End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

Payment Year (PY) 2020 Preview Period

Guide to the PY 2020 ESRD QIP Performance Score Report (PSR)

July 22, 2019

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1. Introduction

1.1 Background

The ESRD QIP promotes high-quality care delivered by outpatient dialysis facilities treating patients with ESRD. The first of its kind in Medicare, this program changes the way CMS pays for the treatment of ESRD patients by linking a portion of payment directly to facilities' performance on quality care measures. Facilities that fail to meet these performance standards may be subject to a payment reduction of up to 2%.

ESRD QIP was established by Congress under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and is administered by CMS. The final rule outlining the program for payment year (PY) 2020 (CMS-1651-F) was first published in the Federal Register on 11/4/2016 (https://www.govinfo.gov/content/pkg/FR-2016-11-04/pdf/2016-26152.pdf).

Updates to programmatic policies for the PY 2020 ESRD QIP were included with the final rule outlining the program for PY 2021 (CMS-1674-F), which was published in the Federal Register on 11/1/2017 (https://www.govinfo.gov/content/pkg/FR-2017-11-01/pdf/2017-23671.pdf).

1.2 Purpose

The purpose of the Performance Score Report (PSR) is to provide each facility with information regarding:

- Performance on each of the quality measures
- The Total Performance Score (TPS) and how the score was calculated
- How Medicare payments to this facility will be affected as a result of the TPS

The purpose of the Guide to the PY 2020 ESRD QIP PSR is to provide additional detail related to the methodology used in the ESRD QIP scoring process, with specific references to elements provided throughout the PSR.

The information presented in this guide applies to the Preview PSR, which will be available for download on 7/22/2019, and the Final PSR, which will be available for download in late 2019. In December 2019, a Performance Score Certificate (PSC) based on the data presented in the Final PSR will be available for each facility. All facilities are required by law to print and display their PSC in a prominent area for the duration of calendar year (CY) 2020, even if the facility did not receive a TPS. The downloadable file that contains the PSC will include a version of the certificate in English and in Spanish. Facilities are required to display both the English and Spanish versions of the PSC in a prominent area within the facility.

Under the PY 2020 ESRD QIP, CMS applies a formula to award points to facilities based on their performance on a total of 16 quality of care measures. The performance measures are a combination of clinical, safety, and reporting measures.

1.2.1 Clinical Measures

- In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Clinical Measure
- Standardized Readmission Ratio (SRR) Clinical Measure
- Standardized Transfusion Ratio (STrR) Clinical Measure
- Standardized Hospitalization Ratio (SHR) Clinical Measure
- Kt/V Dialysis Adequacy Comprehensive Clinical Measure
- Vascular Access measure topic, made up of two measures:
  - Arteriovenous Fistula (AVF) Clinical Measure
  - Catheter > 90 Days Clinical Measure
- Hypercalcemia Clinical Measure

Generally, CMS calculates a facility's score for each clinical measure using the achievement and improvement scoring methodology. Your score for each clinical measure is calculated based on your facility's performance rate during the performance period compared to two ranges.

- The **achievement range** is the scale running from the Achievement Threshold to the Benchmark, where the Achievement Threshold is the 15th percentile of national performance for CY 2016, and the Benchmark is the 90th percentile of national performance for CY 2016.
  - Each facility can earn 0 – 10 points for achievement.
- The **improvement range** is the scale running from the Improvement Threshold to the Benchmark, where the Improvement Threshold is the facility's performance rate during CY 2017, and the Benchmark is the 90th percentile of national performance for CY 2016.
  - Each facility can earn 0 – 9 points for improvement.

Your facility's scores for achievement and improvement are based on where your facility's performance rate falls on the achievement and improvement ranges, respectively. Your score for each measure will be based on the higher of your achievement or improvement score for that measure.

For the PY 2020 ESRD QIP, the Improvement Period is CY 2017 or 1/1/2017 – 12/31/2017, and the Performance Period is CY 2018 or 1/1/2018 – 12/31/2018. If your facility does not have sufficient data to calculate a performance rate during 2017 but does have sufficient information to calculate a performance rate during 2018, then your facility score for that measure is based solely on achievement.

If your facility does not meet the minimum data requirements for a measure in the performance period (e.g., 11 eligible patients who meet the criteria for the measure, 11 index discharges for SRR, 10 patient-years at risk for STrR, 5 patient-years at risk for SHR, or ≥30 returned surveys in the performance period for ICH CAHPS), then your facility is not scored on

that measure. If your facility has 11 – 25 eligible cases for a clinical measure (11 – 41 index discharges for SRR, or 10-21 patient years at risk for STrR, or 5-14 patient-years at risk for SHR), then the rate is subject to a small facility adjustment. The small sample size in these facilities puts them at risk for having one or two challenging patients dramatically alter their performance rates and ESRD QIP performance scores. The ESRD QIP therefore applies a favorable adjustment to performance rates for such facilities, effectively giving them the "benefit of the doubt."

1.2.2 Safety Measures

- The National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Outpatients measure topic, made up of two measures:
  - NHSN Bloodstream Infection Clinical Measure
  - NHSN Dialysis Event Reporting Measure

CMS calculates a facility's score for the NHSN Bloodstream Infection clinical measure according to the methodology described in section 1.2.1 above. See section 1.2.3 below for a description of the methodology used to calculate the NHSN Dialysis Event reporting measure.

1.2.3 Reporting Measures

- Serum Phosphorous Reporting Measure
- Anemia Management Reporting Measure
- Ultrafiltration Reporting Measure
- Pain Assessment and Follow-Up Reporting Measure
- Clinical Depression Screening and Follow-Up Reporting Measure
- NHSN Healthcare Personnel Influenza Vaccination Reporting Measure

CMS calculates ESRD QIP scores for each reporting measure by determining whether (1) your facility reported required data on claims and/or CROWNWeb or (2) reported required data in accordance with the requirements for the measure in question. If your facility does not meet the eligibility requirements for a particular clinical or reporting measure, then your facility will not be scored on that measure.

1.2.4 Total Performance Score

CMS calculates your facility's TPS by weighting the measure scores and translating those weighted scores into a point range of 0 – 100. Your Payment Reduction Percentage is then determined by comparing your TPS to the appropriate score ranges. Facilities with a TPS of fewer than 60 points (out of 100) will have their Medicare payments for CY 2020 dialysis services reduced on a sliding scale, with a maximum 2% reduction.

For further details on the PY 2020 measures and their scoring methodology, please refer to the CMS ESRD Measures Manual at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/ESRD-Manual-v31.pdf.

2. Preview Period and Inquiry Process

During the preview period (7/22/2019- 8/23/2019), facilities may ask an unlimited number of clarification questions (CQs) and systemic clarification questions (SCQs) about how the system calculates scores. If your facility believes an error has been made regarding the calculations or data used for your facility's score, your facility can submit one formal inquiry (FI). Your facility should provide an explanation and evidence of the possible calculation error. All formal inquiries will be addressed prior to finalizing facility performance scores, finalizing payment reduction percentages, and publishing PSCs. Facilities are required to use the ESRD QIP 4.0.0 system at https://www.Qualitynet.org to submit CQs, SCQs, or an FI. Each facility should designate one person as the ESRD QIP facility point of contact (POC) who can ask CQs and SCQs, request patient-level data, and submit an FI. If you wish to submit a CQ, request patient-level data, or make an FI but do not see the options to do so, you may not have the appropriate permission as a facility POC. If you cannot identify your facility's POC, please contact the QualityNet ESRD Help Desk at qnetsupport-esrd@hcqis.org. Please provide your facility's CMS Certification Number (CCN) when contacting the Help Desk.

2.1 Differences between Formal Inquiries, Clarification Questions, and Systemic Clarification Questions

Throughout the preview period, facilities can submit CQs. For example, your facility might have questions about how a measure is calculated. CMS strongly encourages facilities to review their scores early and submit any CQs by 8/8/2019 in order to allow enough time for investigation and determination of whether an FI needs to be submitted.

Facilities can also identify if a systemic error occurred regarding the way the system calculates facility scores. For example, your facility POC can submit an SCQ if your facility believes a scoring algorithm for a measure was improperly configured and resulted in inaccurate scores for all facilities. Facilities are not limited in the number of SCQs they can submit, and all facility scores will be recalculated if a systemic error is verified.

If your facility believes it has identified a scoring error particular to your facility, then your facility's POC may submit a single FI. The FI should include specific evidence or an explanation as to why your facility believes a calculation error occurred. Facilities must indicate approval from the Facility Manager at the time of the FI's submission. CMS will address all FIs prior to finalizing performance scores, finalizing payment reduction percentages, and publishing PSCs. Please note that CMS will respond to CQs, SCQs, and FIs via the ESRD QIP system.

Although each facility is permitted to submit only one FI, facilities may submit an unlimited number of CQs or SCQs. However, if your facility submits CQs after 8/8/2019, CMS cannot guarantee a response with sufficient time to submit an FI. The single FI can and should include all errors or issues identified by your facility for review and consideration by CMS. CMS will not accept FIs, CQs, or SCQs after 11:59 p.m. PDT on 8/23/2019. However, CMS will accept some requests for additional information that are submitted after the end of the preview period.

2.1.1 Formal Inquiries: Submit a Formal Inquiry

Before submitting an FI, it is often useful to submit concerns as CQs and review the patient-level data used to calculate scores. While facilities can submit multiple CQs, each facility can only submit one FI for CMS review. However, facilities can include multiple errors identified in one FI submission. Submitting concerns as CQs first allows a facility to ensure proper use of the one FI.

If your facility has evidence that an ESRD QIP measure calculation is incorrect, or that the data used for calculations were inappropriate, an FI may be submitted for CMS review. An FI requesting to change a measure score must be based on evidence that is explained in the FI itself.

FIs about your facility's Preview PSR must be accompanied with specific evidence or arguments as outlined in this guide. If your facility is uncertain of how to meet the FI requirements, you are encouraged to submit its concerns as a CQ on or prior to 8/8/2019. The QualityNet ESRD Help Desk will help facilities determine whether an FI is appropriate.

2.1.2 Clarification Questions: Question About My ESRD QIP Score

If this guide does not fully address your facility's question, then questions may be submitted via the ESRD QIP system. More details on submitting CQs can be found in the Basic User Manual for EQRS on QualityNet.org.

Facilities can use CQs to address a wide range of concerns, including the following items:

- Details regarding potential errors in facility-specific calculations or data, including patient counts and facility performance
- General questions regarding ESRD QIP methodology
- Reporting potential errors in facility information, including the facility name, address, or CCNs

2.1.3 Systemic Clarification Questions: Question About Multiple ESRD QIP Scores

Facilities can submit SCQs if they suspect logic error(s) in multiple facilities' score calculations.

- Specific question regarding ESRD QIP scoring methodology
- More details on how to submit SCQs can be found in the Basic User Manual for EQRS Manual on QualityNet.org

2.2 Patient-Level Data

A review of the list of patients with Medicare claims data or CROWNWeb data included in facility calculations may need to be conducted before submitting CQs or FIs. Each facility has access to the Preview Patient List Report (PLR); included in this report is the listing of patient names and health care IDs, and the patient information for lab values, index discharges, hospital readmissions, numerators, denominators and other patient-level data, associated with your facility.

2.3 After the Preview Period

In late 2019, a Final PSR will be accessible to each facility. The Final PSR, showing the final results of the PY 2020 ESRD QIP, will reflect the results shown in the Preview PSR unless an inquiry led to CMS-approved changes during the preview period, in which case those changes will be reflected in the Final PSR. In late 2019, the PSC will be made available. Each facility must download and print its English and Spanish PSC. Even if a facility did not receive a TPS, each ESRD QIP-eligible facility must post both of its PSCs in a prominent area for the duration of CY 2019.

3. Contents of the Performance Score Report

3.1 Clinical Measure Domain (Table 1 and Table 2 of PSR)

The Clinical Measure Domain is comprised of subdomains that group measures into two categories: the Clinical Care Subdomain and the Patient and Family Engagement/Care Coordination Subdomain. It comprises 75% of the TPS. Tables 1 and 2 of the PSR display the performance results for your facility on each of the measures included in these subdomains. For the subdomains within the Clinical Measure Domain, the following terms and processes are used for scoring purposes. For the PY 2020 ESRD QIP, the Improvement Period is CY 2017 or 1/1/2017 – 12/31/2017, and the Performance Period is CY 2018 or 1/1/2018 –12/31/2018.

Achievement Threshold: The national Achievement Threshold is the 15th percentile of performance rates nationally during CY 2016.

Benchmark: The national Benchmark is the 90th percentile of performance rates nationally during CY 2016.

Improvement Score: Compares your facility's performance on a measure during the performance period (CY 2018) to its own performance during a comparison period (CY 2017). An Improvement Score is provided if your facility's Performance Period Rate/Ratio meets the following criteria:

- Your facility's Performance Period Rate/Ratio does not exceed your facility's Improvement Period Rate/Ratio
- Your facility's Performance Period Rate/Ratio does not meet the Benchmark

The Improvement Score is determined by the following equation, and then rounded:

10 x [(Performance Period Rate/Ratio – Improvement Period Rate/Ratio) ÷ (Benchmark – Improvement Period Rate/Ratio)] - 0.5

Achievement Score: Compares your facility's performance on a measure during the performance period (CY 2018) to the performance of all facilities nationally during the comparison period (CY 2016). If your facility's Performance Rate meets or exceeds the Benchmark, then 10 points are awarded for the Achievement Score. If your facility's Performance Rate does not exceed the Achievement Threshold (or fall below the Achievement Threshold where lower rates/ratios are better), then 0 points are awarded for the Achievement Score. An Achievement Score is calculated if your facility's Performance Period Rate/Ratio does not meet or exceed the Benchmark.

The Achievement Score is determined by the following equation, and then rounded:

9 x [(Performance Period Rate/Ratio – Achievement Threshold) ÷ (Benchmark – Achievement Threshold)] + 0.5

Measure Score: Your facility's score for each measure is the higher of either the Improvement or Achievement Score.

For the Vascular Access measure topic, the measure topic score is determined by averaging the

individual measure scores for each topic (i.e. VAT Fistula and VAT Catheter) and weighting each measure score based on the patient count for each measure.

For the ICH CAHPS measure, the measure score is determined by averaging the individual scores of the composite items.

Measure Weight (% of Subdomain): Below are the assigned weights for the measures in each subdomain. Note that if your facility is not eligible for a measure, the weight of the measure will be redistributed within the entire Clinical Domain. The subdomain weights will be adjusted proportionally using the Clinical Domain measure weights after redistribution.

Clinical Care Subdomain: Hypercalcemia is weighted at 3.33% of the subdomain, STrR and SHR are both weighted at 18.33% of the subdomain, and both the Kt/V Comprehensive measure and the Vascular Access measure topic are weighted at 30.00% of the subdomain.

Patient and Family Engagement/Care Coordination Subdomain: ICH CAHPS is weighted at 62.50% of the subdomain and SRR is weighted at 37.50% of the subdomain.

Eligible Clinical Care Measures/Measure Topics: The number of eligible measures or measure topic for each subdomain, based on the specified eligibility criteria.

Weighted Subdomain Score: To calculate each subdomain score, each individual measure or measure topic score within the subdomain is converted to a weighted measure score. These weighted subdomain scores are then summed to make up each subdomain score with a scale of 0-100.

3.1.1 Clinical Care Subdomain Measures and Measure Topics (Table 1 of PSR)

The following measures are included in the Clinical Care Subdomain:

- Hypercalcemia
- Kt/V Comprehensive
- Standardized Transfusion Ratio (STrR)
- Standardized Hospitalization Ratio (SHR)
- Vascular Access Measure Topic – AVF
- Vascular Access Measure Topic – Cather > 90 days

For each measure in the Clinical Care Subdomain, facilities must have at least 11 patients who meet the eligibility criteria, or in the case of STrR and SHR, 10 and 5 patient-years at risk, respectively. For the Vascular Access Type measures, the measure topic score will reflect only the measure(s) that meet the applicable case minimum. When an eligible facility does not meet the minimum eligibility criteria for a measure, no score is calculated for the Improvement or Performance Period rate/ratio fields. If the small facility adjustment is applied (10-21 patient-years at risk for STrR, 5-14 patient-years at risk for SHR, or 11-25 eligible patients for the other measures), the adjusted value will be noted in Performance Period

Rate/Ratio cell with an indication ([s]). It is possible for your facility to have enough patients to calculate one measure but not others. If the measure score has the following indication ([c]), it notes that it is a measure topic score that was derived from aggregating the individual measure scores for that topic. A dash (-) within the table indicates that your facility was not eligible to receive a score on the measure, while an "N/A" indicates that the value is not applicable to the measure or measure topic score calculation.

Specific inclusion criteria for each measure in the Clinical Care Subdomain is described in the CMS ESRD Measures Manual, which can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/ESRD-Manual-v31.pdf
The overall calculation process and the details of the content of each cell in the PSR for the Clinical Care Subdomain measures are described in further detail below.

Improvement Period (CY 2017) and Performance Period (CY 2018) Calculations:

Measure	Numerator	Denominator	Rate/Ratio
Hypercalcemia:	The number of patient-months that meet the Hypercalcemia denominator inclusion criteria with a 3-month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL at your facility.	The number of patient- months that meet the Hypercalcemia inclusion criteria at your facility.	The percentage of patient-months with a 3-month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL. For this measure, a lower rate indicates better performance.
Kt/V Comprehensive:	Number of patient months in the Kt/V Comprehensive denominator for patients whose delivered dose of dialysis met the following specified thresholds: • Hemodialysis (all ages): spKt/V ≥ 1.2 (calculated from the last measurement of the month using UKM or Daugirdas II) • Peritoneal dialysis (pediatric <18 years): Kt/V ≥ 1.8 (dialytic + residual, measured within the past 6 months) Peritoneal dialysis (adult >= 18 years): Kt/V ≥ 1.7 (dialytic + residual, measured within the past 4 months)	The number of patient- months that meet the Kt/V Comprehensive inclusion criteria at your facility.	The percentage of all patient-months for patients whose delivered dose of dialysis (either hemodialysis or peritoneal dialysis) met the specified threshold.

Measure	Numerator	Denominator	Rate/Ratio
Standardized Transfusion Ratio (STrR)	The number of observed red blood cell transfusion events (defined as transfer of one or more units of blood or blood products into recipient's blood stream) among patients dialyzing at your facility.	The number of eligible red blood cell transfusion events that would be expected among patients at a facility, given the patient mix at your facility.	The ratio of number of observed eligible red blood cell transfusion events occurring in patients dialyzing at your facility to the number of eligible transfusions that would be expected from a predictive model that accounts for patient characteristics within your facility. For this measure, a lower rate indicates better performance.
Standardized Hospitalization Ratio (SHR):	The number of inpatient hospital admissions among eligible patients at your facility.	The number of hospital admissions that would be expected among eligible patients at a facility, given the patient mix at your facility.	The ratio of number of observed hospitalizations to the number of eligible hospitalizations that would be expected from a predictive model that accounts for patient characteristics within your facility**.** For this measure, a lower rate indicates better performance.
Arteriovenous Fistula (AVF):	The number of patient-months that meet the AVF denominator inclusion criteria with an autogenous AV fistula with two needles in use during a month's last treatment at your facility.	The number of patient-months that meet the AVF inclusion criteria at your facility.	The percentage of patient-months on hemodialysis during the last treatment of the month using an autogenous AV fistula with two needles.
Catheter ≥ 90 Days:	The number of patient-months that meet the Catheter denominator inclusion criteria where patients with a catheter continuously in use for hemodialysis access for at least 90 days prior to the last hemodialysis treatment at your facility.	The number of patient-months that meet the Catheter inclusion criteria at your facility.	The percentage of patient-months where a patient with a catheter continuously in use for hemodialysis access for at least 90 days prior to the last hemodialysis treatment. For this measure, a lower rate indicates better performance.

3.1.2 Patient and Family Engagement/Care Coordination Subdomain (Table 2 of PSR)

The following measures are included in the Patient and Family Engagement/Care Coordination Subdomain:

- In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS)
- Standardized Readmissions Ratio (SRR)

For the ICH CAHPS measure, facilities that are compliant with the ICH CAHPS reporting

requirements must have at least 30 completed surveys during the performance period (CY 2018) in order receive a score on the measure. Facilities that are not compliant with the ICH CAHPS reporting requirements and do not attest in CROWNWeb that they are ineligible for the measure will receive a score of 0 for the measure, regardless of the number of surveys returned during the performance period. Exceptions include: (1) facilities with a CMS certification date on or after January 2018; and (2) facilities that do not provide in-center hemodialysis according to CROWNWeb as of 12/31/2018.

For the SRR measure, facilities must have at least 11 eligible index discharges during each measurement period in order to receive a score for that period. If a facility has 10 or fewer eligible index discharges in the Improvement or Performance Period, no score is calculated for the Improvement or Performance Period rate/ratio fields. If the small facility adjustment is applied to the Performance Period ratio (11-41 index discharges in the Performance Period for SRR), the adjusted value will be noted in Performance Period Rate/Ratio cell with an indication ([s]). Note that the ICH CAHPS will not have a small facility adjustment.

It is possible for your facility to have enough patients to calculate one measure but not others. If the measure score has the following indication ([c]), it notes that it is a measure topic score that was derived from aggregating the individual measure scores for that topic. A dash (-) within the table indicates that your facility was not eligible to receive a score on the measure, while an "N/A" indicates that the value is not applicable to the measure or measure topic score calculation.

Specific inclusion criteria for each measure in the Patient and Family Engagement/Care Coordination Subdomain is described in the CMS ESRD Measures Manual, which can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/ESRD-Manual-v31.pdf. The overall calculation process and the details of the content of each cell in the PSR for the Patient and Family Engagement/Care Coordination Subdomain measures are described in further detail below.

Please also note that the score for the ICH CAHPS measure is determined as a composite score, where the improvement and achievement score is calculated for each sub-measure. The better of the achievement or improvement score is assigned for each sub-measure, then the average is taken to comprise the ICH CAHPS measure score. The measure set includes three composite measures (Nephrologists' Communication and Caring, Quality of Dialysis Center Care and Operations, and Providing Information to Patients) and three global ratings (Overall Rating of Nephrologists, Overall Rating of Dialysis Staff, and Overall Rating of Dialysis Facility). Accordingly, there is no information for the ICH CAHPS measure presented here, except for the Measure Score. For the individual composite items, there is no numerator or denominator information available. All items not available are presented as "N/A" within the PSR.

Improvement Period (CY 2017) and Performance Period (CY 2018) Calculations:

Measure	Numerator	Denominator	Rate/Ratio
Nephrologists' Communications and Caring – ICH CAHPS composite:	*Value is not applicable to the measure/measure topic scoring calculation*	*Value is not applicable to the measure/measure topic scoring calculation*	The percentage of sampled patients who responded that the nephrologist and dialysis center staff "always" communicated well with them.
Quality of Dialysis Care and Operations – ICH CAHPS composite:	*Value is not applicable to the measure/measure topic scoring calculation*	*Value is not applicable to the measure/measure topic scoring calculation*	The percentage of sampled patients who responded that the nephrologist and dialysis center staff "always" operated professionally and according to expectations.
Providing Information to Patients – ICH CAHPS composite:	*Value is not applicable to the measure/measure topic scoring calculation*	*Value is not applicable to the measure/measure topic scoring calculation*	The percentage of sampled patients who responded that the nephrologist and dialysis center staff "always" provided information needed.
Overall Rating of Nephrologists – ICH CAHPS composite:	*Value is not applicable to the measure/measure topic scoring calculation*	*Value is not applicable to the measure/measure topic scoring calculation*	The percentage of sampled patients who rated the nephrologists a 9 or 10 on the respective questions in the survey.
Overall Rating of Dialysis Staff – ICH CAHPS composite:	*Value is not applicable to the measure/measure topic scoring calculation*	*Value is not applicable to the measure/measure topic scoring calculation*	The percentage of sampled patients who rated the dialysis facility staff a 9 or 10 on the respective questions in the survey.
Overall Rating of Dialysis Facility – ICH CAHPS composite:	*Value is not applicable to the measure/measure topic scoring calculation*	*Value is not applicable to the measure/measure topic scoring calculation*	The percentage of sampled patients who rated the dialysis facility a 9 or 10 on the respective questions in the survey.
Standardized Readmission Ratio (SRR):	The observed number of unplanned 30-day hospital readmissions at your facility.	The expected number of unplanned 30-day hospital readmissions at your facility, which is derived from a model that accounts for patient characteristics, the dialysis facility to which the patient is discharged and the discharging acute care or critical access hospital involved.	The number of observed unplanned 30-day hospital readmissions divided by the risk-adjusted expected number of hospital 30-day readmissions. For this measure, a lower ratio indicates better performance.

3.2 Safety Domain (Table 3 and Table 4 of PSR)

The Safety Domain includes the following two measures, and it comprises 15% of the TPS.

- National Healthcare Safety Network (NHSN) Topic – NHSN Bloodstream Infection Clinical Measure
- National Healthcare Safety Network (NHSN) Topic – NHSN Dialysis Event Reporting Measure

For the measure in the Safety Domain, facilities must have at least 11 patients who meet the denominator inclusion criteria. When 0-10 patients are eligible for the NHSN Bloodstream Infection clinical measure, no score is calculated for the Improvement or Performance Period rate/ratio fields. If the small facility adjustment is applied (11-25 eligible patients), the adjusted value will be noted in Performance Period Rate/Ratio cell with an indication ([s]). If the measure score has the following indication ([c]), it notes that it is a measure topic score that was derived from aggregating the individual measure scores for that topic. A dash (-) within the table indicates that the facility was not eligible to receive a score on the measure, while an "N/A" indicates that the value is not applicable to the measure or measure topic score calculation.

Specific inclusion criteria for the measure in the Safety Domain is described in the CMS ESRD Measures Manual, which can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/ESRD-Manual-v31.pdf.

The overall calculation process and the details of the content of each cell in the PSR for the Safety Domain measure is described in further detail below.

3.2.1 Safety Domain Measures (Table 3 Topic and Clinical Measure)

For the NHSN topic within the Safety Domain, the measure topic score is determined by averaging the individual measure scores and weighting each measure score based on the patient count for each measure.

For the NHSN Bloodstream Infection clinical measure, the following terms and processes are used for scoring purposes. For the PY 2020 ESRD QIP, the Improvement Period is CY 2017 or 1/1/2017 – 12/31/2017, and the Performance Period is CY 2018 or 1/1/2018 – 12/31/2018.

Achievement Threshold: The national Achievement Threshold is the 15th percentile of performance rates nationally during CY 2016.

Benchmark: The national Benchmark is the 90th percentile of performance rates nationally during CY 2015.

Improvement Score: Compares your facility's performance on a measure during the performance period (CY 2018) to its own performance during a comparison period (CY 2017). An Improvement Score is provided if your facility's Performance Period Rate/Ratio meets the

following criteria:

- Your facility's Performance Period Rate/Ratio does not exceed Your facility's Improvement Period Rate/Ratio
- Your facility's Performance Period Rate/Ratio does not meet the Benchmark

The Improvement Score is determined by the following equation, and then rounded:

10 x [(Performance Period Rate/Ratio – Improvement Period Rate/Ratio) ÷ (Benchmark – Improvement Period Rate/Ratio)] - 0.5

Achievement Score: Compares your facility's performance on a measure during the performance period (CY 2018) to the performance of all facilities nationally during the comparison period (CY 2016). If your facility's Performance Rate meets or exceeds the Benchmark, then 10 points are awarded for the Achievement Score. If your facility's Performance Rate does not exceed the Achievement Threshold, then 0 points are awarded for the Achievement Score.

An Achievement Score is calculated if your facility's Performance Period Rate/Ratio does not meet or fall below the Benchmark.

The Achievement Score is determined by the following equation, and then rounded:

9 x [(Performance Period Rate/Ratio – Achievement Threshold) ÷ (Benchmark – Achievement Threshold)] + 0.5

Measure Score: Your facility's score for the NHSN Bloodstream Infection clinical measure is the higher of either the Improvement or Achievement Score.

Measure Weight (% of Domain): The NHSN Bloodstream Infection clinical measure comprises 60% of score for the Safety Domain.

Improvement Period (CY 2017) and Performance Period (CY 2018) Calculations:

Measure	Numerator	Denominator	Rate/Ratio
NHSN Bloodstream Infection:	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.	The expected (risk- adjusted) infections in maintenance in-center hemodialysis patients treated in the outpatient hemodialysis unit on the first 2 working days of the month.	The Standardized Infection Ratio (SIR) of Bloodstream Infections (BSI) will be calculated among patients receiving hemodialysis at outpatient hemodialysis centers.

3.2.2 Safety Domain Measures (Table 4 Reporting Measure)

Monthly Calculations:

Measure	Number of Reported Months	Number of Eligible Months
NHSN Dialysis Event Reporting Measure:	Number of months for which your facility reported National Healthcare Safety Network (NHSN) Dialysis Event data to the Centers for Disease Control and Prevention (CDC).	Facilities must be eligible for all 12 months in the Performance Period (CY 2018).

Measure Score: The NHSN Dialysis Event reporting measure score is determined as follows:

- 10 points are assigned for successfully reporting 12 months
- 2 points are assigned for successfully reporting 6-11 months
- 0 points are assigned for successfully reporting 0-5 points.

Measure Weight (% of Domain): The NHSN Dialysis Event reporting measure comprises 40% of the score for the Safety Domain.

Eligible Safety Measures: The number of eligible measures for your facility, based on the specified eligibility criteria.

Weighted Safety Domain Score: The weighted Safety Domain score for your facility, based on the measure scores and measure weights.

Note that if your facility is not eligible for the Safety Domain measures, the Safety Domain weight will be reallocated to the remaining domains such that 60% of the domain weight will be equally distributed across all eligible measures in the Clinical Measure Domain, and 40% of the domain weight will be equally distributed across all eligible measures in the Reporting Measure Domain.

3.3 Reporting Domain (Table 5 and Table 6 of PSR)

The Reporting Domain includes the following six measures, and it comprises 10% of the TPS.

- Anemia Management Reporting Measure
- Serum Phosphorous Reporting Measure
- Clinical Depression Screening and Follow-up Measure
- Ultrafiltration Reporting Measure
- NHSN Healthcare Personnel Influenza Vaccination Measure
- Pain Assessment and Follow-up measure

For each measure in the Reporting Domain, facilities must have at least 11 patients who meet the patient criteria, except for the NHSN Healthcare Personnel Influenza Vaccination Measure. It is possible for your facility to have enough patients to calculate one measure but not others. A dash (-) within the table indicates that your facility was not eligible to receive a score on the measure, while an "N/A" indicates that the value is not applicable to the measure or measure topic score calculation. Specific inclusion criteria for each measure in the Reporting Domain is described in the CMS ESRD Measures Manual, which can be https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/ESRD-Manual-v31.pdf.

Table 5 includes detailed information for the measures that calculate the score based on how many eligible months of data were successfully reported (Anemia Management, Serum Phosphorous, and Ultrafiltration Rate). Table 6 includes

detailed information for the measures that calculate the score based on how many eligible patients' data were successfully reported (Clinical Depression Screening and Follow-up, and Pain Assessment and Follow-up).

Note that the score for the NHSN Healthcare Personnel Influenza Vaccination measure is determined by your facility's submission of data to and compliance with the CDC's NHSN system and reporting guidelines. Thus, the PSR does not display any information for 'Number of Reported Patients' or 'Number of Eligible Patients' for this measure. All items not available are presented as "N/A" within the PSR.

3.3.1 Reporting Domain Measures (Table 5 Reported Months)

Monthly Calculations:

Measure	Number of Successful Reporting Months	Number of Eligible Months	Threshold Reporting Rate
Anemia Management:	The number of months your facility reported hemoglobin or hematocrit values and any ESA dosage on Medicare claims at least once per month for at least 99% of eligible patients in CY 2018.	The number of months your facility was eligible for the measure based on your facility's CMS certification date. Eligible months begin the month after the certification month. I.e., if a facility is certified on January 10th, the first eligible month would be February.	The threshold that is used to consider successful reporting for each eligible month. For PY 2020, a facility must report information for at least 99% of eligible patients for each eligible month.
Serum Phosphorous:	The number of months your facility reported serum or plasma phosphorus levels via CROWNWeb for at least 97% of eligible patients in CY 2018.	The number of months your facility was eligible for the measure based on your facility's certification date. Eligible months begin the month after the certification month. I.e., if a facility is certified on January 10th, the first eligible month would be February.	The threshold that is used to consider successful reporting for each eligible month. For PY 2020, a facility must report information for at least 97% of eligible patients for each eligible month.
Ultrafiltration Rate:	The number of months your facility reports all required data elements for ultrafiltration rate (UFR) in CROWNWeb for all hemodialysis sessions during the week of the monthly Kt/V draw submitted for that clinical month for each eligible patient in CY 2018.	The number of months your facility was eligible for the measure based on how many patients your facility treated.	The threshold that is used to consider successful reporting for each eligible month. For PY 2020 a facility must report for 100% of eligible patients for each month.

Measure Score: Your facility's score for the performance measure. For both the Anemia Management and Serum Phosphorous measures, it is determined using the following equation:

[(Number of Months Facility Successfully Reports/Number of Eligible Months) x 12] - 2

Measure Weight (% of Domain): The Anemia Management, Serum Phosphorous, and Ultrafiltration Rate measures each comprise 16.67% of the score for the Reporting Domain. Note that if your facility is not eligible for a reporting measure, the weight will be redistributed within the Reporting Domain.

3.3.2 Reporting Domain Measures (Table 6 Reported Patients)

Patient Calculations:

Measure	Number of Reported Patients	Number of Eligible Patients
Clinical Depression Screening and Follow-up measure:	The number of eligible patients for which your facility successfully reported one of the six conditions in CROWNWeb once before March 1, 2019.	The number of eligible patients at your facility, based on patient age and treatment length.
Pain Assessment and Follow-up measure:	The number of patients for which your facility successfully reported one of the six conditions in CROWNWeb once during the first six-month reporting period (before September 1, 2018), and once during the second six-month reporting period (before March 1, 2019). The results for each six-month reporting period are presented as separate rows in Table 6.	The number of eligible patients at your facility, based on patient age and treatment length.

Measure Score: Your facility's score for the performance measure. For the Clinical Depression Screening and Follow-up measure, it is determined using the following formula:

Number of Eligible Patients for Whom a Facility Successfully Reports one of six conditions / Total Number of Eligible Patients

For the Pain Assessment and Follow-up measure, it is determined using the following formula:

[(# of patients for whom the facility reports 1 of 6 conditions in first 6 months) / (# of eligible patients in the first 6 months) + (# of patients for whom the facility reports 1 of 6 conditions in second 6 months) / (# of eligible patients in the second 6 months)] x 10 / # of eligible periods

For the NHSN Healthcare Personnel Influenza Vaccination measure, if your facility submitted the NHSN Summary Report to the CDC by 5/15/2018, you will receive 10 points for the measure. If not, your facility will receive 0 points. If your facility is not eligible for the measure, the score will be missing (indicated by a dash [-] on the PSR).

Measure Weight (% of Domain): The Pain Assessment and Follow-up, Clinical Depression Screening and Follow-up, and NHSN Healthcare Personnel Influenza measures each comprise 16.67% of the score for the Reporting Domain. Note that if your facility is not eligible for a reporting measure, the weight will be redistributed within the Reporting Domain.

Eligible Reporting Measures: The number of eligible measures for your facility, based on the specified eligibility criteria.

Weighted Reporting Domain Score: The weighted Reporting Domain score for your facility, based on the measure scores and measure weights.

3.4 Preview Performance Score (Table 7 of PSR)

Table 7 displays your facility's TPS and your facility's score, state average score, and national average score for each measure and Domain. Additionally, it also includes the weights applied to each measure and the score after the weights are applied. Note that if your facility is not eligible for a measure, the weight will be redistributed within the applicable Domain. A dash (-) within the table indicates that your facility was not eligible to receive a score on the measure/measure topic, while an "N/A" indicates that the value is not applicable to that row of the table. The content of each cell in Table 7 as well as the other values listed on the Preview Performance Score page of the PSR are described in further detail below.

Facility Score: The TPS prior to any deductions, each measure domain, individual measure, or measure topic score.
State Average Score: The State Average TPS prior to deductions, each measure domain, individual measure, or measure topic score. Note that the State Average Scores are unweighted.
National Average Score: The National Average TPS prior to deductions, each measure domain, individual measure, or measure topic score. Note that the National Average Scores are unweighted.
Facility Measure Weights: The weights for each measure within each measure domain.
Facility Weighted Score: The measure domain, individual measure, and measure topic scores after applying each weight.
Minimum TPS: The minimum TPS a facility must receive in order to not receive a payment reduction. For PY 2020, the Minimum TPS is 59.
Extraordinary Circumstance Exception (ECE): The ECE allows facilities to be exempt from all the requirements of the ESRD QIP clinical and reporting measures during the time that a facility was forced to close temporarily due to a natural disaster or other extraordinary circumstance. If your facility received approval for an ECE, the applicable number of months or years will be listed here.
Total Performance Score before Applicable Deductions: The TPS that is calculated before any deductions are applied.
Feasibility Study and/or Pilot Validation Study: Facilities were randomly selected to participate in the Feasibility and Pilot Validation studies. The selected facilities were required to provide CMS with the requested information within 60 days of receiving a request. Facilities that did not provide CMS with the required information within the specified time period received a 10-point deduction from their TPS. It is possible for your facility to be included in both the Feasibility and the Pilot Validation studies and therefore possible to have a total of 20 points deducted from its TPS. If your facility was selected and did not comply with the requirements, the total points deducted from the TPS will be listed.
Total Performance Score: The TPS after any applicable deductions.
Total Payment Reduction: The payment reduction resulting from the TPS. The payment reduction indicates the reduction percentage that will be applied to your facility's

reimbursement of all Medicare dialysis claims for services delivered during all of CY 2020.

Your facility's payment reduction is defined as follows:

- No reduction for a TPS of 59 to 100 or if a TPS could not be calculated due to insufficient data
- A 0.5% reduction for a TPS of 49 to 58
- A 1.0% reduction for a TPS of 39 to 48
- A 1.5% reduction for a TPS of 29 to 38
- A 2.0% reduction for a TPS of 0 to 28

If a TPS could not be calculated, then your facility will not receive a payment reduction. However, all facilities eligible for the ESRD QIP still receive a PSR and PSC.

Acronyms

AVF	Arteriovenous Fistula
BSI	Bloodstream Infection
CCN	CMS Certification Numbers
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
CQ	Clarification Question
CQI	Continuous Quality Improvement
CY	Calendar Year
ECE	Extraordinary Circumstance Exception
ESRD QIP	End-Stage Renal Disease Quality Incentive Program
FI	Formal Inquiry
ICH CAHPS	In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
NHSN	National Healthcare Safety Network
NQS	National Quality Strategy
POC	Point of Contact
PSC	Performance Score Certificate
PSR	Performance Score Reports
PY	Payment Year
SCQ	Systemic Clarification Question
SHR	Standardized Hospitalization Ratio
SRR	Standardized Readmission Ratio
STrR	Standardized Transfusion Ratio
TPS	Total Performance Score
UFR	Ultrafiltration Rate