



Outpatient Quality Program Systems and Stakeholder Support Team

Calendar Year (CY) 2022 End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) Final Rule: ESRD Quality Incentive Program (QIP) Finalized Proposals

Presentation Transcript

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**January 13, 2022
2 p.m. Eastern Time**

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Karen

VanBourgondien: Hello, everyone. Thank you for joining us. My name is Karen VanBourgondien. Today we are fortunate to have Dr. Delia Houseal with us to go over the final rule as it relates to the ESRD QIP. Delia, for those of you who do not know, is the program lead for the End-Stage Renal Disease Quality Incentive Program. We also have Arbor Research available to assist with answering any measure-related questions in the chat box. Before I hand things over to Delia, let me just cover a few housekeeping items.

First, the slides are available on CMS.gov. I will place that direct link in the chat box in just a minute. We will have a word-for-word transcript and a recording of this event available at that same location shortly. Second, Delia will be going over the finalized proposals for the Calendar Year 2022 ESRD PPS Final Rule as it relates to QIP. After the presentation portion, Delia will be taking questions and responding to those questions.

If you would like to address a question or a comment to Delia, please use the Raised Hand feature. To use this feature, you will just click on the hand icon that's located in the chat box. During the open discussion portion, we will monitor this feature and call your name. Your line will be unmuted, so that you can interact verbally. Once your question has been addressed, please lower your hand to provide opportunity for others. We will make every effort to get to as many people as possible. We do request that you stick to the subject matter of today's call. Additionally, we will not be able to address any facility-specific questions. Those types of questions should be directed to the QualityNet Question & Answer Tool.

So, without any further delay let me hand things over to Dr. Delia Houseal. Delia?

Delia Houseal: Awesome. Greetings. Thank you and welcome to our annual webinar on the Calendar Year 2022 ESRD PPS Final Rule. As my colleague Karen mentioned, my name is Dr. Delia Houseal, and I am the ESRD QIP Program Lead. So, we have a really full agenda today, so we're going to go right ahead and get started. Next slide, please.

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Again, thank you all for joining today's webinar. We hope that after today's webinar you will be able to recognize the statutory and legislative components of the ESRD QIP, identify our finalized proposals and the rationale for those proposals, as well as learn how and where to access additional resources for the ESRD QIP. Next slide, please.

As a reminder, the content covered on today's call should not be considered official guidance. This webinar is only intended to provide information regarding program requirements. The official reference to all finalized policies is the Calendar Year 2022 ESRD PPS Final Rule. We encourage you to review the final rule in the *Federal Register* to gain a more complete understanding of the finalized policies which I will be discussing. Next slide, please.

I know my colleague Karen mentioned this, but to find the rule, you can access the top link that you see in our slide. The slides are available on CMS.gov and a link should be in the chat box for you to quickly access those slides. Here, again, if you look at the first link it will take you directly to the ESRD PPS final rule in the *Federal Register*. For those of you that prefer a PDF version, you can use the second link that you see here in the deck. That link will take you to the direct location of the PDF. The rule is quite lengthy. So, for those of you that want to jump right to the ESRD QIP section and our related proposals, they begin in Section IV on page 34 in the PDF version. So, now, let's take a look at our final rule. Next slide, please.

So, over the last two years, we have all been faced with dealing with the COVID-19 Public Health Emergency. In this year's calendar rule, we focused on proposing and finalizing policies to help provide maximum flexibility and relief for dialysis providers as they continue to take on the arduous task of providing care to ESRD patients during the pandemic. The flexibilities provided were consistent with our policy goal of providing relief to facilities when they were faced with situations and conditions that are beyond their control. Next slide, please.

So, as you all are aware, the COVID-19 Public Health Emergency presented many challenges that affected providers ability to provide care and our ability to accurately measure quality performance. For example, we heard from stakeholders that there were several changes to clinical practices that were implemented to accommodate safety protocols for medical personnel and patients. We also found that there were unpredicted changes in the number of stays and facility-level case mixes, as well as staffing shortages. Further, given that COVID-19 prevalence was not consistent across the country, dialysis facilities located in different areas were or may have been affected differently at different times throughout the pandemic. We decided, again, as our primary policy goal for this calendar year's rule was to really be able to implement the program in a way that was fair and equitable to all facilities. So, with that, we finalized several policies that we believe helped us achieve our policy goals. Next slide, please.

On this slide, you'll see the three major policies that were finalized in response to our concerns related to the COVID-19 Public Health Emergency and I'll be going into these in greater detail. Here, I just wanted to summarize those three major policies. Our first was that we adopted a measure suppression policy which allows us to exclude any measures from the program that we believe were impacted by the pandemic. Based on the criteria established in our suppression policy, we finalized a policy to suppress four quality measures from the payment year 2022 program. Lastly, we adopted a special scoring and payment rule for payment year 2022 to address concerns that we had with our data collection system and the COVID-19 pandemic. So, now, I'll go over each of these policies and others in greater detail. Next slide, please.

So, we're going to begin with our measure suppression policy. We stated in the proposed rule that we viewed this measure suppression proposal as a necessity to ensure that the ESRD QIP does not penalize facilities based on external factors that were beyond the control of facilities. We intended for this proposed policy to provide short-term relief to dialysis facilities when we have determined that one or more of the Measure Suppression

Factors warrants the suppression of an ESRD QIP measure. Our measure suppression policy, we believe that the policy enables CMS to suppress the use of ESRD QIP measure data if it is determined that circumstances caused by the public health emergency significantly affected those measures and the resulting Total Performance Scores. So, in those situations, we also proposed that we would publicly report the data with the appropriate caveats. Again, I will discuss the aspects of that in a little more detail shortly. All right, next slide.

Along with the suppression policy, we developed four Suppression Factors that we believe would serve as guideposts for our determination of whether to propose to suppress ESRD measures for one or more payment years that overlap with the COVID-19 emergency. The Measure Suppression Factors will help us to evaluate measures in the ESRD QIP and their adoption in the other VBP programs noted previously will help to ensure consistency in our measure evaluations across programs and peer settings. So, the first of these two factors are noted here on the slide. The first factor looked at the extent to which there was a significant deviation in the national performance on a measure during the COVID-19 Public Health Emergency. The second factor looked at the clinical proximity of the measure's focus to the health impacts of the COVID-19 Public Health Emergency. Next slide.

Factor 3, you'll see here, looks at the extent to which we detect rapid or unprecedented changes in clinical guidelines, treatments, and or scientific understanding of the disease or diseases. Factor 4 looked at the extent to which a measure was impacted by significant or rapid changes in the healthcare personnel, supplies, and/or patient case volumes. As you can see, these factors, we believe, will address a variety of the challenges that we heard and saw stakeholders were faced with during the Public Health Emergency. All right, next slide.

So, why did we propose these policies? Again, we believe that the COVID-19 pandemic resulted in significant distortions to quality measurement and that our measure suppression policy and the suppression factors will ensure that CMS does not penalize facilities based on external

factors that are beyond their control. So, based on public comments, we finalized our proposal to adopt a measure suppression policy for the duration of the COVID-19 Public Health Emergency. We also finalized the proposed Measure Suppression Factors that we proposed for purposes of this measure suppression policy. Next slide, please.

So, based on our measure suppression policy, we conducted analyses of 14 of our current ESRD QIP measures to determine whether and how COVID-19 may have impacted our measures. We concluded that COVID-19 impacted four of our quality measures. Based on those impacts, we believe that we were unable to fairly and equitably score these measures for the payment year 2022 program year. Accordingly, we proposed to suppress these measures for the payment year 2022 program year for all ESRD QIP participants. We proposed to suppress these measures rather than remove them because we believe that they are still an important part of the ESRD QIP. Here we can see the measure and the measure suppression factors that were associated with the suppression of each measure. So, for example, for the SHR measure, we were concerned that the COVID-19 Public Health Emergency affected measure performance on the current SHR, or Standardized Hospitalization Ratio, clinical measure such that we would not be able to score facilities fairly or equitably on it. We stated in the proposed rule that we were currently exploring ways to adjust effectively for the systematic effects of the COVID-19 Public Health Emergency on hospital admissions for the SHR clinical measure. We will continue to collect the measure's claims data from participating facilities so that we could monitor the effects of the circumstances on quality measurement and determine their appropriate policies in the future. We also conducted analysis of the SRR, or Standardized Readmission Ratio, clinical measure. What we saw was that the resulting performance would not be sufficiently reliable or valid for use in the ESRD QIP. Again, we are still working to improve any COVID-19 related adjustments and verify the validity of a potential modified version of the SRR clinical measure as additional data become available.

As an alternative approach, we might also consider eliminating from the calculation of the SRR clinical measure any cases of patients who had COVID-19 prior to or at the time of index hospitalization. We believe that this approach might help us to distinguish between ESRD-related readmissions and COVID-19 related readmissions that might otherwise impact SRR clinical measure calculations. So, because of the ECE, I know many of you may be aware. Earlier in calendar year 2020, we issued an Extraordinary Circumstance Exception which waived data submission requirements for the first half of the year. Because of that ECE, facilities were not required to submit calendar year 2020 spring ICH CAHPS, which is the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems data for purposes of the ESRD QIP. So, the only data that was available for CAHPS was the fall calendar year 2020 survey. So, based on our analyses, we did not find it feasible to include that only one time period of data for scoring purposes in the QIP. Lastly, we also proposed to suppress the Hemodialysis Vascular Access: Long-term Catheter measure. Here we found that our data indicated that long-term catheter use rates increased significantly during the COVID-19 Public Health Emergency. We were concerned that the COVID-19 Public Health Emergency impacted the ability of ESRD patients to seek treatment from medical providers regarding their catheter use, either due to the difficulty accessing treatment due to all of the COVID-19 safety precautions at healthcare facilities or due to increased patient reluctance to seek medical treatment because of the risk of exposure and increased resulting health risks. So, because of that, again we decided that the data were not reliable and valid and that particular measure should be suppressed from the program. So, as I mentioned earlier, while these are the current measures that we proposed to and finalize the suppression policy on, we will continue to monitor the effects of the circumstances on quality measurement and determine the appropriate policies in the future. Again, I think I may have mentioned this earlier but, while we did finalize to suppress these measures, we also finalized that we will continue to provide confidential feedback reports to facilities as a part of our normal program activities just to make sure that facilities are made aware of the changes in performance rates over time. Next slide, please.

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So, I know we really discussed this, but again, based on our analysis, we identified that COVID-19 impacted those, you know, the four aforementioned measures and, because of that, we finalized our policy to suppress those four measures. Next slide, please.

So, now I'll move along to our special scoring proposal. Again, during calendar year 2020, we experienced several operational issues that prevented facilities from submitting September through December 2020 patient and clinical data into the End-Stage Renal Disease Quality Reporting System.

As I previously mentioned, we also finalized our policy to suppress four of our measures due to the impact of the COVID-19 Public Health Emergency. So, to address the challenges that we saw, both of those challenges with the data and the measure that we suppressed, we proposed a special rule for payment year 2022 scoring that would allow us to calculate measure rates for all measures, but not calculate achievement and improvement points for any of the measures. Because we would not calculate achievement and improvement scores for any of the measures, we also proposed under this special rule that we would not score any of the measures in the four domains or calculate or award Total Performance Scores for any facilities. So, what that would result in is that the Performance Score Certificates that were generated with the TPS would show as Not Applicable. We also proposed to not apply any payment reductions to ESRD facilities for payment year 2022. In order to ensure that a facility is still aware of the changes to its measures rates that we observed, we also proposed to provide confidential feedback reports that contain the measure rates that were calculated for payment year 2022. Next slide, please.

As I know, I have mentioned this several times, but again, this proposal was really based on our desire not to penalize facilities based on the performance of data that we believe was impacted by the Public Health Emergency and or may not reflect the quality of care that measures in the program are designed to assess. Again, the ESRD QIP measures, you know that we identified the four measures that were impacted by the

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Public Health Emergency and, also based on the operational issues that we believe that we encountered, we believe that and our analysis found that the results would actually distort measure performance. So, after considering public comments, and, as I mentioned, take a look at all of our analyses, we finalized our special scoring and payment policy for the payment year 2022 ESRD QIP. Okay, next slide, please. I'm sorry. I may have lost connection. Can you all hear me?

Karen

VanBourgondien: We can, Delia. Thank you.

Delia Houseal: Okay, awesome. I'm going to just check in. Did I finish that slide? Did you all hear the end of the slide? Okay, perfect. Just wanted to check in.

Karen

VanBourgondien: Yes. Yes.

Delia Houseal: All right. So, now, let's discuss some of the updates to requirements beginning with payment year 2024.

Under our current policy, we retain all of our ESRD QIP measures from year to year unless we propose through rulemaking to remove them or otherwise provide notification of immediate removal if a measure raises potential safety concerns. Accordingly, the payment year 2024 ESRD QIP measure set will include the same 14 measures as the payment year 2023 ESRD QIP measure set. Next slide, please.

So, for payment year 2024, we proposed to update our Standardized Hospitalization Ratio, SHR, clinical measure beginning with payment year 2024. In November, NQF completed its most recent review of the SHR clinical measure, a measure maintenance review, and renewed the measure's endorsement. As a part of this review, the NQF endorsed updating the prevalent comorbidity adjustment, which would group 210 individual ICD--9 prevalent comorbidities into 90 condition groups. The updated prevalent comorbidity adjustment would also limit the source of prevalent comorbidities to inpatient claims. The switch to using only Medicare inpatient claims to identify prevalent comorbidities is due to the

lack of Medicare outpatient claims data for the growing Medicare Advantage patient population. By using the original set of Medicare claims data, the NQF stated its concern that Medicare Advantage patient prevalent comorbidities would be systematically biased. The updated NQF-endorsed SHR clinical measure would also include all time at risk for Medicare Advantage patients and added a Medicare Advantage indicator for adjustment in the model. So, we proposed to update the SHR clinical measure specifications to align with the NQF endorsed updates. These updates included an update to the risk adjustment method of the measure, which include a prevalent comorbidity adjustment, the addition of Medicare Advantage patients, and a Medicare Advantage indicator in the model. It also updated the calculation process of existing adjustment factors and re-evaluation of interactions, and an indicator for a patient's time spent in a skilled nursing facility. So, lots of updates were made. Next slide, please.

Okay. So, we proposed the updates because we wanted to align with the NQF-endorsed updates, and we believe that adopting these updates would be consistent with our goal of evaluating opportunities to more closely align our current measure sets with the NQF measure specifications. After considering public comments, we finalized our proposal to update the SHR clinical measure specifications for use in the ESRD QIP beginning with payment year 2024, which is equivalent to calendar year 2022. All right. Next slide, please.

So, we also made some updates to our performance standards. Under our current policy, we automatically adopt a performance and baseline period for each year that is one year advanced from those specified for the previous payment year.

So, under this policy, calendar year 2022 is currently the performance period for payment year 2024, and calendar year 2020 would be the baseline period for the payment year 2024 ESRD QIP. We proposed to calculate the performance standards for payment year 2024 using calendar year 2019 data, which would be the most recently available full calendar year data that is available to us. As I mentioned earlier, calendar year 2020

data, which is traditionally the data that we would use, are actually incomplete because we issued an Extraordinary Circumstances Exception which excluded that data from the ESRD QIP for scoring purposes. So, again, consistent with our established policy, we wanted to make sure that we were utilizing a full calendar year's worth of data to establish those benchmarks. Next slide, please.

This just really lays out some of our rationale. I know I mentioned some of that on the previous slide. Again, because we issued the Extraordinary Circumstance Exception, or ECE, the first removed both the first and second quarter data from calendar year 2020. We were concerned that it would be difficult to assess levels of achievement and improvement if the performance standards were based on partial year data. So, we conducted some analyses and we did find that we did see an effect. We did see that the excluded data would create higher performance standards for certain measures and lower performance standards for other measures, which in turn would skew achievement and improvement thresholds for facilities and therefore result in performance standards that do not accurately reflect levels of achievement and improvement. So, our current policy substitutes or allows us to substitute the performance standard, achievement threshold, and/or benchmark for a measure for a performance year if we find that the numerical values for the performance standard, achievement threshold, and/or benchmark are worse than the numerical values for the measure in the previous year of the ESRD QIP. So, we were concerned that this may create performance standards for certain measures that would be difficult for facilities to attain with a full 12 months of data. After looking at our analyses and considering public comments, we finalized our proposal to calculate the performance standards for payment year 2024 using calendar year 2019 data instead of calendar year 2020 data. All right. Next slide, please.

So, again, this slide just again summarizes some of our other policies that were finalized. As I mentioned earlier, we finalized a special rule policy, in which facilities would not receive a payment reduction, nor would they receive a Total Performance Score in payment year 2022.

We also finalized a special scoring policy that would not issue any achievement and improvement points for scores. Then, lastly, all of the measure rates as I mentioned earlier would be calculated for all of the measures. That information would be provided to facilities via Performance Score Reports. All right. Next slide, please.

Here is just a slide that shows our domains under these finalized proposals. Again, there were no changes to our measures and domains for payment year 2022. Items that you see here marked with a star, you'll see that on the left-hand side, the Long-Term Catheter Rate, and you'll see ICH CAHPS and other measures here. Those are the measures that were suppressed for payment year 2022. This chart also contains new domains and measure rates for each domain for payment year 2022. Again, there are four domains including the Clinical Care Domain, Care Coordination, the Safety Domain, and the Patient & Family Engagement Domain. As I have stated previously, no facility was awarded a Total Performance Score nor will any facility receive a payment reduction in payment year 2022. Okay. Next slide, please.

So, in the Calendar Year 2022 ESRD PPS Proposed Rule, we stated that if we did not finalize the proposed update to our performance standards policy, that we would update the minimum Total Performance Score for payment year 2024, as well as the payment reduction ranges for that payment year, in the rule using data from calendar year 2020. However, as we discussed a moment ago, we finalized the update to our performance standards for payment year 2024. Therefore, we will use the minimum TPS and payment reduction ranges for payment year 2024 that are described in Table 6 in the final rule, which you also see here in this slide. Again, you'll see that these are based on calendar year 2019 data and not calendar year 2020 data. All right. Next slide.

So, in addition to our proposals, we also requested information, comment, and feedback on a variety of topics relevant to the program. Next slide.

So, here, during the proposed rule, we received multiple requests for information and comment on several topics. We received some really great information on strategies to close the health equity gap in CMS, not only in ESRD QIP, but across all of our programs. We also received some great feedback on the feasibility of establishing COVID-19 measures, vaccination measures for both healthcare personnel and patients. Again, there is some really great feedback and we appreciate all of the comments that were given. We also, and lastly, we solicited feedback on strategies to advance the digital quality measurement for the program and by using Fast Healthcare Interoperability Resources. So, again, we appreciate all of the comments that were received on these three topics. We believe that the input was very valuable in helping to continue to shape our ability to refine and strengthen the program. All of your comments will be taken into account as we develop future regulatory proposals and or guides for our program efforts. At this time, that concludes our presentation.

Karen

VanBourgondien: Okay. Thank you. Next slide, Rachel.

So, again, Delia, thank you so much for spending time with us today and going over the rule. It's always nice to have CMS to keep us up-to-date on all these important program updates. Thank you, again. We also want to thank Arbor Research for their assistance today and for being available to help respond to questions.

We do have some resources here on this slide. Additionally, again the presentation slides, a recording, and a transcript of this event will be posted on CMS.gov. I did place that direct link in the chat box for you.

So again, thanks, thanks to all of you for joining us. We know that you're busy, and we appreciate you taking the time to be with us. Have a great day, and you may disconnect. Thank you.