Proposed PY 2017 Clinical Measure

Kt/V Dialysis Adequacy Measure Topic: Hemodialysis

Hemodialysis Adequacy Clinical Performance Measure III: Hemodialysis Adequacy--HD Adequacy-- Minimum Delivered Hemodialysis Dose Higher rate desired	
Measure Description	Percentage of hemodialysis patient-months with spKt/V greater than or equal to 1.2. NQF#0249
Numerator	Patient-months in the denominator for patients whose delivered dose of hemodialysis (spKt/V) was greater than or equal to 1.2 during the measurement period.
Denominator	Number of Medicare patients-months at the facility during the measurement period. Exclusions: 1. Patients younger than 18 years 2. Peritoneal patients 3. Patients on dialysis for fewer than 90 days 4. Patients dialyzing 4 times or more per week on average 5. Patients dialyzing 2 times or less per week on average 6. Patients having a spKt/V value less than 0.5 7. Patients having a spKt/V value greater than 2.5 8. Patients treated at the facility fewer than twice during the claim month 9. Patients not on chronic dialysis as defined by a completed 2728 form, a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims
Minimum Claims	1
Data Source(s)	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth)
Additional Information	1. Calculated from the last measurement of the month. 2. Must be calculated using UKM or Daugirdas II method. 3. Dialysis sessions per week is calculated as the number of dialysis sessions in the claim divided by the time period covered by the claim, with no rounding for the number of sessions per week. Frequent dialysis (4 or more sessions per week) is determined by (i) calculated sessions per week is 4 or more; (ii) Kt/V is 8.88 on claim; (iii) Other administrative data (e.g. CROWNWeb) indicates 4 or more sessions per week. 4. The reported spKt/V should not include residual renal function. 5. Patients with missing spKt/V values or spKt/V=9.99 (not reported) are included in the denominator.

Proposed PY 2017 Clinical Measure

Kt/V Dialysis Adequacy Measure Topic: Peritoneal Dialysis

Peritoneal Dialysis Adequacy Clinical Performance Measure III - Delivered Dose of Peritoneal Dialysis Above Minimum Higher rate desired	
Measure Description	Percentage of peritoneal dialysis patient-months with Kt/V greater than or equal to 1.7 Kt/V (dialytic + residual) during the four month study period. NQF#0318
Numerator	Patient-months in the denominator for patients whose delivered dose of peritoneal dialysis was equal to or greater than 1.7 Kt/V (dialytic + residual) during the measurement period.
Denominator	Number of Medicare patient-months at the facility during the measurement period. Exclusions: 1. Patients younger than 18 years 2. Hemodialysis patients 3. Patients on dialysis for fewer than 90 days 4. Patients having a Kt/V value less than 0.5 5. Patients having a Kt/V value greater than 5.0 6. Patients not on chronic dialysis as defined by a completed 2728 form, a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims
Minimum Claims	1
Data Source(s)	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth)
Additional Information	1. If no Kt/V value is reported for a given patient in a claim month, the most recent Kt/V value in the prior 4 months is applied to the calculation for that month. 2. Patients with missing Kt/V values or Kt/V=9.99 (not reported) are included in the denominator.

Proposed PY 2017 Clinical Measure

Kt/V Dialysis Adequacy Measure Topic: Pediatric Dialysis

Minimum spKt/V for Pediatric Hemodialysis Patients Higher rate desired	
Measure Description	Percentage of pediatric in-center hemodialysis patient-months with spKt/V greater than or equal to 1.2. NQF#1423
Numerator	Patient-months in the denominator for patients whose delivered dose of hemodialysis (spKt/V) was greater than or equal to 1.2 during the measurement period.
Denominator	Number of Medicare patient-months at the facility during the measurement period. Exclusions: 1. Patients 18 years or older 2. Peritoneal patients 3. Home hemodialysis patients 4. Patients on dialysis for less than 90 days 5. Patients having a spKt/V value less than 0.5 6. Patients having a spKt/V value greater than 2.5 7. Patients dialyzing 5 times or more per week on average 8. Patients dialyzing 2 times or less per week on average 9. Patients treated at the facility fewer than twice during the claim month 10. Patients not on chronic dialysis as defined by a completed 2728 form, a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims
Minimum Claims	1
Data Source(s)	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth)
Additional Information	1. Calculated from the last measurement of the month. 2. Must be calculated using UKM or Daugirdas II method. 3. Dialysis sessions per week is calculated as the number of dialysis sessions in the claim divided by the time period covered by the claim, with no rounding for the number of sessions per week. Frequent dialysis (5 or more sessions per week) is determined by (i) calculated sessions per week is 5 or more; (ii) Kt/V is 8.88 on claim; (iii) Other administrative data (e.g. CROWNWeb) indicates 4 or more sessions per week.The reported spKt/V should not include residual renal function. 4. Patients with missing spKt/V values or spKt/V=9.99 (not reported) are included in the denominator.

Proposed PY 2017 Clinical Measure

Vascular Access Type: AV Fistula

Hemodialysis Vascular Access – Maximizing Placement of Arterial Venous Fistula Higher rate desired	
Measure Description	Percentage of patient-months on hemodialysis during the last hemodialysis treatment of the month using an autogenous AV fistula with two needles. NQF#0257
Numerator	Patient-months in the denominator where an autogenous AV fistula with two needles was the means of access.
Denominator	Number of Medicare patient-months at the facility during the measurement period. Exclusions: 1. Patients younger than 18 2. Peritoneal patients 3. Claims with both a fistula and graft reported 4. Claims with fistula, graft, and catheter reported 5. Patients not on chronic dialysis as defined by a completed 2728 form, a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims
Minimum Claims	4 months
Data Source(s)	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth)
Additional Information	1. If claim indicates fistula and catheter, then only the fistula is counted. 2. Last claim of the month used for calculation.

Proposed PY 2017 Clinical Measures

Vascular Access Type: Catheter ≥ 90 Days

Hemodialysis Vascular Access – Minimizing Use of Catheters as Chronic Dialysis Access Lower rate desired	
Measure Description	Percentage of patient-months for patients on hemodialysis during the last hemodialysis treatment of month with a catheter continuously for 90 days or longer prior to the last hemodialysis session. NQF#0256
Numerator	Patient-months in the denominator for patients continuously using a catheter for hemodialysis access for 90 days or longer prior to the last hemodialysis treatment during the month.
Denominator	Number of Medicare patient-months at the facility during the measurement period. Exclusions: 1. Patients younger than 18 years and 3 months 2. Peritoneal patients 3. Claims with both a fistula and graft reported 4. Claims with fistula, graft, and catheter reported 5. Patients not on chronic dialysis as defined by a completed 2728 form, a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims
Minimum Claims	4 consecutive months
Data Source(s)	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth)
Additional Information	1. If claim indicates fistula and catheter, then only the fistula is counted. 2. If a claim indicates catheter and graft, then only the graft is counted. 3. Measure uses data prior to performance or comparison period (e.g., October – December 2014 for the performance period) to determine catheter history. 4. Last claim of the month used for calculation.

Proposed PY 2017 Clinical Measure

Hypercalcemia

Proportion of Patients with Hypercalcemia Lower rate desired	
Measure Description	Percentage of patient-months with 3-month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL. NQF #1454
Numerator	Number of patient-months in the denominator with 3-month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL.
Denominator	Number of patient-months at the facility during the measurement period. Exclusions: 1. Patients younger than 18 2. Patients present at facility for fewer than 30 days 3. Patients on dialysis for fewer than 90 days 4. Patients without an uncorrected serum calcium value at that facility in the reporting month 5. Patients not on chronic dialysis as defined by a completed 2728 form or a REMIS/CROWNWeb record
Minimum Claims	3 months
Data Source(s)	1. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD, time at facility, and date of birth)
Additional Information	1. November and December of the previous year will be used in calculating the three-month rolling average for January and February of the performance period. 2. Includes all patients (i.e., not just those patients on Medicare). 3. The last value reported in the month is used for calculation. 4. A patient need only have an uncorrected serum calcium value for the reporting month to be included in the measure. Any value reported during the two months prior to the reporting month will be used to calculate the 3-month rolling average. 5. No interpolation between uncorrected serum calcium values for peritoneal dialysis patients. 6. The uncorrected serum calcium value reported by the facility is used. The facility may obtain this value from an external source. 7. “Uncorrected” indicates albumin is not considered in the calculation.

Proposed PY 2017 Clinical Measure

Infection Monitoring: NHSN Bloodstream Infection in Hemodialysis Patients

NHSN Bloodstream Infection in Hemodialysis Outpatients Lower Adjusted Ranking Metric (ARM) value desired	
Measure Description	Adjusted Ranking Metric (ARM) of Bloodstream Infection will be calculated among patients receiving hemodialysis at outpatient hemodialysis centers. Based on NQF #1460
Numerator	The observed number of new positive blood culture events based on blood cultures drawn as an outpatient or within 1 calendar day after a hospital admission and adjusted for vascular access type, unmeasured variation and patient exposure volume reported by a given facility to NHSN for the entire year.
Denominator	The number of positive blood culture events predicted to have occurred in a given facility for the entire year. Calculation for this denominator incorporates the number of in-center hemodialysis patients treated in the outpatient hemodialysis facility for the year stratified by vascular access type. Exclusions: 1. Facilities that do not offer in-center hemodialysis 2. Facilities with a CCN open date after January 1, 2015
Data Source(s)	1. NHSN 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2744 to obtain facility type and certification date)
Additional Information	1. Facilities are required to meet enrollment and training requirements, as specified at http://www.cdc.gov/nhsn/dialysis/enroll.html and http://www.cdc.gov/nhsn/Training/dialysis/index.html. 2. Data are collected as specified by the NHSN Dialysis Event Surveillance Protocol: http://www.cdc.gov/nhsn/PDFs/pscManual/8pscDialysisEventcurrent.pdf. 3. A positive blood culture is considered a new event and counted only if it occurred 21 days or more after a previously reported positive blood culture in the same patient. 4. Patients receiving inpatient hemodialysis are excluded from the measure. 5. Patients receiving home hemodialysis or peritoneal dialysis are excluded from the measure. 6. Facilities who do not submit 12 months of accurately reported data receive zero points for the measure. 7. For more information about the methodology used to calculate the Adjusted Ranking Metric (ARM), please see http://www.cdc.gov/nhsn/dialysis/ and http://www.cdc.gov/nhsn/PDFs/dialysis/NHSN-ARM.pdf.

Proposed PY 2017 Clinical Measure

Standardized Readmission Ratio

Standardized Readmission Ratio Lower rate desired	
Measure Description	Risk-adjusted standardized hospital readmissions ratio of the number of observed unplanned readmissions to the number of expected unplanned readmissions.
Numerator	Number of observed and unplanned hospital readmissions
Denominator	The expected number of unplanned readmissions in each facility, which is derived from a model that accounts for patient characteristics and the discharging acute care hospitals involved. Index hospital discharges that: 1. End in death 2. Result in a patient dying within 30 days with no readmission 3. Are against medical advice 4. Include a primary diagnosis for certain types of cancer, mental health conditions or rehabilitation 5. Occur after a patient's 12th admission in the calendar year 6. Are from a PPS-exempt cancer hospital 7. Result in a transfer to another hospital on the same day
Minimum Claims	Facilities with fewer than 11 index hospital discharges are not eligible for the measure.
Data Source(s)	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data
Additional Information	1. Hospitalizations are counted as events in the numerator if they (a) occurred within 30 days of a hospital discharge; and (b) are not considered a "planned" readmission. 2. Additional information about the measure can be found in the SRR Measure Methodology Report posted at [http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html].

Proposed PY 2017 Reporting Measure

Mineral Metabolism

Mineral Metabolism Reporting	
Measure Description	Number of months for which facility reports serum phosphorus values for each Medicare patient.
Exclusions	1. Facilities with a CMS certification on or after July 1, 2015 2. In-center hemodialysis patients treated at facility fewer than 7 times during claim month 3. Home dialysis patients for whom a facility does not submit a claim during the claim month 4. Facilities treating zero patients during the performance period who are (i) in-center Medicare patients who have been treated at least 7 times by the facility during the reporting month; or (ii) home dialysis Medicare patients for whom the facility submits a claim during the reporting month. 5. Patients not on chronic dialysis as defined by a completed 2728 form or a REMIS/CROWNWeb record
Data Sources	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2744 to obtain certification date)
Additional Information	1. The serum phosphorus values reported by the facility are used. The facility may obtain these values from an external source. 2. If a facility treats less than 11 eligible patients, then it must report data for all but one patient. 3. If a facility treats 11 or more patients, then it must report data for all patients. 4. The measure will be scored according to the following formula: $\left(\frac{Number\ of\ Months\ Facility\ Successfully\ Reports}{Number\ of\ Months\ in\ the\ Performance\ Period\ Facility\ has\ CCN}\ x\ 12\right) - 2$

Proposed PY 2017 Reporting Measure

Anemia Management

Anemia Management Reporting	
Measure Description	Number of months for which facility reports ESA dosage (as applicable) and hemoglobin/hematocrit for each Medicare patient at least once per month.
Exclusions	1. Facilities with a CMS certification on or after July 1, 2015 2. In-center hemodialysis patients treated at a facility fewer than 7 times during claim month 3. Home dialysis patients for whom a facility does not submit a claim during the claim month 4. Facilities treating zero patients during the performance period who are (i) in-center Medicare patients who have been treated at least 7 times by the facility during the reporting month; or (ii) home dialysis Medicare patients for whom the facility submits a claim during the reporting month 5. Patients not diagnosed with ESRD as defined by a completed 2728 form or a REMIS/CROWNWeb record
Data Sources	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2744 to obtain certification date)
Additional Information	1. Hemoglobin value of 99.99 is not considered valid for purposes of measure. Note: we will not penalize facilities for using the default 99.99 value for a patient in his/her first month of treatment at that facility. 2. The hemoglobin/hematocrit reported by the facility is used. The facility may obtain this value from an external source. 3. No ESA dosage need be recorded if patient is not treated with ESAs. 4. ESA dosage must be reported via HCPCS codes and corresponding units, as applicable. 5. If a facility treats less than 11 eligible patients, then it must report data for all but one patient. 6. If a facility treats 11 or more patients, then it must report data for all patients. 7. The measure will be scored according to the following formula: $\left(\frac{Number\ of\ Months\ Facility\ Successfully\ Reports}{Number\ of\ Months\ in\ the\ Performance\ Period\ Facility\ has\ CCN}\ x\ 12\right) - 2$

Proposed PY 2017 Reporting Measure

Patient Experience of Care: ICH CAHPS Survey Administration

ICH CAHPS Administration	
Measure Description	Facility administers the In-Center Hemodialysis CAHPS survey (ICH CAHPS) on a twice-yearly basis, using a third-party CMS-approved vendor, in accordance with specifications available at https://ichcahps.org and submits (via CMS-approved vendor) survey results to CMS.
Exclusions	1. Facilities treating fewer than 30 eligible in-center hemodialysis adult patients during the "eligibility period," which is defined as the year prior to the performance period 2. Facilities that treat 30 or more eligible in-center hemodialysis adult patients during the "eligibility period," but are unable to obtain at least 30 completed surveys during the performance period 3. Facilities with a CCN open date on or after January 1, 2015 4. The following patients are excluded in the count of 30 eligible patients: a) Patients less than 18 years on the last day of the sampling window for the semiannual survey b) Patients receiving hemodialysis from their current facility for less than 3 months c) Patients receiving hospice care d) Patients currently residing in an institution, such as a residential nursing home or other long-term care facility, or a jail or prison
Data Sources	1. ICH CAHPS 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2744 to obtain certification date and facility type)
Additional Information	1. Facilities are required to register on the https://ichcahps.org website in order to authorize a CMS-approved vendor to administer the survey and submit data on their behalf. 2. Facilities are required to administer the survey twice during the performance period, using a CMS-approved vendor. 3. Facilities are required to ensure that vendors submit survey data to CMS by the date specified at https://ichcahps.org. 4. Additional specifications may be found at https://ichcahps.org.