



ESRD Quality Incentive Program: CY 2020 ESRD PPS Final Rule Call

Moderated by: Aryeh Langer
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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 Aryeh Langer. Thank you. You may begin.

Announcements & Introduction

Aryeh Langer: Thank you so much, Dorothy. And as you just heard, my name is Aryeh Langer, and I am 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 Medicare Learning Network call on the End-Stage Renal Disease Quality Incentive Program or, simply, ESRD QIP.

During today's call, learn about the finalized proposals for the ESRD QIP and the calendar year 2020 ESRD Prospective Payment System, or PPS, Final Rule. A question-and-answer session follows today's 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/mln-events. Again, that URL is go.cms.gov/mln-events.

Today's event is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the question-and-answer session. If you have inquiries, please contact press@CMS.HHS.gov.

At this time, I would like to turn the call over to Delia Houseal from CMS, who is the Program Lead for the Center for Clinical Standards and Quality's ESRD QIP program. Delia?

Presentation

Dr. Delia Houseal: Thank you, Aryeh. And good afternoon to you all. Again, my name is Dr. Delia Houseal, and I am the program lead for the End-Stage Renal Disease Quality Incentive Program, also known as ESRD QIP. Thanks to all of you for joining us this afternoon, and welcome to this Final Rule Medicare Learning Network event. For your reference and convenience, the acronyms used in this presentation are listed on slide 3 – excuse me – slide 2.

On slide 3, you'll see objectives for our call. At the conclusion of today's call, we hope that you will have an increased familiarity with the statutory foundations of the ESRD QIP and two of our driving initiatives, the CMS Meaningful Measures Initiative and Patients Over Paperwork.

We also hope that you will have a broader understanding of finalized policies and their rationale and impact. Lastly, we hope that you will learn more about how to access additional resources pertaining to the ESRD QIP.

We are on slide 4. Before we begin, I'd like to share the content of today's call should not be considered official CMS guidance. This webinar is only intended to provide information regarding requirements for the program. Please refer to the Final Rule located in the *Federal Register* to clarify and provide a more complete understanding of the modifications to the program we will be discussing.



Statutory Foundations & Legislative Drivers

So, now, I'll provide a high-level summary of our statutory foundations and legislative drivers. Okay. On slide 6. So, the ESRD QIP, as described in Section 1881(h) of the Social Security Act, was enacted by the Medicare Improvements for Patients and Providers Act of 2008, otherwise known as MIPPA.

The overall purpose of the ESRD QIP is to promote patient health by providing a financial incentive for renal dialysis facilities to deliver high-quality patient care. And to do this, CMS is authorized to apply payment reductions of up to 2% if a facility does not meet or exceed the minimum Total Performance Score, or TPS, as set forth by CMS.

The ESRD QIP calculates the minimum Total Performance Score by assessing and scoring performance on a core set of measures. The Protecting Access to Medicare Act of 2014, or PAMA, added the additional requirement of ESRD QIP, including measures to specific conditions treated with oral-only drugs.

Under MIPPA, ESRD QIP is responsible for selecting measures that will address anemia management reflecting the Food and Drug Administration labeling; dialysis adequacy; patient satisfaction as specified by the HHS Secretary; iron management, bone mineral metabolism, and vascular access, all as specified by the HHS Secretary.

CMS is also required to establish performance standards that apply to individual measures, specify the performance period for a given payment year, develop a methodology for assessing total performance of each facility based on performance standards and, in addition, apply an appropriate payment percentage reduction to facilities that do not meet or exceed the established Total Performance Score.

Lastly, CMS is required to publicly report results, and facilities are required to post their Performance Score Certificates within 15 days of their availability, but no later than January 1st of each year. Currently, CMS publicly reports the results on Dialysis Facility Compare and [CMS.gov](https://www.cms.gov).

Key Initiatives

Next, I'll discuss two key initiatives that help guide our policy development process. The first initiative is the Meaningful Measures Initiative. On slide 9, you will see a high-level view of the Meaningful Measures Initiative. The Meaningful Measures Initiative serves as a framework for CMS to achieve our goals of high-quality care, better patient outcomes, and reduced provider burden by identifying the highest priorities of quality measurement.

As you can see in the image, there are six core areas – promote effective communication and coordination of care, promote the effective prevention and treatment of chronic diseases, work with communities to promote best practices of healthy living, making care affordable, making care safer by reducing harm caused in the delivery of care and, lastly, strengthening person and family engagement as partners in care.

As we develop measures across these six areas, we do it with several core principles in mind – eliminate – the elimination of disparities in care, tracking measurable outcomes and impact, safeguarding public health,



achieving cost savings, improving access for rural communities and, lastly, reducing provider and patient burden, which is a good segue into our next initiative found on slide 10, Patients Over Paperwork. This initiative is designed to cut the red tape and reduce burdensome regulations. To support this initiative, CMS established an internal process to evaluate and streamline regulations with the goals of reducing unnecessary burden, increasing efficiencies, and improving the beneficiary experience.

Our actions have delivered results and have saved the health care system at least \$5.7 billion through 2021 and have eliminated at least 40 million hours of burden through 2021, giving that time back to providers and suppliers to spend with their patients and not on needless paperwork.

Finalized Changes

Okay. So, next, on slide 11, I'll begin the discussion around the policies that were finalized in the calendar year 2020 ESRD Final Rule. Before we review the finalized proposals, let's discuss the measure sets for payment years 2022 and 2023.

On slide 12, you will see the measures sets – the measures, domains, and weights that will be used in our payment year 2022 and 2023 program. Under our previously adopted policy, we were continuing – we are continuing all measures from the payment year 2022 ESRD QIP for payment year 2023. Also, as you will see from this slide, we did not propose to adopt any new measures beginning with the payment year 2023 program.

Payment year 2022 is the first year for each of these measures, and that means performance period for them will begin in January of 2020. A facility must be eligible to receive a score on at least one measure in two of the four domains to receive a Total Performance Score in any given payment year.

Each measure is assigned to one of four domains. The scores for the four domains are weighted, combined, and the sum will provide the TPS. The payment year 2022 and payment year 2023 measure sets are identical. This includes the measure domains and their assigned measures and weights.

So, now, let's take a closer look at each of these domains. You will see the Clinical Care Domain accounts for 40% of the Total Performance Score and includes the following measures – Kt/V Dialysis Adequacy, a comprehensive version; the VAT Measure Topic, which includes the Standardized Fistula Rate and the Long-Term Catheter Rate; Hypercalcemia; the Standardized Transfusion Ratio; and the Ultrafiltration Rate reporting measure.

Next, we will take a look at the Care Coordination Domain. This domain accounts for 30% of the Total Performance Score and includes four measures. Those measures are the Standardized Readmission Ratio or SRR, the Standardized Hospitalization Ratio or SHR, Clinical Depression Screening and Follow-Up, and the Percentage of Prevalent Patients Waitlisted or PPPW.

The Safety Domain provides 15% of the TPS and consists of three measures – the NHSN Bloodstream Infection or BSI, the NHSN Dialysis Event reporting measure, and the Medication Reconciliation measure. And the fourth and final domain is Patient and Family Engagement, which accounts for 15% of the Total Performance Score and includes only one measure, which is the ICH CAHPS measure.



Okay. Moving on to the finalized proposals. Here on slide 13, you will see a summary of these proposals. So, this year, we codified program requirements in the regulatory text. We also updated the scoring methodology for the NHSN Dialysis Event reporting measure.

We converted the STrR clinical measure into a reporting measure. And while we proposed changes to the scoring equation for the MedRec, we did not finalize those changes. We will talk more about that later in the – in the presentation. And, lastly, we continue our data validation efforts for payment year 2022 and all subsequent years.

So, now, I'll go into a little more detail regarding these proposals. So, we will begin our discussion here with some of the updates to our regulatory text. So, this year, we codified certain program requirements. And I think you will see those on slide 14.

First, we proposed to adopt the baseline periods and performance periods for each payment year automatically. And, so, what that means that the payment – the baseline and the performance periods will be advanced each period by 1 year from the baseline and the performance period that were adopted during the previous payment year.

We also finalized the proposal to codify the requirement that facilities must submit measures data for CMS on all measures. And, lastly, we codified the Extraordinary Circumstances Exception process and included a new option for facilities to reject an ECE that has been granted by CMS under certain circumstances. This new option will provide facilities with flexibility under the ECE process.

So, why do we codify program requirements? We believe that codifying program requirements and regulation texts will make it easier for the public to locate and understand those requirements. We believe that this also helps CMS meet its goal of providing clear guidance or policies and requirements that affect the stakeholders.

For these policies, we received overwhelming support of our proposals. And we appreciate and thank all of the commenters. After consideration of all the comments we received, we finalized all of our policies with one technical change. And the changes that we will now clarify that CMS will not – we clarified that CMS will not consider an ECE request unless the facility making the request has complied with all of the reporting requirements. So, again, we encourage you all to visit our website and make sure when you submit those ECEs that they are – that they do contain all of the requirements – reporting requirements.

And so, now, we will turn our attention to some of the measure-related changes. Okay. For those of you following along, I'm on slide 16. In the calendar year 2020 rule, we updated the scoring methodology for the National Healthcare Safety Network, or NHSN, Dialysis Event reporting measure.

As we have accumulated experience with this policy over the years, we were concerned that new facilities and facilities for which we grant an ECE for part of the performance period were not eligible to receive a score on this measure because they were not eligible to report data for full 12 – for the full 12-month period.

And, as a result, we did not believe that this policy appropriately accounted for the efforts made by these facilities to report the data for the month in which they were eligible to report. We were also concerned that if a



facility was aware that it would not be eligible to receive a score on the NHSN Dialysis Event reporting measure that that facility would not be incentivized to report data at all for the payment year.

So, to address these concerns, we proposed to remove the NHSN Dialysis Event reporting measure's exclusion of facilities with fewer than 12 eligible reporting months. We also proposed to assess acceptable reporting based on the number of months a facility was eligible to report. So, common in both of the aforementioned changes, we also proposed to assign scores based the percentage of data reported.

And, lastly, we proposed to remove a requirement that to be eligible to receive a score on the NHSN Dialysis Event reporting measure that new facilities must have a CCN open date before October 1 prior to the performance period that applies to the payment year. And, so, under this change, new facilities would not be required to have a CCN open date before the October 1 prior to the performance period.

On slide 17, you will see an example of our updated scoring distribution. You can see in the box here with the finalized scoring distribution a facility that reports a 100% of eligible months would be awarded 10 points and a facility reporting less than 100% but 50% or more of the eligible months would get two points and a facility reporting less than 50 percent would receive zero points.

By this – for example, if a facility – excuse me – if a facility had 10 eligible reporting months because it was granted an ECE for 2 months of the performance period, under our finalized proposal, the facility will receive the full 10 months because they would have reported 100% of their eligible months. Under the previous policy, the facility would not have received the score.

And, as a point of clarification, eligible months include the months in which dialysis facilities are required to report data to NHSN. And it includes facilities offering in-center hemodialysis, as well as facilities that treat at least 11 eligible patients during their performance period.

So, as – here, you will see our rationale. As stated earlier, we recognized based on years of collecting data that we needed to make some adjustment to this measure. We also – we believe that it was important to encourage new facilities and facilities with an approved ECE to report complete and accurate data – Dialysis Event data to NHSN for all of the months in which they were eligible to submit data.

So, we – and we also believe that this policy encourages complete and accurate reporting of NHSN data while maintaining the integrity of the NHSN surveillance system. We thank all the commenters for their support. And we believe that the comments submitted regarding the scoring methodology will allow facilities to be awarded too many points for reporting – excuse me.

We believe that the comments submitted regarding the scoring methodology would allow facilities to be awarded too many points for reporting fewer than 100% of eligible months and could encourage facilities to pick and choose which months they want to report.

We believe that our proposed methodology better incentivizes facilities to report data for all 12 months while also discouraging the selective suppression of data. And, after considering public comments, we finalized the update to the scoring methodology as proposed, which included the minimum eligibility requirements for payment year 2022 and beyond.



Okay. The next finalized measure concerns the Standardized Transfusion Ratio, or STRR, measure which – we proposed to convert this measure from a clinical measure to a reporting measure. Facility scores would be based on whether their required data was reported rather than based on the reported values.

We stated that facilities that meet minimum data and eligibility requirements will receive a score on the STRR reporting measure based on the successful reporting of data and not on the values that are actually reported. In order to receive 10 points on the measure, a facility would need to report the data required to determine the number of eligible patient-years at risk and have at least 10 eligible patient-years at risk.

We also stated in the rule that a patient-year at risk was a period of 12-month increments during which a single patient is treated at a given facility. A patient-year at risk can be comprised of more than one patient if, when added together, their time and treatment equal a year.

And, so, I know that was a bit complex, so we will take a moment and try to explain it a little further here. So, on slide 20, you will see we provided a summary or an example of how to determine patient-years at risk. So, when determining patient-years at risk, you will first determine each individual's patient time at risk, which is measured in days.

The time at risk is based on the CROWNWeb admit/discharge data, Medicare claims data, and other administrative data. This assessment begins at the start of the facility treatment period and continues until the earliest occurrence of one of the following – it is 3 days prior to a transplant, the date of death, end of facility treatment, or it is December 31st of the year.

The time at risk is excluded if there is a Medicare claim within 1 year of the patient at risk for any of the following conditions. And I won't go through all of those, but a few of those are lymphoma, multiple myeloma, leukemia, head and neck cancer, metastatic cancer, and sickle cell anemia.

Okay. Slide 21. Additionally, a patient is required to be on ESRD treatment for at least 90 days and to be treated at a facility for at least 60 days before being attributed to that facility. A patient-month is considered eligible within 2 months of a month in which a patient has either of the following – \$900 in Medicare-paid dialysis claims or at least one Medicare inpatient claim.

Next, the patient time at risk is aggregated across all patients treated at a facility during their performance year. Lastly, it is converted into patient years. Here on this slide, we have an example of a facility with 4,000 days at risk during a performance year would have 10.96 patient-years at risk.

To illustrate this point in much simpler terms, you can see here that multiple patients can be included within one patient-year. Here Patient A is a – is a patient for 4 months and Patient B is a patient for 8 months. The experience for the two of them can be combined to report one full patient-year.

Now, because we are finalizing that we will now score the measure as a reporting measure, we will no longer score the measure based on the actual clinical values reported by facilities. Rather, for the STRR reporting measure, facilities with at least 10 patient-years at risk will receive a score of 10 on the measure. Facilities with fewer than 10 patient-years at risk will not be eligible to receive a score on the measure. So, you won't be penalized. You just won't receive a score.



Okay. And, so, why did we propose these changes? We proposed and finalized these changes in light of the concerns raised about the validity of the STrR clinical measure. And we believe that these changes were the most appropriate way to continue fulfilling the statutory requirement to include a measure of anemia management in the program, while assuring that dialysis facilities were not adversely affected during that continued examination of the measure. Updates to the scoring methodology will begin with payment year 2022.

And, so, moving on. We also proposed an – we also proposed a revision to the MedRec reporting measure scoring equation. We stated in the calendar year 2020 ESRD proposed rule that inadvertently used the term “patient-months” in the MedRec reporting measure scoring equation.

There, we also stated that we calculate a subset of our clinical measures using patient-months – for example, with Kt/V and (inaudible) and hypercalcemia, and that because patient months is the unit of analysis based on the measure specifications. We also stated that facility-months are generally used for a reporting measure because they assess the proportion of months in a year that a facility reported to CMS the data necessary to calculate the measure. The use of facility-months was also consistent with the scoring methodology we have used for all other reporting measures which require monthly reporting.

Lastly, we also clarified that for the MedRec reporting measure, facilities with a CCN open date before the October – before the October performance period, which for the payment year 2022 ESRD QIP would be a CCN open date before October 1, 2019, must begin collecting data on that measure.

Okay. And, so, we recognize the value – in recognition of the value of alignment with NQF specifications, where possible, and our desire to incorporate more outcomes-based measures, in addition to many of your comments and concerns, we decided to not finalize our proposed recommendation to the MedRec measure. I have decided to retain our use of patient-months instead of facility-months when calculating eligible months for this measure.

Again, we thank all of you for your feedback. We had an opportunity to listen and hear from lots of folks. And, so, we wanted to be good measure stewards and, as I mentioned, retain our use of patient-months for this measure.

Okay. And so, next, I’ll move on to the NHSN data validation study. So, in the calendar year 2020 ESRD proposed rule, we stated that one of the critical elements of our program’s success is ensuring that the data submitted to calculate measure score, the TPS, are accurate. We stated that the ESRD QIP includes two validation studies for this purpose. We have our CROWNWeb validation study as well as our NHSN validation study.

We also adopted a methodology for the payment year 2022 NHSN validation study which targets facilities for NHSN validation by identifying facilities that may be at risk for underreporting. We proposed to adopt NHSN validation as a permanent feature of the ESRD QIP with the methodology that we first finalized for payment year 2022, and proposed to continue our validation efforts in payment year 2023 and beyond.

And, so, the purpose of our validation program is to ensure that accurate and completeness of data that are scored under the – ensure the accuracy and completeness of the data that are scores under QIP. And, so, by validating the NHSN data using the methodology, we believe that we are able to achieve that goal.



A recent statistical analysis conducted by the CDC concluded that to achieve the most reliable results for a payment year, CMS would need to review approximately 6,072 charts submitted by 303 facilities. The sample size would produce results with a 95% confidence level and a 1% margin of error.

And, so, based on those results and, again, our desire to ensure that the data that's reported is accurate, we proposed to continue using our methodology in the payment year 2023 NHSN validation and all subsequent years. We – again, we believe that the methodology ensures enough precision within the study and also signals our commitment to ensuring the accuracy of data reported for NHSN. And after consideration of public comments, we finalized that proposal which, again, continues our NHSN validation study work.

Updates to Regulatory Text for ESRD QIP

Okay. And, so, in order to give you some clear guidance on policies for payment year 2023 and future payment years, we will do a quick overview for payment year 2023. And to be clear, we did not propose any changes that would affect measures for the payment year 2023.

As I stated when discussing the statutory guidance, the statute dictates that ESRD QIP must specify the performance period for each payment year. And we continue to believe the 12-month performance and baseline period provide us with sufficiently reliable quality measure data for the program.

In the calendar year 2020 ESRD PPS proposed rule, we stated our continued belief that the 12-month performance and baseline period would provide us with reliable quality measure data. We, therefore, proposed to established calendar year 2021 as the performance period for the payment year 2023 ESRD QIP for all measures.

We also proposed to establish calendar year 2023 – excuse me – 2020 as a baseline period for the payment year 2023 ESRD QIP for all purposes of calculating the improvement threshold, and that calendar year 2019 will be used as a baseline period for the payment year 2020 ESRD QIP for all measures for purposes of calculating the achievement threshold benchmark and minimum TPS.

Beginning with payment year 2024, we will automatically adopt a performance and baseline period for each year that is a – that is 1 year advanced from those specified for the previous payment year. The illustration here on the slide breaks this down for payment years 2024 and 2025.

In the example for payment year 2024 and under this policy, we would automatically adopt calendar year 2022 as the performance period for the payment year 2024 ESRD QIP. We would also automatically adopt calendar year 2020 as the baseline period for purposes of calculating the achievement threshold, benchmark, and minimum TPS and calendar year 2021 as a baseline period for purposes of calculating the improvement threshold for the payment year 2024. And the same concept would apply for payment year 2025.

And, so, as I mentioned earlier, again, we proposed these changes to provide clear guidance to all of you on our policies for payment year 2023 and for future payment years. We also hope that this will reduce our need to add lots of text in our – in our calendar year final rules and proposed rules.



Okay. So, let's now move on to the finalized Payment Reduction Scale. I'm on slide 33 for those of you following along. At the time the proposed rule was published, the most recently available data for a complete year was calendar 2017. We have now updated the payment reductions that will apply to the payment year 2022 ESRD QIP using calendar year 2018 data.

The minimum Total Performance Score for payment year 2022 will be 54, and the updated Payment Reduction Scale is shown here on the slide. So, if your Total Performance Score is 23 or less, you will be scheduled to receive a 2% reduction; if it is 33 to 24, a 1.5% reduction; 34 to 43, a 1% reduction; 44 to 53, a 0.5% reduction; and if your score is 54 or higher, you will not be subject to a reduction.

So, the table on this slide shows the overall estimated distribution of payment reductions resulting from both the payment year – payment years 2022 and 2023 ESRD QIP. To estimate whether a facility will receive a payment reduction for those payment years, we scored each facility on achievement and improvement on several clinical measures that we have previously finalized and for which there were available data from CROWNWeb and Medicare claims.

And, so, as you will see here – and I want to reiterate that these are only estimates. They are only used with – we don't have data for all of our measures. But you will see here we are estimating that 73% or about 74% of facilities would not receive a payment reduction.

Resources

And, so, this concludes my review for the finalized proposals in the current rulemaking cycle. Here we have some very important and useful links, as well as contact information for your convenience. We encourage you to please take advantage of this information. There are several links to our program information. We also have a direct link to the final rule. And we have some more details on public reporting files, which will be available on Dialysis Facility Compare shortly.

And we also have our contact information. If you have any questions, we encourage you to utilize our Q&A tool, which can be found on QualityNet or via the link that's embedded in the presentation. You can also reach out to us via email at esrdqip@cms.hhs.gov. Okay. And, now, I'd like to open it up for a few questions.

Question & Answer Session

Aryeh Langer: Thank you so much, Delia. We will now take your questions. As a reminder, this event is being recorded and transcribed. In an effort to get to as many questions as possible, each caller is limited to one question. To allow more participants the opportunity to ask questions, please send questions specific to your organization to the mailbox that was just mentioned on slide 35 so our staff can do more research. All right, Dorothy, we are ready to take our first caller, please.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to ensure 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, one 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 Smith.

Susan Smith: Hello, Susan Smith, Central Pennsylvania Dialysis Clinics. I have a question about the transfusion measure – transfusion reporting measure. We are seeing in CROWNWeb that there are fields for the medication reconciliation reporting. How are we going to be reporting transfusions?

Dr. Delia Houseal: Thank you, Susan. Is that correct? Thank you so much for the question. I'm going to turn it over to the team to help answer that question.

Alissa Kapke: Hi. This is Alyssa Kapke from Arbor Research. You will not be required to enter any transfusion information in CROWNWeb for the STrR Reporting Measure. All the information will be obtained just from the CROWNWeb admit and discharges and claims presented.

Susan Smith: Thank you.

Operator: Your next question comes from Heidi Ferguson.

Heidi Ferguson: Yes. How can you accurately report Kt/V if the single pool is less than 1.2 but the calculated is greater than 1.2?

Dr. Delia Houseal: Okay. Thank you, again, for that question. Alyssa, did you want to take that question, or do we want to have her to submit that question to our inbox? I know that's a lot of numbers and details. We may not have the time to adequately answer that on this call. But I'll defer to the team.

Alissa Kapke: Yes. I think it would be better to submit that through the Q&A tool so we can review and respond accordingly.

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 Susan Harris.

Susan Harris: Hi. Yes. My name is Susan Harris. I'm with Blue Cross Blue Shield. And I just had a question. I've noticed that online the year 2020 consolidated billing and PC pricer is not updated. There is no 2020. Everything is still 2019. Is that going to be updated, and do you know when?

Dr. Delia Houseal: So, just to get a little bit more detail, when you say online, which page are you – are you referencing?

Susan Harris: It is the CMS End-Stage Renal Disease. There are tabs for the consolidated billing list and for the PC pricer for your end-stage renal disease. And neither one have been updated for 2020.



Dr. Delia Houseal: Yes. So, that is a question that would be most appropriate for our colleagues within the Centers for Medicare. If you can – if you give me a minute, I will get their email address for you.

Susan Harris: Okay.

Dr. Delia Houseal: They are the ones that is responsible for updating that information. So, I will ...

Susan Harris: Okay.

Dr. Delia Houseal: After this next caller, I will come back on and give you their direct email.

Susan Harris: Thank you.

Operator: Your next question comes from the line of Lisa Bright.

Lisa Bright: Hi. Thank you. I wanted to know is there a clarifier for the patients who are considered eligible for the Medication Reconciliation measure? In other words, do they have to have been on census the entire month or is it just a minimum of seven treatments? Because the seven treatments only addresses in-center. Thank you.

Dr. Delia Houseal: All right. Yes. Thanks, again, for that question. Alyssa, did you want to take that one?

Alissa Kapke: Sure. The patients that are on home hemodialysis or peritoneal dialysis will be eligible for the measure if they are assigned to your facility for that entire reporting month. And we determine that through admits and discharges in CROWNWeb.

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 Navena. Navena, your line is open.

Navena: Okay. Great. Hi. My question is about the percent of prevalent patient's waitlist. How do we report that on CROWNWeb?

Dr. Delia Houseal: All right. Thanks, again, for your question. Alyssa, did you want to take that one as well?

Alissa Kapke: The waitlist information won't require additional reporting in CROWNWeb. We would obtain that information from the transplant data obtained through UNOS.

Navena: Okay. Thank you.

Dr. Delia Houseal: Okay. I just wanted to weigh in for the caller that had the question around the payment information. The direct email for our colleagues at CM is esrdpayment – which is one word – esrdpayment@cms.hhs.gov.



Operator: As a reminder, if you would like to ask a question, please press star, then the number 1 on your telephone keypad. That is star, 1 to ask a question. And there are no further questions at this time. I will turn the call back over to management for closing remarks.

Additional Information

Aryeh Langer: Well, thank you very much. We really appreciate everybody taking their time out of their schedules today. It looks like you have a few extra minutes, so that's good. I just want to remind you again if you have any questions that you would like to send in after the call is over, please refer to slide 35 for how to reach out to CMS.

We also ask that you take a few moments to evaluate your experience with today's call. And if you could please look at slide 37 for more information, we'd appreciate that.

An audio recording and transcript will be available in about two weeks at the URL I mentioned earlier – go.cms.gov/mln-events. Again, my name is Aryeh Langer. I'd like to thank Delia for her fantastic presentation and also the team for participating in the Q&A session and thank you, all, 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.