



ESRD QIP: Final Rule for Calendar Year 2018 Call

Moderated by: Leah Nguyen
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Table of Contents

Announcements & Introduction.....	2
Presentation	2
CMS Strategic Goals.....	2
CY 2018 ESRD PPS Final Rule	3
ESRD QIP Overview	4
CY 2018 ESRD PPS Final Rule: ESRD QIP Policies	4
Changes Impacting 2021	6
ESRD QIP Q&A Tool	8
Question and Answer Session	8
Additional Information	17

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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® Event.

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 Leah Nguyen. Thank you. You may begin.

Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS and I am your moderator today. I'd like to welcome you to Medicare Learning Network call on End-Stage Renal Disease Quality Incentive Program or ESRD QIP.

During this call, learn about provisions in the calendar year 2018 ESRD Prospective Payment System final rule, including plans for the ESRD QIP and payment year 2019, 2020, and 2021. A question and answer session will follow the presentation.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL: go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

At this time, I would like to turn the call over to Tamyra Garcia.

Presentation

Tamyra Garcia: Thank you very much and good afternoon, everyone. We really appreciate you joining us today to discuss the ESRD QIP policies finalized in the calendar 2018 rule. But before we begin, I'd like to take a few moments to do two things, first, to direct you to slide 2 to ensure that you all are aware of the acronyms in the presentation and some explanations provided there for your convenience.

And second, I'd like to just take a few moments to highlight CMS's strategic goals, which could be found on slide 4. As you all well know, CMS has always been dedicated to putting people first. And in order to ensure we fulfill this main goal, CMS seeks to do the following things strategically.

CMS Strategic Goals

The first thing we look to do to achieve this goal is empower patients and doctors to make decisions about their health care. And some of the activities related to this include reducing burden from regulations so that providers are able to focus on high-quality health care to their patients. Some of the more recent initiatives, including the Patients over Paperwork initiative and the Meaningful Measures initiative, reflect this desire to move forward with this strategic goal.

Next, we'd like to put policies in place that build a patient-centered system of care that increases competition and quality, along with access. We're also looking to empower patients to really take ownership of their health and ensure that they have the flexibility and information, whether that be public reporting or other mechanisms, to make choices that they seek care.



The second major goal that we'll look to achieve is to usher in a new era of state flexibility and local leadership. And although we're not speaking to that on the call today, we're really sort of ensuring that states are accountable for achieving outcomes and results and states and local communities have the flexibility to design and innovate programs to something that the agency is interested in doing as well.

Next, we're looking to support innovative approaches to improving quality, accessibility, and affordability. And in order to do this, we're looking to use data-driven insights to ensure cost-effective care, which leads to improvement in patient outcomes. So that item is very much related to what we'll be discussing today.

Another subset of that goal is to really look to leverage technology like the EQRS system to identify and prevent waste, fraud, and abuse so that we can focus on providing high-quality care to beneficiaries.

We're also, last but not least, looking to improve the CMS customer experience. And that requires that we provide patients and providers with the tools that they need to make decisions that best work for them. It also requires that we empower states with their efforts to drive innovation and improve quality and health outcomes at the state level, not simply at the national level.

So that, in a nutshell, is really sort of the main focus of CMS in the context of their strategic goals currently. And it's a lot to think about, a lot of great information on the CMS website for those who'd like to learn more. And, with that being said, we appreciate you taking the time out of your busy day to engage with us.

And what I'm going to look to do now is turn it over to the speakers who will be presenting on the ESRD QIP calendar year 2018 final rule, Celeste Bostic, who is the clinical subject matter expert for the program, who will be followed by Joel Andress, the CMS ESRD Quality Measures Lead. Thank you.

CY 2018 ESRD PPS Final Rule

Celeste Bostic: Thank you so much, Tamyra. Good afternoon, everyone, and thank you for joining us to discuss the ESRD QIP's most recent final rule.

The calendar year 2018 final rule was published in the federal register on November 1, 2017. We have provided a link at the end of the presentation on slide 27.

Here on slide 5, today, we will provide an overview of the policies finalized in the calendar year 2018 final rule. At the end, we will open the call up for questions.

After attending today's presentation – on slide 6 you'll find the objectives. We hope that participants will be able to locate the calendar year 2018 ESRD PPS final rule, identify changes that we finalized in the calendar year 2018 proposed rule for payment years '19, '20 – '19 and 2020, and describe the finalized policies for the payment year 2021 program.



ESRD QIP Overview

On slide 7, we will begin with an overview of the program so that you are all familiar with the basics of the ESRD QIP. I know most of you all are familiar with this information, but since we may have some new participants in the audience, I'd like to make sure we all start off together.

On slide 8, we'll begin with a quick legislative overview and a summary of current measures and a review of the rulemaking process. As many of you well know, the ESRD QIP was established by the Medicare Improvements to Patients and Providers Act of 2008 or MIPPA, adding a new subsection, H2, Section 1881 of the Social Security Act.

This was later amended by the Protecting Access to Medicare Act, or PAMA. The program incentivizes high-quality care for outpatient dialysis facilities by adjusting Medicare payments to those facilities that fail to meet performance standards on specified quality measures.

The table on slide 9 lists the finalized measures and performance periods for payment year 2019, which measured facility performance last year which was calendar year 2017. The table also shows payment year 2020, which measures facility performance in calendar year 2018.

Comparing the two payment years, you will see that the standardized hospitalization ratio, clinical measure, and the ultrafiltration rate reporting measure were added to payment year 2020 and the Mineral Metabolism reporting measure was replaced with the Serum Phosphorus reporting measure.

Slide 10 provides an overview of the process CMS uses to develop ESRD QIP rules. By issuing a proposed rule, CMS proposes quality measures for a given payment year, as well as how those measures will be scored. Then, the public has a 60-day opportunity to comment on the proposals and to suggest approaches it would like to see in the program. In this way, facilities and the general public have an opportunity to influence policy governing each payment year.

CY 2018 ESRD PPS Final Rule: ESRD QIP Policies

We'd now like to turn our attention to the policies that were finalized in the calendar year 2018 final year. On slide 12, as a part of the rule development process following publication of the proposed rule, the public is provided a 60-day period within which to provide their comments on proposed policies. These comments help to inform and guide further adjustments to the proposed rule. As you know, CMS pays close attention to the comments received by the public.

As you see on slide 12, we received about 58 public comments on the proposed rule this year and we incorporated the feedback we received in the policies we ultimately finalized.

On slide 13, we will now discuss the specific policies that were finalized. The first is the simplification of the Performance Score Certificate or PSC beginning in payment year 2019. This was one of our burden reduction efforts for the program.



We finalized our PSC policy to simplify language and improve readability based on feedback we received from facilities and patient organizations. We recognize that the amount of information contained on the PSC can be overwhelming for patients and families and also burdensome for facilities to post on their walls.

When the payment year 2019 certificate is released in December of 2018, it will continue to reflect the total performance score that the facility achieved, as well as basic clinic identifying information, including the name and the address and so on for the facility.

In addition, we will include a comparison to the national average TPS for that year. We also plan to provide an additional explanation of the scores for patients and families. This will no longer be contained in the certificate.

Slide 14 shows the major policy changes that we finalized for payment year 2020. We will discuss each of these in greater detail in the coming slide.

Slide 15 shows the clarification of the minimum data policy for scoring measures that we adopted in the final rule. We finalized a correction to count the number of months the facility is open on the first day of the month after the facility CCN Open Date. We have included a reference here to the calendar year 18 final rule for additional information on the minimum data requirement.

We also expanded our ECE policy to accomplish the three goals shown on slide 16. The expanded policy allows the Authorizing ECE Form to be signed by the CEO or designated personnel and allows additional circumstances during which a facility may request an ECE. We made this change in response to stakeholder feedback in an effort to better align with other VBP programs and increase flexibility for facilities.

We also adjusted our sampling approach for the NHSN-based measure validation with the intention of collecting a more representative sample of participating facilities. The purpose of the validation efforts is to ensure that facilities report accurate information so that CMS can calculate similar accurate TPS scores.

Here on slide 17, this expanded validation process includes facilities that are doing well, as well as those that have been identified as being at risk for under-reporting. Once a CMS contractor sends a request to a facility for medical records, the facility will have 60 calendar days to respond to the request and send records for all patients with candidate events during the evaluation period. This would include patients with positive blood cultures and those receiving antibiotics.

On slides 17 and 18, we show the finalized payment year 2020 performance standards that will be used to score clinical measures. These values can also be found in the finalized rule.

On slide 20, we have the minimum Total Performance Score or mTPS that a facility must achieve to avoid a payment reduction in payment year 2020. The finalized minimum TPS is 59 points. The range for each payment reduction can also be found in the table at the bottom of the slide. Facilities that meet or exceed the minimum TPS will not receive a payment reduction.

Now, I'd like to turn the presentation over to my colleague, Joel Andress, the ESRD Measures Lead, who will discuss changes impacting payment year 2021, as well as provide an overview of the payment year 2021 measures and scoring methods. Joel?

Changes Impacting 2021

Joel Andress: Thank you so much; I appreciate that. Good afternoon, everyone. My name is Joel Andress. As Celeste brought out, I am the Quality Measure Lead for the dialysis facilities here at CMS.

On slide 21, you can see the major changes to quality measures – I should say the only changes to quality measures – for payment year 2021. As I think many of you are probably aware, we did not add any new measures to the program, rather, we have updated the standardized transfusion ratio and we have replaced the previous vascular access measures with two new vascular access measures that were developed by using the VAT recently in 2015.

The original vascular access measures are replaced by two measures that allow for individual – more individualized care through the use of risk adjustment in the case of the fistula measure and, in the case of both measures, an expanded set of exclusion criteria.

And the attempt with this was to address clinical concerns that the previous measures were too expansive in their requirements and did not reflect certain cases in which a placement of a fistula would not be appropriate for a dialysis patient or wherein a catheter may be appropriate for an access for certain kinds of patients, for instance, those who are terminally ill.

The Standardized Transfusion Ratio has been updated to align with the NQF-endorsed measure specifications and we'll continue to monitor the overuse of blood transfusions in an area of more conservative dosing of ESAs. The measure revisions themselves were intended to address concerns about regional variability and hospital coding of transfusions. The changes essentially removed the potential bias that could be introduced during that variability.

The vascular access measures are likewise endorsed by the National Quality Forum, were supported by the measures application partnership, and can currently be calculated using data that facilities are already reporting. A key point for all of these measures is that there is no additional data collection or modification to current data collection required for the implementation of these measures. That means that they won't require any changes to what you're already submitting to us in order for them to be implemented within the program and used to calculate the TPS.

We move to slide 22. You can see the full overview of payment year 2021 measures. The measures that have been modified or replaced are indicated by a gold star.

As you can see, the overall structure of the program's measures, including the domains and the weighting of those measure domains remains essentially unchanged from payment year 2020. And the consequence of this is that there isn't a whole lot to discuss in terms of any changes to those domains. The main – the main change that will interest you at this point are the switch – are the switching out of the specifications to the updated and NQF-endorsed versions for the three measures we discussed on the last slide.

On slide 23, we provide a slide that describes an overview of the scoring method that is applied to calculate the TPS. And because there really hasn't been a lot of change to the measurement domains or the structure of the



measures themselves, the scoring methodology has likewise not changed over much, and so we don't intend to spend a great deal of time on it.

If you're interested in greater detail, then you may find that detail in the final rule materials for the payment year 2020 NPC. You may also look at the ESRD QIP section of cms.gov to review the CMS ESRD measures manual and review the CMS ESRD measures manual posted on the measuring quality page.

We're now going to turn to two topics for which we sought and received comment in last year's rule, those two topics being acute kidney injury and social risk factor adjustment. On slide 24, we'll discuss briefly the comments that we received regarding the inclusion of AKI patients within the ESRD QIP.

I think, as most of you are aware, CMS has begun reimbursing dialysis facilities for treatment provided to AKI patients and there has been a fair amount of discussion about whether or not the care provided for these patients is appropriate for inclusion in the ESRD QIP.

CMS is preferring at this time to take an advised approach with regard to AKI patients, so we are – we did not currently including them in any of the measures within the ESRD QIP. That said, we are, we did collect comments on the issue and I think the comments were split a bit in terms of how to address the issue and we're still – we'll be taking that into consideration.

In some cases, commenters supported the inclusion of AKI patients under the rationale that acute kidney injury is increasing in prevalence or in incidence, I should say. And as it becomes an increasing issue and is a more frequent form of therapy provided by dialysis facilities, is going to require quality measurement in the same form as – in the same way that care is required for other – for – I should say, for ESRD dialysis patients.

That said, there are a lot of concerns raised by the community about including the AKI patients in the ESRD QIP. These included concerns about the appropriateness of the current measure set, the measure specifications for these patients, and they tend to recommend collecting data on AKI before making any decisions about the inclusion of AKI patients.

At present – well, I should say, but you can review the comments – the specific comments that we received and the responses to those comments in the CY2018 final rule, which is published from the Federal Registry.

We are intending to continue collecting feedback on how to incorporate AKI patients' information into ESRD QIP in the future. I should also note that we are considering, on a more individualized basis, whether or not specific quality measures can or even should incorporate AKI patients within the numerator or denominator specifications. And I think, you know, until we've had a chance to analyze that we'll very much be in an investigative mode for this issue.

On slide 25, we turn to comments that we sought regarding how to account for social risk factors. This is an issue that we've sought comment on across a number of settings, not just dialysis facilities. I think at present there are concerns amongst the dialysis community that ESRD patients are disproportionately affected by social risk factors and I think our evidence certainly bears that out and that it's important to understand how risk adjustment can be used to address this.



I think there are some recognition in the comments that we received that we both want to appropriately account for factors that are outside of the facility's control, but also ensure that we don't mask disparities in the actual care that is being provided by dialysis facilities. We are continuing to conduct additional research.

We're also making—in this topic we're also staying abreast of the work being done by ASPI under the Impact Act to investigate appropriate ways to address social risk factors within quality programs in general. And we expect that we will be taking into account both your feedback and the input from these research efforts in the future through rulemaking.

So I certainly want to say thank you for the comments that you've provided to date and expect to hear more back from you on both of these topics in the future.

Now I'll hand the discussion back over to Celeste. We'll discuss with you the ESRD QIP Q&A tool.

ESRD QIP Q&A Tool

Celeste Bostic: Great. Thanks, Joel. We will now begin the Q&A – the question and answer portion of our presentation. There may be some questions that we may – we will be unable to answer on today's call.

Those questions that remain after we take a look at the resources found on slide 27 can be sent to the ESRD QIP question and answer tool which can be found on slide 26. This tool will largely replace the ESRD QIP mailbox. It will help streamline communications and provide faster responses to questions about the program.

The tool will provide ready access to answer common questions through the Frequently Asked Questions feature. Again, on – after you review the information found on slide 27, please feel free to submit your questions to the Q&A tool.

For our question and answer session, we also have a few of our support contractors on the line to assist us with responding to your questions. And, with that, I'll turn the presentation over to Leah.

Question and Answer Session

Leah Nguyen: Thank you. We will now take your questions. As a reminder, this event is being recorded and transcribed. All right, Dorothy, we are ready for our first caller.

Operator: To ask a question, press star, followed by the number 1 on your touch-tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity. Once your line is open, state your name and organization.

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. If you have more than one question, press star 1 to get back into the queue and we will address additional questions as time permits. 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 Susan Senich.



Susan Senich: Hello. Susan Senich, North Central Pennsylvania Dialysis Clinics. I have a question on the standardized hospitalization measure. Is that – are they only considering unplanned hospitalizations? Is – are there exclusions in the measure?

Joel Andress: Thank you for your question. This is Joel Andress, ESRD Measures Lead. The answer to your question is that, no, the standardized hospitalization ratio does not take into account planned or unplanned status for hospitalization. It includes all hospitalizations within the patient population.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Joe Rich.

Joe Rich: Hi, yes. I'm just looking for some clarification on the vascular access. Oh, Joe Rich. I'm with FMC, Vice President of Quality in the Western Group.

Anyway, I'm – what I'm calling about is the dialysis vascular access standard that you were talking about, catheters for those who are terminally ill and then fistulas and the rate for those who may not be a good candidate. Is there any clarification, definitions of that somewhere that I could look up, or that you're going to be sending out after this call?

Joel Andress: Thank you for your question, Joe. This is Joel. So, first of all, we have technical specifications up on the CMS website on the ESRD QIP page. They are also available on the ESRD measures manual.

I would also point out that you can look for the standards for the measure at the National Quality Forum under the NQF number, which is 2978, where you can read about the measure specifications, including the denominator exclusion.

Just for your information here, with regard to the exclusions for limited life expectancy, we've excluded patients from the measures who are under hospice care in the current reporting month, patients with metastatic cancer in the past 12 months, patients with end stage liver disease in the past 12 months, and patients with coma or anoxic brain injury in the last 12 months. At – if you look at NQF you can actually get a – some additional detail with regard to the data dictionary and the data sources for those elements.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Deborah Holinski.

Deborah Holinski: Hi. This is Debbie Holinski from Winthrop University Hospital. Another question to follow up on vascular access. So I have the actual technical specifications and, with those exclusions that are listed, how or where are we going to be documenting that to make sure that those patients that meet the exclusions aren't included in the database?

Joel Andress: Thank you. So the current method for identifying those exclusions is through the – is through Medicare claims data. So we currently don't require additional documentation from you, but we do incorporate it through Medicare claims.



Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Stacey Catanya.

Stacey Catanya: Good morning. This is Stacey. I'm from Fresenius in Anchorage, Alaska.

I'm just going to piggyback on the same thing with the long-term catheter rate. The exclusions are appreciated. Have we ever considered excluding those patients who are not candidates for permanent accesses? I know I've been working here for about 7 years and I have the same patients that they're just not a candidate for any type of fistula graft, anything like that. And so, it's – they're always on it against me.

Joel Andress: This is Joel again. So I think the exclusion criteria we've included within the measure were those that were recommended by the technical expert panel for inclusion in the measure inclusion, but then were recommended for the – by the panel for exclusion criteria to get at just that issue.

I think if there are additional exclusion criteria that you'd like us to consider for implementation of the measure, we would certainly welcome that. I think the Q&A tool would be a good way to submit those – that information to us – and then we can take it back to our maintenance process. But we don't currently have additional exclusions available for the measures.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Shelly Guyer.

Shelly Guyer: Hi. This is Shelly with Children's Mercy in Kansas City. I have a couple of questions. The first one is about the standardized readmission ratio and I'm asking if the index discharge or the unplanned 30-day admission afterwards, do they have to be inpatient admissions or do observation admissions count just like an inpatient would?

Joel Andress: Thank you, this is Joel. The index discharge has to be an inpatient admission. Observation stays and any visits do not count toward the index stay at this time.

Leah Nguyen: Thank you.

Shelly Guyer: Okay.

Operator: Your next question comes from the line of Amy Marthenze.

Amy Marthenze: Hi. Amy Marthenze calling from Aspirus Hospital. And my question is about the standardized hospitalization ratio.

Just wondering where I can find information on how we would calculate the denominator for the expected among our eligible patients at the facility so that we could calculate that and see how we're doing throughout the year?



Joel Andress: So because of the nature of the standardization model, it's not possible for you to calculate the expected value. The reason for that is the required data from all other hospitals, or, I'm sorry, from all other dialysis facilities as well, in order to calculate the model.

What we can provide for you are stay-level data on request that allows you to identify what patients are incorporated within the calculation so you can review those. But, unfortunately, HIPAA requirements prevent us from being able to provide you more detailed information about patients treated at other facilities.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Theresa Foushee.

Theresa Foushee: Good afternoon. This is Theresa Foushee and I am with the Nancy and C.J. Lewis Cancer Research Pavilion. We are hospital outpatient-based, and this question, listening to everybody, may be a little off topic.

We are just trying to find out, with the new codes that have been deleted for payment for ESAs and anti-neoplastic chemotherapy and chronic kidney disease, are those only being billed by nephrologists now, or are they still payable with us billing? It's the D63.0.1 and the T451X.

Joel Andress: Hello. This is Joel. So this isn't a measure issue, but it's also unfortunately not an issue that we're going to be able to address. I think there are others here at CMS that could address that question more adequately than we're equipped to do.

My suggestion would be to submit the question to the Q&A tool and then we can see to it that your question gets to the right people. Unfortunately, we're not going to be able to answer it satisfactorily, I think.

Leah Nguyen: Thank you.

Operator: As a reminder, if you would like to ask a question, please press star, then the number 1 on your telephone keypad. Your next question comes from the line of Arturo Corotan.

Arturo Corotan: Yes. And the question is what is the information about adding AKI patient to QIP?

Joel Andress: Thank you. This is Joel. So I think the decision right, for now has been to not incorporate the patients in AKI. If we did incorporate AKI patients into the QIP, it would probably most – it would most likely be in the form of updates to individual quality measures where that was considered to be appropriate.

Right now what we're planning to do is investigate the appropriateness of doing so for specific measures? So that we can determine whether or not a given clinical measure can appropriately be applied to AKI patients. And that's something that we're in the process of investigating and I don't think until – but until we make a change to the policy through rulemaking, AKI patients are not and will not be included in – within the program.

Leah Nguyen: Thanks.



Operator: Your next question comes from the line of Lynette Stipp.

Lynette Stipp: Yes. I'm – again, this might not be a question for you guys, but I'm – also would like further interpretation of the billing for calcimimetics in medications, oral medications. Is it mandatory that we contract now with the pharmacy and provide those such as Sensipar for dialysis patients? And, if not, I'm looking for a resource for that.

Celeste Bostic: Hi, Lynette. This is Celeste. Thank you so much for your question. Again, we ask that you submit that through the Q&A tool and we will be happy to provide you with the contact information for the ESRD payment team. Thank you.

Operator: Your next question comes from the line of Herbert Williams.

Herbert Williams: Good afternoon, everyone. I'm calling in reference to the ESRD QIP DFP, the dialysis facilities performance scoresheet. I'm not sure if this is online with anyone that can answer this question.

But I'm looking at the total performance score and I'm wondering if, out of the 10 questions or 10 categories, if a majority of them do not apply to our facility, are we still graded based on a 10 that's listed, or do we just get graded by the three or four that apply to our facility?

Celeste Bostic: Hi, Herbert. This is Celeste. Thank you so much for your question. Just to clarify, are you referring to the performance score certificate, the information contained on that?

Herbert Williams: Yes.

Celeste Bostic: Okay. So you will – you'll find scores that are – for the measures that your facility was eligible for that year.

Herbert Williams: Right.

Celeste Bostic: And for those that your facility was not scored on or were not eligible on, you'll see an NA there. So are you looking to find out more about which ones – which measures you are eligible for?

Herbert Williams: No. I see what you're referring to, the ones that we're eligible for and not eligible for. Some of my colleagues wanted to know because of the score that we had, 26 out of 100 compared to last time, we had, like, 58 out of 100, the numbers are pretty much the same and we're just trying to figure out, did the NAs take us – or have any factor in the grading or was it because the scores were slightly off that it dropped from 58 to 26.

Celeste Bostic: Right. I totally understand. So it – that's a really specific question to your facility that we would definitely be happy to look into and dive a little deeper for you to provide you more explanation.

Usually that – those type of questions are handled during our preview period over the summer, but we – we're happy to provide you with some additional clarification on your score. So please submit that question to the



Q&A tool and be sure to include your CMS certification number so that we can look into your facility and provide you with further details. Thank you.

Herbert Williams: Yes, ma'am. Thank you.

Celeste Bostic: Thank you.

Operator: As a reminder, please limit yourselves to one question, and if you have more than one question, press star 1 to get back into the queue and we will address additional questions as time permits. Your next question comes from the line of Sumi Sun.

Sumi Sun: Hi. This is Sumi from Satellite Healthcare. I have a quick question. I was just wondering what data periods was – were used to calculate the standards that were shown on slide 18 and 19.

Celeste Bostic: Thank you, Sumi. Give me one second. This is Celeste. Give me one second while I flip back to that slide for you. And will someone from Arbor Research be able to provide us with the dates for those performance measures – performance standards?

Alissa Kapke: Hi. This is Alissa from Arbor Research. We couldn't hear the question very well, but we would recommend that you submit this through the Q&A tool and then we can respond that way so that we can make sure that we give the proper response.

Sumi Sun: Okay.

Operator: Your next question comes from the line of Sonia Shepherd.

Sonia Shepherd: Hi, everyone. This is Sonia Shepherd. My question is in regards to the transfusion ratio that is now null on the measure.

For my center especially, I have candidates highly acute with (trach) patients that come outside for outpatient dialysis. We do not give transfusions in the center, they go to the hospital for these needed transfusions secondary to leukemia, cancer, and other GI bleeds. I'm wondering what was the need to have this included in the dialysis performance score for the transfusion ratio.

Joel Andress: Thank you. This is Joel. We'll start with – the answer to the – to the rationale for why we included the transfusion ratio measure is that the intent of the measure is to reduce excessive numbers of transfusions within the – within the dialysis population for all the reasons you want to reduce transfusions.

The measure is intentionally developed to include transfusions that occur outside of a facility. The goal isn't to reduce the number of transfusions of the dialysis facility it chooses to undertake, but rather to assess the need for transfusions to occur as a result of anemia management provided by the dialysis facilities.

So, for that reason, and in the same way we would want to capture hospitalizations and readmissions for–as outcomes of care for dialysis patients, we also want to capture transfusions that patients receive even if those transfusions don't occur within the dialysis facility itself.



Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Charlene Podach.

Charlene Podach: Good afternoon. This is Charlene and my question is pertaining to – I hear everybody talking about, like, the transfusion ratio; the patient data vascular access; you know, standardized hospital ratio.

Are you talking about the data that's submitted into CROWNWeb, or where is this information submitted to that you're gathering this information from?

Joel Andress: Thank you. This is Joel. So it depends – the specifics depend on the measure. For the standardized measures that you've referenced, we frequently – we primarily use either Medicare claims data or data off of the 2728 evidence form for the measures. So there's no additional data typically that are submitted by the dialysis facilities to support their calculations.

We incorporate claims data for patients from – essentially from all sources, inpatient, outpatient, and so on; for the risk adjustment models for identifying hospitalizations and readmissions and for the purpose of identifying transfusion events. So there's not a reporting requirement associated with QIP. For those measures they're captured – the data are captured through readily available administrative data that CMS has possession of.

Leah Nguyen: Thank you.

Charlene Podach: I'm sorry. You said the 2728 and what was the first thing?

Joel Andress: Medicare claims data inpatient and outpatient claims.

Charlene Podach: Okay. So Medicare claims data and the 2728 is where you pull all of this type of information?

Joel Andress: Right. And if you...

Charlene Podach: Okay.

Joel Andress: If you look at the measure specs as they're provided on the National Quality Forum's website, the Forum will have the dictionary data – I'm sorry, the data dictionary that will provide those details about where those are from. They're also available on the CMS ESRD measures manual.

Leah Nguyen: Thank you.

Operator: As a reminder, if you would like to ask a question, please press star, then the number 1 on your telephone keypad. Your next question comes from the line of Adrienne Adkins-Provost.

Adrienne Adkins-Provost: Hi. This is Adrienne from Fresenius Kidney Care. I have a couple of questions and I wanted to – we received from one of the CMS leads an adjusted measure weight percentage chart that



included the adjusted weight for a facility that's a home-only facility and it had an error with regard to the ultrafiltration rate in it and we're wondering if...I requested a QIP tool to get another copy of that spreadsheet, and I'm wondering if I could request another copy of that spreadsheet.

Celeste Bostic: Hi, Adrienne. This is Celeste. Yes, thank you so much for your question for following up. Yes, we are – we will – we are happy to provide you with that information via the question and answer tool.

Adrienne Adkins-Provost: Okay. Thanks, Celeste. I have two more questions. We're expecting the list for the CROWNWeb NHSN DBR audit and I'm wondering – it's very late, and I'm wondering if there's any timeline for expectations that the facilities that are part of that sample.

Celeste Bostic: Are you referring to the validation study?

Adrienne Adkins-Provost: Right. The CROWNWeb NHSN data validation audit.

Celeste Bostic: Sure. Yes. You can absolutely send that question as well and I can certainly follow up. The letters, if they have been mailed already, the facilities have been contacted, so perhaps your facilities maybe haven't been selected. But we can – I can certainly follow up to ensure that those letters have been mailed.

Leah Nguyen: Thank you. And if you have additional questions, please press star 1 and you can get back into the queue.

Operator: Your next question comes from the line of Navina Reddy.

Navina Reddy: Hi. I'm a quality management consultant. Quick question, I ran into the Quality Net Q&A webpage and there are quite a few questions, but they look more like a Frequently Asked Questions.

But is there a way for me to look up on, let's say, someone like Celene put it up there, a question like in other administrators? Is there a way to access those as well?

Celeste Bostic: Hi. This is Celeste. Thank you so much for your question. That's a really excellent one.

So, currently, no, the tool does not allow you to see questions that other people submitted. However, we do plan to make all questions that are submitted via the tool Frequently Asked Questions. So you will be able to see what others submit via the Frequently Asked Questions. So over time you'll – you will see additional questions added to that function.

Navina Reddy: Okay. So just to get to the consensus of what others are responding, I will not be able to see at this time, right, basically what you responded?

Celeste Bostic: Right. As we begin to move all questions that we receive through the tool into Q&A, Frequently Asked Questions, you will begin to see those questions pop up. So you won't be able to see each and every one that is submitted, when they're submitted. But we will be pulling – pushing them over into Frequently Asked Questions over time.



Navina Reddy: Okay. Thank you.

Celeste Bostic: I hope that helps. And just to follow up on the question from Sumi around the data periods that were used to calculate the performance standards for payment year 2020, those standards were calculated based on calendar year 2016 data. I hope that helps. You can also find that in the final rule. Thank you.

Operator: Your next question comes from the line of Noah Espinoza.

Noah Espinoza: Hello, everybody. This is Noah Espinoza over at Northwest Kidney Centers. My question today was, to what extent is the SHR measure similar to that reported on the DFR in terms of methodology for calculating that? Thank you.

Joel Andress: Yes. This is Joel. So I will confess that I am not up to date on the specifications and use of the DFR. I believe the DFR is currently making use of the updated specifications; I believe the FHR, which is currently endorsed, which includes Medicare claims data as a source of risk adjustment in the model.

That is the measure that we will be implementing for payment year 2020 that was finalized in QIP. It's the (specifications that were endorsed by NQF and that were reviewed by the MAP and were finalized in the rule. I believe that is – those are the same specifications. Those are also the specifications that will begin public reporting on DFC starting in October 2018.

Leah Nguyen: Thank you.

Noah Espinoza: Great. Thank you.

Operator: You have a follow-up question from the line of Shelly Guyer.

Shelly Guyer: Hi. I also wanted to know – I had called earlier and asked about the index discharge for the SSR needing to be an inpatient admission, so the readmission in 30 – within 30 days also has to be an inpatient admission, correct?

Joel Andress: Yes. That is correct...

Shelly Guyer: Okay.

Joel Andress: We are, in fact, working on developing measures for ED visits that are not implemented in any program, including the QIP, and they function in a way similar to the SHR and the SRR, but they are independent measures. The SHR and the SRR are comprised entirely of inpatient visits both in terms of outcomes and for the SRR's index discharges.

Shelly Guyer: Thank you.

Leah Nguyen: Thank you.

Joel Andress: Certainly.



Operator: There are no further questions at this time.

Additional Information

Leah Nguyen: Thank you, Dorothy. For information on evaluating today's event, see slide 28. Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network Event on ESRD QIP. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters please hold.