a Prospective Payment System, as opposed to traditional fee-for-service reimbursement. Rather than paying dialysis facilities based on how many services they provide patients, Medicare now pays dialysis facilities based on how well those services keep patients safe and healthy.

ESRD QIP uses the government's purchasing power through Medicare to incentivize improvements in the treatment of patients with ESRD. These incentives drive care throughout the healthcare sector, not just the Medicare.

Next. On slide 7, we — the ESRD QIP for payment year 2019 addresses five of the six National Quality Strategy domains as developed by the Department of Health and Human Services. Those domains are safety, patient and family engagement, treatment and prevention of chronic disease, population and community health, and care coordination. The next few slides will provide an overview of the legislative aspect of the program. And for that, I will turn the presentation over to Tamyra Garcia.

### **ESRD QIP Legislative Framework**

Tamyra Garcia: Thank you Jim, and good afternoon to everyone on the call. We really appreciate you calling in today. As Jim referenced, in this section we'll share some information about the legislative nature of the ESRD QIP generally before delving into the composition of the proposed rule.

We begin with the ESRD QIP legislative drivers, as described on slide 9. The Medicare Improvements for Patients and Providers Act, or 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. MIPPA provides the mechanism for establishing standards of care, and it authorizes payment reductions for facilities failing to meet those standards.

On slide 10, we are provided with the MIPPA requirements, which give 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 also specify that the program measures cover other important aspects there, including patient satisfaction, iron management, bone mineral metabolism, and vascular access.

The ESRD QIP also establishes the way individuals — individual measures are used to create an overall score. CMS will impose a payment reduction of up to 2 percent if the facility's score does not meet a minimum Total Performance Score, or TPS score as it's also referred to. Information about the facility's performance in the ESRD QIP is contained in the Performance Score Report, also referred to as the PSR.

Public reporting of the results is a key component because it allows beneficiaries to select facilities based on the quality of care provided, and it provides a mechanism by which facilities may judge their performance compared to the performance of other facilities. The Performance Score Certificate, also known as the PSC, is the prime vehicle for communicating the facility's performance under the ESRD QIP to its patients within facilities. Facilities are required to display this document in a public place each and every year.

Dialysis Facility Compare, or DSC, also provides information regarding facility performance to the public. In addition, CMS releases detailed facility performance information in a large spreadsheet and posts it on the web. With the structure of the program in mind, we now turn to how it evolves from year to year through the rulemaking process.

On slide 11, the steps associated with rulemaking are summarized. 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 a program.

Please note that we are currently in the comment period, and we'll discuss a bit more about that later on in the presentation. In this way, facilities and the general public have an opportunity to influence the shape of the rule governing each payment year. The comments that we receive are taken very seriously by CMS. And comments have led to the postponement of implementing measures. Those measures were actually stronger when they were implemented in future years due to the comments that CMS received.

With that being said, 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 end-stage renal disease.

Now, on to slide 12, which highlights how it's also important to make sure the public understands how CMS gathers and uses facility information to calculate performance rates and scores for all ESRD QIP measures. Many facilities and other stakeholders often wonder what the reason is for the delay between the performance period, where the facility data actually come from, and the impact on payment. The main reason for this lapse is the reliance on Medicare reimbursement claims for a lot of the data that we need.

As we move to other data sources, we will not be as dependent on claims data, and we hope to reduce this interim between performance and the resulting payment impact. That said, the preview period is a statutory requirement, so facilities will always have an opportunity to review and formally inquire about their scores before they are finalized.

And with that overview in mind, I'd like to hand the presentation off to Pierre Yong, who will begin our discussion on proposals for payment year 2019. Pierre?

### **Proposed Clinical Measures and Scoring**

Pierre Yong: Thanks Tamyra. This portion of our discussion will review the proposed clinical measures and the methods we intend to use for scoring performance. I want to call your attention to the disclaimer at the bottom of the slide, 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, so this material is subject change — potentially a significant amount of change, depending on public comments.

Let me also mention that CMS is interested in getting your comments and feedback on any elements of the proposed rule and on the ESRD QIP generally. So we encourage you to use the methods we'll outline later in the presentation to share your opinions and concerns during the public comment period about any aspect of the proposed rule and the program overall. So let's now start by looking at the measures, old and new, that we propose to use in the payment year 2019 rule.

On slide 14, here we have a graphical presentation of the proposed rule and the two new categories of measures. Just as in payment year 2018, clinical measures are grouped into subdomains with their own distinct weight.

These 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 National Quality Strategy goals. New measures are indicated by the gold star, three overall, with one new clinical measure and two new reporting measures. For clinical measures, we're proposing to adopt a comprehensive Kt/V dialysis adequacy clinical measure, which we'll discuss in the next slide. For reporting measures, we're proposing to add the ultrafiltration rate and the full-season influenza vaccine — vaccination measure.

On slide 15, beginning with the payment year 2019 ESRD QIP, we propose to replace the existing four measures of the dialysis adequacy measure topic with a single comprehensive dialysis adequacy clinical measure. This measure assesses the percentage of all patient months for adult and pediatric patients alike whose average delivered dose of dialysis, either hemodialysis or peritoneal dialysis, met the specified threshold during the performance period.

A primary difference between the single comprehensive dialysis adequacy clinical measure and the four current individual clinical measures is how facility eligibility is determined. A facility's eligibility to receive a score on the proposed dialysis adequacy clinical measure is determined by the total number of qualifying patients treated at a facility.

For example, a facility might not be eligible to receive a score on one or more current dialysis adequacy clinical measures because it did not meet the 11 patient case minimum for an individual measure. Under this proposed measure, that facility would be eligible to receive a score on the comprehensive dialysis adequacy clinical measure if it had at least 11 total qualifying patients across patient ages and modalities at the facility during the performance period instead of needing 11 patients for each individual measure. We anticipate that adopting the comprehensive dialysis adequacy clinical measure will allow us to evaluate the care provided to a greater proportion of ESRD patients, particularly pediatric ESRD patients and those on peritoneal dialyses.

CMS is conducting further analysis on how this comprehensive measure might impact their scores. CMS will post that analysis on the Technical Specifications page of the ESRD QIP section when it's available. And we also plan to disseminate it in a CROWN memo.

Moving on to slide 16. This section uses a few terms with specific definitions in the scoring context. We want to provide them in an introductory slide for your reference. We will see the achievement threshold, benchmark, and performance standards illustrated in the next slide. Note that the performance standard is not used in scoring any individual measures but is critical in determining whether a facility will be subject to a payment reduction because it is used to calculate the minimum Total Performance Score. Note also that the performance period for the two influenza vaccination reporting measures is not a calendar year but rather the flu season, spanning October 2016 through March 2017.

Moving on to slide 17. When talking about clinical measures, it is important to understand that bigger isn't always better. This is what we mean by directionality of a measure, and it varies according to what element of care is measured.

For the measures listed at the top of the slide, a higher rate indicates better care. A higher rate of dialysis adequacy is also a great outcome for patients. Likewise, the use of fistulas to — tend to reduce infections, so a larger patient population having that method of vascular access is similarly positive.

For the measures at the bottom of the slide, a lower rate indicates better care. For example — for example, catheters are not an ideal method of vascular access for most patients, so this number should be small as well. And CMS wants to prevent

hypercalcemia and reduce incidents of infection, hospitalization, and transfusion, so those rates also should be small as possible.

Different directionalities may even exist within a measure topic. With regard to vascular access type, an 80 percent rate on the fistula measure would be a favorable outcome, but an 80 percent rate on the catheter measure would be quite unfavorable.

On slide 18, this presents the general approach for scoring clinical measures, which has been in place since payment year 2014. CMS uses the better of two results as the facility's score on the measure. The achievement method compares the facility's 2017 performance to the performance of all facilities during 2015.

The improvement method compares each facility's 2017 performance to its own performance during 2016. That 2016 performance is the facility's improvement threshold, the rate at which that facility can begin to earn points on the measure using that method. In this way, a facility can increase its score if it shows improvement over its previous performance while it strives to reach a national average of performance on a measure.

CMS favors achievements over improvement, which is why a facility can score a maximum of 10 points using the first method, but the maximum number of points is limited to nine points using the improvement method.

So now that we have identified the eight clinical measures, Tamyra will take over here to talk about the seven reporting measures in the proposal. Tamyra?

### **Proposed Reporting Measures and Scoring**

Tamyra Garcia: Thank you very much Pierre. That was actually quite a lot of information to digest in a few slides. But now we will take just a moment to look at the reporting measures proposed for payment year 2019. I would ask everyone to please note that a disclaimer similar to what was presented for the clinical measures also applies to the reporting measures, as seen on slide 19.

So as mentioned, we propose to continue using the five reporting measures finalized for payment year 2018. The proposal also adds two new reporting measures, listed in slide 20. They represent an enhanced focus on patient health and the ongoing assessment of effective dialysis treatment. They also align with the expanded National Quality Strategy domains. So for the ultrafiltration rate measure, it's aligned with making care safer. And the full-season influenza vaccination measure is aligned with community best practice and healthy living.

In slide 21, we provide the calculations for scoring the reporting measures. The formula for ultrafiltration rate mirrors what is currently used for mineral metabolism and anemia management. For full-season influenza immunization, we propose using a

straightforward ratio comparing the number of patients for whom the facility submits the required report to the number of eligible patients the facility treats during the performance period.

That concludes our discussion related to the reporting measures.

### **Proposed Methods for Calculating TPS and Payment Reductions**

Just as the process of scoring individual clinical and reporting measures is not changed, we propose to continue applying the method established for payment year 2018 by which the measure scores are used to create the Total Performance Score, or TPS.

In slide 23, we propose to continue using the 100-point scale for the TPS as well as the requirement that a facility needs a score on at least one clinical measure and one reporting measure in order to receive a Total Performance Score. The method for calculating the TPS likewise remains the same, both clinical measures making up 90 percent of the TPS and reporting measures making up 10 percent. The reporting measures are weighted equally to create that remaining 10 percent of the TPS.

We propose to retain the subdomain-based weighting structure for clinical measures, which is a little more involved. So we want to take a couple of minutes to illustrate that part of the calculation, starting with slide 24.

Over the next few slides, we will use hypothetical facility scores on payment year 2019 measures to illustrate how these scores are used to create the clinical measure domain score. On the left-hand side of the slide is a list of each measure or measure topic score, along with the hypothetical facility, Facility A's, scores.

On the right-hand side, we have the formulas for each of the three clinical subdomains with the weight for each score represented as its portion of the subdomain score. In this example, the facility qualifies for a score on each of the measures. The arrows illustrate the connections where each clinical measure score will be used in the formula.

So the clinical measure domain, the clinical measures, and measure topics will be divided into three subdomains, as 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 finally, the clinical care subdomain makes up the remaining 50 percent of the clinical domain score.

The weight of the subdomains and the weight of individual measures within those subdomains were selected according to:

1. The number of measures in each subdomain,
2. Facility experience with the measures, and
3. How closely the measures align with CMS priorities for quality improvement.

Here in slide 25, we see each score calculated in three formulas and the result of each calculation. Following that, on slide 26, we take each subdomain score and apply the relative weight to each, as described earlier. The weighted results are added to calculate the clinical measure domain score to be 91.2, which is quite a respectable result for Facility A.

Next, we'd like to discuss the method we propose for calculating the minimum Total Performance Score for payment year 2019. It's actually very similar to the approach we proposed — proposed using in the past, with the dates changed to account for the applicable comparison and performance period. Because payment year 2019 performance standards are based on facility performance throughout 2015, we cannot calculate the minimum Total Performance Score at this time. The applicable performance standards, achievement thresholds, and benchmarks will be published in the next round of rulemaking, along with the minimum TPS for the payment year. These details will be included in the calendar year 2017 ESRD Prospective Payment System Final Rule, which will be published in November of 2016.

Now, although we cannot calculate or even estimate the TPS at this time for payment year 2019, we propose that the payment reduction structure remain consistent to what we proposed in previous years. On slide 28, we have a table which shows the ranges for each reduction percentage category.

Slide 29 provides us with a summary graphical interpretation of how facilities will be scored, how these scores will translate into a TPS, and whether a payment reduction will be applied as part of the proposed rule for payment year 2019. It includes the measures, clinical measures subdomains, subdomain weights, relevant calculations, and the scale for the payment reduction, where applicable. And as we've done throughout this presentation, proposed new measures are, again, identified with a gold star.

And with that, I would actually like to turn the presentation back over to Aryeh for an important announcement before we continue with the discussion related to proposals beyond the payment year 2019 program itself. Aryeh?

## **Keypad Polling**

Aryeh Langer: Thank you Tamyra. At this time, we will pause a few moments to complete keypad polling so that we can get an accurate number of folks on the call today.

Can we start the keypad polling, please?

**Operator:** CMS appreciates that you minimize the Government’s teleconference expense by listening to these calls together 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. Please hold while we complete the polling.

Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling.

Thank you for your participation. I’d now like to turn the call back over to Aryeh Langer.

## **Presentation Continued**

Aryeh Langer: Thank you Kalia. And I’m going to turn over the call back to Tamyra for the next portion of our presentation.

## **PY 2018 Proposed Payment Provisions**

Tamyra Garcia: Thanks Aryeh. As mentioned previously, the proposed rule addresses issues beyond the scope of the payment year 2019. Some of these are administrative in nature and, if finalized, will become effective shortly after publishing the final rule. Other proposals are more substantive, and we want to take a few minutes to detail them. Let’s begin that by examining what was — what the proposed rule has in store for payment year 2018.

For payment year 2018, we propose to modify how we would score the pain assessment and followup reporting measure when it first appeared in the ESRD QIP for payment year 2018.

In slide 31, we describe how the original calculation from the results of two 6-month reporting periods and divided them by two to produce a measure score. That approach did not take into account the situation where a facility did not treat an eligible patient during one of those periods. As it stands, such a facility might receive a lower score than it otherwise should. This proposal seeks to rectify that scenario with a provision to calculate compliance on the basis of the applicable 6-month period alone.

Next up, the charts on slides 32 and 33 list the projected achievement thresholds, benchmarks, and performance standards for these payment year 2018 clinical measures based on the currently available data. Data used to calculate these estimated values may be found in the ESRD QIP payment year 2019 proposed rule data file, which has been posted on the Public Reporting & Certificates page of the [ESRD QIP section](#) on cms.gov. These values will be finalized after all data for 2014 national performance have been calculated. And those finalized values will be published in the payment year 2019 final rule — final rule, which will be available this November.

Moving on to slide 34. Now that we've sort of estimated these values, we can also look to estimate the minimum TPS for payment year 2018. As with the estimated clinical measure value, the minimum TPS is yet to be finalized. 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.

We've added this estimated minimum TPS to our now standard illustration of how facilities will be scored, how these scores will translate into a TPS, and whether a payment reduction will be applied for payment year 2018.

On slide 35, we can see the measures, clinical measure subdomains, subdomain weights, relevant calculations, and the scale for the payment reduction, where applicable. And as we've done throughout the presentation, again, measures appearing in the program for the first time are identified with a gold star.

That piece covers a lot of information with respect to scoring methodology for payment year 2018 and changes we'd like to update. Now we'll move on to the portion of the proposed rule that covers a great deal of programmatic grounds.

### **Proposed Programmatic Changes**

So let's take a look at those programmatic changes. We want to review these issues at a very high level at this time to demonstrate some of the aspects of the ESRD QIP that we wish to refine as we go along.

Determining a facility's eligibility for a measure, or even for the ESRD QIP in and of itself for a given payment year, often involves determining when a facility began to operate. CMS uses the CCN Open Date to mark that benchmark, and some confusion has emerged surrounding how that data's identified.

On slide 37, CMS would like to clarify that we use the Medicare effective date, the date on which the facility can begin to receive Medicare reimbursement under the ESRD PPS, to identify the CCN Open Date.

Last year's Protecting Access to Medicare Act, or PAMA, amended the Social Security Act provisions regarding the ESRD QIP. Slide 38 addresses how we look to address the PAMA in the ESRD QIP.

The QIP is required to adopt measures specific to the conditions treated with oral-only drugs. PAMA further requires that any such measure be endorsed by an entity with a contract under Section 1890A or that they be endorsed or adapted by a consensus organization recognized by the Secretary that has expertise in clinical guidelines for kidney disease. CMS determined that the hypercalcemia clinical measure satisfies the statutory requirements mandated by PAMA because it is a condition frequently treated with calcimimetics, which are one type of oral-only drug and is currently NQF endorsed.

Moving on to slide 39. We look to discuss another proposed revision, which is a modification on how the small-facility adjuster is calculated. The goal of the small-facility adjuster is to ensure that any error in measure rates due to a small number of cases at a facility will not adversely affect facility payment. The current calculation uses a lot of facility-specific data to determine the amount of adjustment. And facilities do not always have read ac — ready access for the exact data sets CMS uses to determine that.

To alleviate this uncertainty, CMS proposes using the publicly available national mean as the basis for adjusting the scores on each measure. We posted a detailed analysis of the proposal on the ESRD QIP Technical Specifications page in support of the proposal. Please reference that if you would like to learn or to see more information regarding the small-facility adjuster.

In slide 40, there's another proposal which involves measure maintenance and the development of an ESRD Measures Manual. CMS has already initiated a two-pronged plan for providing the ESRD community with detailed information regarding measure calculation algorithms, as well as an inclusive process for considering recommendations for nonsubstantive measure changes.

Policies adopted in the payment year 2015 final rule establish that CMS will make nonsubstantive measure changes via a process rather than notice and comment rulemaking. As part of this process, we've begun developing the ESRD Measures Manual, which will provide micro-specifications for the measures used in the ESRD QIP and the DFC, or Dialysis Facility Compare. After we release the initial manual, facilities will have the opportunity to provide comments and recommendations for improvement using the JIRA tool referenced in the slide. More information on this process will be forthcoming, as we are very excited about this.

CMS remains committed to making sure that the data it uses to score facility performance is as accurate as possible. The proposed rule furthers this effort by continuing the studies performed in previous years. There are two continuing data evaluation studies described in slide 41 for payment year 2018. And CMS proposes applying a significant TPS reduction for facilities failing to respond to requests for information used to support these validation efforts. We would like to point out that the second study seen on the slide is similar in structure to that used in another CMS Value-Based Purchasing program in order to assure alignment.

Last year's final rule requires the ESRD QIP to assess the impact of the Standardized Readmission Ratio clinical measure, which will debut in payment year 2017. Part of that assessment will involve a CMS study on the access that Medicare beneficiaries will have to care as a result of the SRR. As described in slide 42, CMS intends to publish the methodology for that study later this year.

Finally, we continue to refine ESRD QIP's policies, including ways to encourage facilities to strive for continuous improvement in their delivery of care to patients with ESRD. In slide 43, we describe policies we are considering for future rulemaking, such as increasing the achievement thresholds from the 15<sup>th</sup> percentile to the 25<sup>th</sup> percentile of national performance during the baseline period. We believe that an increase in the achievement threshold would further incentivized facilities to improve performance, thereby improving patient outcomes and, most important, quality of care. We've posted a detailed analysis of the proposal on the ESRD QIP Technical Specifications page as well. It assesses the impact of this policy change on facility payment reduction.

### **Participating in the Proposed Rule Comment Period**

And with that, we will move on to sharing some guidance and recommendations for participating in the comment period of the proposed rule. So let's begin with an overview of the program from a timeline perspective so that you all are aware of the extremely important dates.

Slide 45 provides us with an ESRD QIP timeline. Given the overlap of the rulemaking process and the scoring process, it's easy to see that a lot of activity impacting multiple payment years happens at the same time. This graphic illustration shows us what's going on with the program as we speak.

So right now, we're in the midst of payment implications from the payment year 2015 program. The 30-day preview period — an opportunity for facilities to review their ESRD QIP scores for payment year 2016 — will continue for the next couple of weeks, ending on August 17<sup>th</sup>. Additionally, we have the performance period under way for payment year 2017. And as we've discussed, the comment period for the payment year 2019 proposed rule is under way. In this way, the ESRD QIP can be seen as a series of multiple year programs.

The next slide, slide 46, provides us with a description of the process of creating and implementing Federal regulations included in the period in which the public may provide input on proposed rules. In the past years, the comments that CMS received helped shape the final rules, and they sometimes reflected significant differences from the proposed rules as a result of those comments. For example, the payment year 2015 proposed rule included hypercalcemia as a clinical measure. But CMS changed course in the final rule due to the feedback it received as part of the comment process.

The hypercalcemia measure finalized for payment year 2016 was written in part to address the issues that commenters raised last year. Therefore, your participation in the process is essential in creating the best possible program for measuring facility performance and providing quality care to the ESRD population. Again, please note that the comment period will end at 11:59 p.m. eastern standard time on August 25<sup>th</sup>.

On slide 47, we've provided a chart to help you find your way around the pretty lengthy proposal and to get specific details in the proposal more easily. This is offered to assist you in reviewing and commenting on the rule. Please do read the proposed rule in its entirety to ensure you have all the pertinent information.

Perhaps the most convenient way to submit a comment is online via [regulations.gov](https://www.regulations.gov). Please see slide 48 for a screenshot of that home page. You can use the Search box to navigate to the rule and the comment portion. We were able to use several search terms that successfully returned the proposed rule as a result, including the file number as pictured in the slide and calendar year 2016 ESRD PPS, which is part of the proposed rule's formal title.

On slide 49, we provide a screenshot of our search results. The proposed rule is the second result returned when using the file number. The first result refers to the initial display of the proposed rule prior to its publication in the *Federal Register*. It is not the version linked to the comment functionality. Please use the Comment Now button to submit your comments.

This slide, slide 49, also identifies some resources for additional help in using the system. You can upload files as a part of your comment as well. On this comment form, your State, ZIP code, country, and your category are now required fields. You must also disclose whether you're submitting the comment on behalf of a third party, as well as that organization's name, as described on slide 50.

Of course, you do not have to use the online interface to submit comments, as explained in slide 51. In this slide, we have identified 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 on this can be found at the very beginning of the proposed rule.

With that said, to recap today's presentation, the proposed rule for payment year 2019 shares a lot of structure with payment year 2018 but includes new measures and important programmatic changes.

### Resources and Next Steps

On slide 53, we list some useful content about the program that is available online, including [MIPPA](#) — information on MIPPA, [the ESRD QIP section at cms.gov](#), the [ESRD Network Coordinating Center](#), links to [QualityNet](#), [Dialysis Facility Compare](#), and the link to the [proposed rule](#) itself.

Finally, on slide 54, there are a few actions that we recommend you all take in the remainder of 2015. These steps include commenting on the proposed rule by the August 25<sup>th</sup> deadline, reviewing your Preview Performance Score Report, reading the payment year 2019 final rule when posted in November, as well as reviewing the Final

Performance Score Report when it's made available in December through the ESRD QIP 1.0.0 system, and posting payment year 2016 PSCs in both English and Spanish in your facility when they become available, along with the PSR in mid-December.

With that being said, CMS appreciates your cooperation, input, and recommendations. We thank you very much for your attention. And I will now hand the presentation over to Aryeh to proceed to our question-and-answer portion. Thank you Aryeh.

## Question-and-Answer Session

Aryeh Langer: Thank you Tamyra for that very comprehensive presentation. Our subject matter experts will now take your questions. Before we begin, I would like to remind everyone that this call is being recorded and transcribed. Please state your name and the name of your organization once your line is open. In an effort to get to as many participants as possible, we ask that you limit your questions to one per caller.

All right, Kalia, we're ready to take 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. 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&A roster.

Please hold while we compile the Q&A roster.

Your first question comes from the line of Joann Simard.

Joan Simard: Yes, this is Joan Simard from Intermountain Healthcare in Salt Lake City. I have a very large concern. I'm doing my ESRD QIP right now on my ICH CAHPS. I am finding patients listed there that either transferred out, were transplanted, or expired prior to January 1<sup>st</sup>, 2014, or patients that were never at my facility but went to the local transplant hospital at some point prior to January 1<sup>st</sup>, 2014, and they're on my ICH CAHPS list. My concern is, what is the source of these things? And is this going to have some kind of an impact in the future when we're looking at the hospital readmissions and my ICH CAHPS and transfusions in the future? Am I still going to see individuals that are no longer active during that period? These patients are also showing up on my improvement ESRD QIP lists as well.

Tamyra Garcia: Good afternoon Joan, and thank you so much for your question. I would advise you to submit a clarification question through the ESRD QIP 1.0.0 System, so that we can have folks sort of take a look at that to see what you might be encountering. That would sort of be the best mechanism to have that question answered.

Joan Simard: I have done that. And I'm finding out from my network that other hospitals or other dialysis organizations are seeing the same thing, where patients that are not affiliated with us but go to the local hospital are being attributed to us for the ICH CAHPS. And I'm concerned that they're going to also be using that data source, that data pool, for the readmissions in the future as well as transfusions. And I don't want to see that impact my thing. I've already — I've already addressed that.

Tamyra Garcia: OK, great. So now that I understand that other facilities may be encountering this, it may also be beneficial to submit an option that we've included. It's called a systemic clarification question. And so, I would advise you to initially talk to the other facilities to obtain information from them, and submit a systemic clarification question, sharing that you're not the only facility who's experiencing this so we can look at this issue in a systemic level.

Joan Simard: I've already done this for my organization, ...

Tamyra Garcia: OK.

Joan Simard: ... but the network is telling me it's other organizations as well besides Intermountain.

Tamyra Garcia: OK, so what we'll do is, while that's going through the clarification question process, you know, — I'll look — I'll look into it, and we should reply to you shortly.

Joan Simard: Thank you.

Tamyra Garcia: I will let our — the folks know who are sort of analyzing the question and the issue, I will let them know that you and I spoke during the National Provider Call, and that we should definitely focus on resolving this issue.

Joan Simard: Right, because I've submitted those inquiry questions — the clarification questions — last week. And I keep going into the ESRD QIP thing, and I don't see any kind of a notice for clarifications from CMS yet.

Tamyra Garcia: OK, thank you. You should be hearing from us soon.

Joan Simard: All right. I'm back in the queue I think because I have other questions as well so, well if I can get to them later. Thank you.

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

Susan Carson: Hi, I'm calling from Renal Hypertension Centers, and we do the physicians' billing. Does this impact our monthly dialysis billing at all?

Tamyra Garcia: Thank you for your question, Susan. Can you give me one moment to consult with the team?

Susan Carson: Um-hum.

Tamyra Garcia: Thank you.

So the answer to that question is no, it does not impact your billing, but it does impact your reimbursement. So as you well know, facilities can receive up to a 2 percent reimbursement reduction, but it does not impact your billing.

Susan Carson: OK, because we're not associated. We're just a group of physicians. We are not a dialysis center.

Tamyra Garcia: OK, so, just that — you will most likely not be included in the ESRD QIP.

Susan Carson: OK. All right, thank you very much.

Tamyra Garcia: Thank you.

Susan Carson: OK.

**Operator:** Your next question comes from the line of Bruce Upton.

Bruce Upton: This is Bruce Upton with Ozarks Dialysis. I have a question about the slide 21, the ultrafiltration rate. And my question is, your formula says this, "number of months successfully reporting." Is successfully reporting 100 percent of your patients? How do you define successfully reporting?

Tamyra Garcia: Thank you for your question, Bruce. Please give me a moment to consult with the team.

So, Bruce, in an effort to answer your question, we have determined that successfully indicates that you've reported 90 percent — I mean, 97 percent, I apologize, of your patients.

Bruce Upton: Ninety-seven percent?

Tamyra Garcia: Yes.

Bruce Upton: OK, thank you.

Tamyra Garcia: Um-hum.

**Operator:** And as a reminder, to ask a question, please press star followed by the number 1 on your touchtone phone.

Your next question comes from the line of Christi Lines.

Christi Lines: I'm Christi Lines from CDC in Dallas, Texas. Thank you for your presentation. Would you please explain how the 50<sup>th</sup> percentile performance standard for a clinical measure is used to calculate the Total Performance Scores?

Tamyra Garcia: I'm sorry, are you referring to the mTPS, the minimum Total Performance Score?

Christi Lines: I was wondering about the performance standard, the 50<sup>th</sup> percentile. How is that incorporated into the Total Performance Score, if at all?

Tamyra Garcia: So it's not incorporated into a facility's performance score. It is associated with the development of the mTPS, the minimum Total Performance Score, which is what facilities are evaluated against.

Christi Lines: And the mTPS would be that 39 number QIP?

Tamyra Garcia: Yes.

Christi Lines: I see, thank you very much.

Tamyra Garcia: Um-hum.

**Operator:** And there are no further questions in queue.

## **Additional Information**

Aryeh Langer: Oh, well, thank you very much for everybody for participating in today's call. As a reminder, an audio recording and written transcript of the call will be posted to the [MLN Connects Call](#) website. We will release an announcement in the [MLN Connects Provider eNews](#) when the material becomes available.

On slide 57 of today's presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few minutes to evaluate your experience today.

Again, my name is Aryeh Langer. I'd like to thank our presenters here at CMS and also thank all of you on the lines for participating in today's MLN Connects Call. Have a great day everyone.

This document has been edited for spelling and punctuation errors.

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

-END-

