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**Centers for Medicare & Medicaid Services**
**ESRD QIP Payment Year 2017 and 2018 Final Rule**
**MLN Connects National Provider Call**
**Moderator: Aryeh Langer**
**January 21, 2015**
**2 p.m. ET**

## Contents

**Operator:** At this time, I would like to welcome everyone to today's MLN Connects National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Aryeh Langer. Thank you, you may begin.

## Announcements and Introduction

Aryeh Langer: Thank you, and as Victoria said, this is Aryeh Langer from the Provider Communications Group here at CMS. And as today's moderator, I'd like to welcome everyone to this MLN Connects National Provider Call on ESRD QIP, the End Stage Renal Disease Quality Incentive Program.

MLN Connects Calls are part of the Medicare Learning Network. This MLN Connects National Provider Call provides an overview of the final rule, which was published November 6th, 2014, that operationalizes the ESRD QIP for payment year 2017 and payment year 2018. The performance period for payment year 2017 began on January 1st, 2015.

The ESRD QIP is a pay-for-performance quality program that ties a facility's performance to a payment reduction over the course of a payment year. After the presentation, participants will have an opportunity to ask questions of our subject matter experts here at CMS.

Before we get started, there are a few items I'd like to quickly cover. You should have received a link to the slide presentation for today's call in an email earlier this afternoon. If you have not seen the email, you can find today's presentation on the CMS Call Details web page, which can be found by visiting www.cms.gov/npc. Again, that URL is www.cms.gov/npc. On the left side of that page, select National Provider Calls and Events, and then select today's call by date from the list. The slide presentation is located there in the Call Materials section.

I'll also note that the call is being recorded and transcribed. An audio recording and written transcript will be posted to the CMS Call Details web page within 2 weeks of the call and an announcement will be placed in the MLN Connects Provider eNews.

At this time, I would like to begin the formal part of our presentation by turning the call over to Rick McNaney, Deputy Director of the Quality Improvement Group here at CMS. Rick?

Rick McNaney: Thank you. And thank you everyone for joining today on this snowy afternoon here in Maryland. Joining me today and presenting the information will be Jim Poyer, the Director of Value Incentives and Quality Reporting for the CMS Quality

Improvement Group; Tamyra Garcia, the ESRD QIP program lead and policy lead; Joel Andress, the measure development lead for ESRD; and Brenda Gentles, the ESRD QIP communications lead.

So today we are going to provide an overview of the final rule for payment year2017 and 2018 for the ESRD QIP, which as you know is a very complex and detailed rule. We'll discuss why the rule is important to you while presenting a great deal of detail over the next 90 minutes. And I think that we'll be able to provide a good understanding of how facilities will be impacted by the rule.

We'll go over our prepared presentation with you and then we'll open up some time for questions and answers. Many of you will want additional information that we won't be able to cover today, so I invite you to review the online resources listed in the slide deck. Questions that remain can always be sent after this call and sent into our mailbox at esrdqip@cms.hhs.gov. Again, that's esrdqip@cms.hhs.gov.

And so with that, I'm happy to turn the presentation over to Jim Poyer, again the Director of Value Incentives and Quality Reporting, and he'll get things started for you. So Jim?

## Presentation

Jim Poyer: Thanks Rick. Payment years 2017 and 2018 represent the sixth and seventh payment years for the End Stage Renal Disease Quality Incentive Program, or ESRD QIP. These regulations represent a benchmark in the development of the program that build upon earlier measures and approaches in a wide variety of ways, as we'll discuss. But how does the program fit into CMS's overall goal for improving quality?

Next slide. The Value-Based Purchasing, or VBP, programs incentivize better care through across-care settings. Beneficiaries expect cost-effective quality care, and VBP is an avenue to assist us in achieving this goal. VBP promotes CMS's three-part aim of:

- First, better health care for individuals;
- Second, better care for populations and communities; and
- Third, lower cost through improvement.

The ESRD QIP was CMS's first fee-for-service/pay-for-performance program. Rather than paying dialysis facilities based on how many services they provide patients, Medicare now pays dialysis facilities based on how well those services help keep patients safe and healthy. ESRD QIP uses the government's purchasing power through Medicare to incentivize improvements in the treatment of patients with ESRD. These incentives drive care throughout the healthcare sector, not just to Medicare patients.

Next slide. The ESRD QIP for payment years 2017 and 2018 address five of the six National Quality Strategy domains:

- Safety,
- Patient and family engagement,
- Treatment and prevention of chronic disease,
- Population and community health, and
- Care coordination.

The next few slides will provide an overview of the legislative aspects of the program, and for that I will turn it over to Tamyra Garcia.

**Legislative Drivers of ESRD QIP**

Tamyra Garcia: Thank you Jim, and good afternoon everyone. As Jim stated, in this section we're going to provide a quick overview of the ESRD QIP and we'll share some information about the legislative nature of the program generally before delving into the composition of the payment years 2017 and 2018 final rule.

Beginning with slide 10, we're going to give a bit of background on the ESRD QIP legislative drivers. MIPPA amended the Social Security Act to mandate the creation of the ESRD QIP. The QIP is intended to promote patient health by encouraging renal dialysis facilities to deliver high quality patient care. MIPPA provides the mechanism for establishing standards of care and it authorizes payment reductions for facilities failing to meet these standards. The program intends to promote patient health by providing a financial incentive for renal dialysis facilities to deliver high quality patient care.

In slide 11 we are provided with a description of ESRD QIP requirements under MIPPA. MIPPA gives CMS the authority to establish standards by which ESRD facilities will be evaluated. The ESRD QIP is required to include measures of anemia management and dialysis advocacy. The Secretary may specify that the program also cover measures related to patient satisfaction, iron management, bone mineral metabolism, and vascular access. The ESRD QIP also defines or determines the way individual measures are used to create an overall score.

CMS will impose a payment reduction up to 2 percent if a facility score does not meet a minimum total performance score. Information about the facility's performance in the ESRD QIP is contained in the Performance Score Report, also known as the PSR.

Public reporting of the results is the key component of the ESRD QIP program because it allows beneficiaries to select facilities based on quality of care provided and it provides a mechanism by which facilities may judge their performance compared to the performance of others.

The Performance Score Certificate, also known as the PSC, is a prime vehicle for communicating the facility's performance under the ESRD QIP to the patient. Facilities are required to display in a highly visible area this document each year.

Dialysis Facility Compare, or DFC, also provides information regarding facility performance to the public. CMS releases detailed facility performance information in a large spreadsheet as well, which is available on the CMS website. With the structure of the program in mind, we turn now to how it evolves from year to year through rulemaking.

**ESRD QIP Rulemaking**

In slide 12, ESRD QIP rulemaking is summarized. By issuing a proposed rule, CMS proposes the clinical and reporting measures as well as the scoring mechanisms it wants to include in any given payment year. Then the public has a 60-day opportunity to comment on the proposal and suggest approaches it would like to see in the program. In this way, facilities and the general public have an opportunity to influence the shape of the rule governing each payment year.

These comments are taken very seriously by CMS. Comments have led to postponement of implementing measures, and those measures are stronger when they're implemented in future years. So it's very important that stakeholders participate in the comment period and share their thoughts on how ESRD QIP can best serve the needs of ESRD patients.

Slide 13 describes the process of scoring facility performance. In these public presentations we focus a lot on the development and implementation of policies we put into payment year 1, but we also think it's important to make sure that the public understands how information is gathered and processed so that scores can be calculated. Many facilities and other stakeholders often wonder what the reason is for the delay between the performance period where the facility data comes from and the impact on payment. The main reason for this is the reliance on Medicare reimbursement claims for a lot of the data that we need.

As we move to other data sources, we will not be as dependent on claims data and we hope to reduce this interim between performance and the resulting payment impacts. The preview period is also a statutory requirement, so facilities will always have an opportunity to review and formally inquire about their scores before they're finalized in the final rule.

Slide 14 describes the impact of the comment period, which we touched on previously. The comment period last summer certainly resulted in several changes reflected in the final rule, particularly for the payment year 2018 program. As an example, CMS revised its proposal on case minimum and partial credit for scoring reporting measures as well

as CMS set aside the reporting measure adjuster approach to calculate the total performance score.

The text of the final rule addresses the subject of each of the public comments and provides a response to each and every one. So with that, I would like to turn the presentation over to Joel to begin our discussion on the payment 2017 rule. Joel?

**PY 2017 Clinical Measure Scoring**

Joel Andress: Thank you Tamyra. Good afternoon everyone. My name is Joel Andress. Before we begin discussing the payment year 2017 clinical measures, I want to go over briefly the reasoning behind proposing payment year 2017 and 2018 for this rule. As many of you may be aware, we have proposed two rules simultaneously in the — proposed two payment years simultaneously in a single rule once in the past for the payment year 2013 and 2014 rules. The reasoning behind this was to ensure that when we proposed and finalized measures this would occur prior to the start of any applicable performance period within the rule.

This time around we have proposed these two rules simultaneously because we wanted to place ourselves on a track where we could provide a — provide up to 14 months from the finalization of a rule's requirements to the start of the performance period. We believe that this would be helpful to providers in gearing up infrastructure for additional reporting to initiate quality improvement efforts and so forth. And it would also be helpful to us to ensure that our infrastructure was in place to allow for the reporting of data.

We will continue to propose rules along this track to retain this 14-month period. So for example, next year we plan to publish in November 2015, the payment year 2019 rule, which will then allow for 14 months before the start of the performance period, which will be calendar year 2017.

To begin the review of payment year 2017, we'll start with the clinical measures. If you look on slide 16, you'll see that we now have eight clinical measures, which comprise a total of 75 percent of the facility's total performance score and three reporting measures that will comprise the remaining 25 percent of the total performance score. Also indicated by a gold star is the single new clinical measure, the standardized readmission ratio, and we'll talk a little bit about that fairly soon.

If you look on slide 17, we actually have an error that we want to be sure that we correct before going forward. We presented here the quality measures that are — the clinical measures changes that are relevant for your review and the errors under the measures that are unchanged from the payment year 2016 final rule. We have listed here the dialysis clearance measure for adult peritoneal dialysis patients. This should include all of the Kt/V dialysis adequacy measures. These all remain unchanged for payment year 2017.

Also unchanged are the two vascular access measures and the hypercalcemia measure. We have proposed and finalized the removal of the hemoglobin greater than 12 grams per deciliter measure due to it — due to it being topped out as a performance metric. And finally, we finalized the implementation of the standardized readmission ratio, or SRR, for payment year 2017. This is a ratio of the number of observed, unplanned readmissions to those that would be expected using a predictive model that accounts for patient comorbidities and other characteristics.

Technical specifications for each of these measures were included in the rule, which provide measure definitions and exclusion criteria. This is available on the CMS website, for which we have provided a link at the end of this presentation.

On slide 18, we are covering some familiar ground, as most of you are probably aware. Measures may indicate a better performance by having a higher score or a lower score. Our scoring methodology accounts for this difference in directionality, as you see presented here with examples for — with examples for all of our measures.

On slide 19, we come to some familiar scoring terms that you should be familiar with as you're deciphering the payment year rule. We present them here. The definitions have not changed from prior years, except, of course, to move forward the period of time represented by the period of performance and the comparison and the years we're using for comparison for improvement and achievement.

We'll also note that the performance standard, while it is not used to assess any particular facility score, is used in the calculation of the minimum TPS, which will be discussed later in the presentation.

On slide 20 we present a representation of the scoring methodology for the quality measure, or I should say the clinical quality measures. As always, we include assessments of achievement and improvement using comparisons to the performance thres — to the achievement threshold and the — I'm sorry, to the achievement period and the improvement period. This way a facility can increase its score if it shows an improvement over its previous performance as it strives to reach a national average of performance. As always, we favor achievement over improvement reaching the – you can achieve a maximum score of 10 points through achievement and a maximum score of nine points through improvement — and receive, of course, the highest of the two scores that you attain.

In past presentations we've illustrated exactly how these calculations are performed. We do not do that here because they have not changed in some time. They are still available on the CMS website if you wish to — wish to look at the educational material that we have provided. Again, we have a link to the site and the resources that are available to you there.

On slide 21 we discuss the primary scoring exception, which is the National Healthcare Safety Network bloodstream infection measure. The exception here is that we used the calendar year 2014 data as the comparison period for both achievement and improvement scores. And additionally, facilities with the CCN open date after the 1st of January 2015 will not be scored on this measure.

On slide 22 we present, as we have in the past, the values that we've published for the achievement threshold benchmark and performance standard for each of the individual quality measures. The values for the NHS and bloodstream infection measure will be based on 2014 National Performance Data, which we do not have yet available. We will be publishing the threshold benchmark and performance standard for this measure at a future date.

Now having discussed the clinical measures for payment year 2017, I return to Tamyra to discuss the reporting measures.

**Reporting Measures for PY 2017**

Tamyra Garcia: Thanks Joel. So in this section we'll examine the three reporting measures finalized for our payment year 2017. We'll also consider the measure requirements, as well as the scoring methodology associated with the measures. The three reporting measures in place for payment years 2016 are also in place for payment year 2017. There were a few modifications, one of which was a global modification that does away with CROWNWeb attestation. This determines whether a facility is eligible for a given measure based on the number of patients treated. Starting with payment year 2017, we use claims, CROWNWeb, and other administrative data and CMS data bases to determine ineligibility.

The other eligibility modification applies only to the ICH CAHPS measure. In order to be eligible for this measure in payment year 2017, the facility must treat at least 30 patients in 2014, and that facility must receive at least 30 completed surveys during 2015. And just to sort of list the measures, we have the ICH CAHPS measure as well as mineral metabolism and anemia management.

Now to sort of have a discussion around the scoring methodology for these measures, they remain the same as they did in the payment year 2015 final rule. In looking at slide 25, we see a formula for mineral metabolism and anemia management, comparing the number of months with the appropriate reporting to the total number of months of eligibility. This formula has been in place since payment year 2015. The ICH CAHPS reporting measure remains the same as well — it's an all-or-nothing endeavor. The facility will either score 10 points for meeting the requirements or zero points for failing to meet those requirements.

Now that we've discussed how clinical and reporting measures will be scored in the payment year 2017 rule, we're going to go on ahead and talk about the methods we

used to create the total performance score and the structure by which any payment reductions will be applied for payment year 2017. Please keep in mind that this approach closely resembles the process used in payment year 2016.

And similar to previous years, the total performance score will range from zero to 100 points. Clinical measures will account for 75 percent and hypercalcemia will have two-thirds of the weight applied to each of the other eligible clinical measures. To provide you all with an example of this and expand upon this, if a facility is eligible for all of the payment year 2017 clinical measures, then each clinical measure and measure topic except hypercalcemia would be worth 16.1 percent of the facility's total performance score. And hypercalcemia would be worth about 10.7 percent of the facility's total performance score. And we'll sort of expand upon this a little later on in the presentation. Again, reporting measures will continue to be weighted equally to make up 25 percent of the total performance score.

And taking a look at slide 28, we summarize how we calculated the minimum total performance score. The minimum total performance score for payment year 2017 is 60 points. We assess the score for the NHS in bloodstream infection measure at zero points and for the other clinical measures as if the facilities met the national performance standard that we mentioned earlier. In contrast with how the minimal total performance score was constructed in payment year 2016, beginning in payment year 2017, we are factoring that a facility scores 10 points on each of the reporting measures. We introduce this change because 10 points was the 50$^{th}$ percentile of facility performance on all of the reporting measures in payment year 2015. And we do not wish to incentivize facilities to provide below-average care.

In slide 29 there is a chart demonstrating the ranges for payment reductions based on the facility's total performance score. To reiterate, a zero payment reduction would be applied to those who received a minimum score of 60 points up to 100 points. And those who received 29 or fewer points will receive a maximum payment reduction of 2 percent.

Moving on to slide 30, we can take a look at an illustration which examines how facilities will be scored, how those scores will translate into a total performance score, and whether or not a payment reduction will be applied. This figure defines the measures, clinical and reporting, category weight, and the scales for the payment reduction if applicable.

Now that we've reviewed the makeup and the calculation of the payment year 2017 program, I'd like to turn the presentation back over to Aryeh for an important announcement before we continue with payment year 2018. Aryeh?

## Keypad Polling

Aryeh Langer: Thank you. Before we move into the next portion of our presentation, we would like to pause a moment to complete keypad polling so CMS has an accurate count of the number of participants on the line with us today. Please note that there will be silence on the line while we tabulate the results. Victoria, we're ready to start the polling please.

**Operator**: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Thank you. I would now like to turn the call back over to Aryeh Langer.

## Presentation continued

Aryeh Langer: Thank you. And I'm going to turn over the call back over to Joel for the next part of the presentation.

### The PY 2018 Rule

Joel Andress: Thank you Aryeh. Good afternoon again. We move now to the discussion of the payment year 2018 rule. We'll be starting again with the clinical measures, and I'll just remind everyone that these clinical measures are relevant to the performance period for calendar year 2016 and are not in effect starting in 2015.

On slide 32 we present again a representation of how the quality measures are structured for payment year 2018. And these reflect a significant evolution in how we are structuring quality measures in the QIP, in part because we are no longer grouping measures together but are dividing them among particular quality domains for safety, patient family engagement and care coordination, and clinical care. These are reflective of the quality domains that were mentioned earlier in the presentation as part of the CMS National Quality Strategy.

The goal — the goal is to ensure that quality of care in multiple domains impact patients' lives, and as such we seek to ensure that our quality measures address quality concerns across a continuum of issues the patients may face as they're receiving care.

In the first case, we have separated out the NHS in bloodstream infection measure as part of the safety domain. This is weighted to incorporate 20 percent of the clinical measure domain score. We have included the standardized readmission ratio and a new clinical performance measure, the ICH CAHPS measure, as part of the patient and family engagement and care coordination subdomain, which comprises 30 percent of the clinical score. And finally, the last subdomain is for clinical care and comprises 50 percent of the clinical measure domain score. And this includes the measures with which you're already familiar for payment year 2017, as well as two new measures, the standardize transfusion ratio and the Kt/V dialysis adequacy measure for pediatric peritoneal dialysis.

If you look on slide 33, we present to you the unchanged measures, again just for your review. These include the NHS in bloodstream infection measure, the dialysis adequacy measure topic, vascular access measure topic, the standardized readmission ratio, and hypercalcemia.

On slide 34 we review the three new clinical performance measures that have been added to — added in payment year 2018. The first of these, in fact, has previously been a reporting measure for the QIP. And this is the ICH CAHPS survey, which provides information on patient experience of care.

The second measure is the standardized transfusion ratio, which calculates the number of observed red blood cell transfusion events for patients dialyzing at a facility compared with those that we would expect at a similar facility using a predictive model that accounts for patient characteristics and comorbidities.

And then finally, we have rounded out our dialysis adequacy measures by incorporating the pediatric peritoneal dialysis measure for Kt/V — assessing a dialysis clearance for this small but highly vulnerable population. As before, the technical specifications for each of the clinical measures is available at the ESRP QIP section on cms.gov and we provide you a link at the end of this presentation.

Slide 35 again repeats the warning that some of these measures reflect better care with higher scores, some of these measures reflect better care with lower scores, and it is important to pay attention to that. And our scoring methodology accounts for this as well. The scoring terms on slide 36 are unchanged from those provided earlier, and so I leave them to you for your review.

On slide 37 we again show you the scoring methodology for the clinical performance measures. This has not changed tremendously; however, we do note that as part of this — part of the change and how we've weighted the domains, we are currently — the measured topics for dialysis adequacy and for vascular access measures remain intact. Again, you may want to review the payment year 2016, the final rule National Provider

Call presentation, which we held last year at this time, for a demonstration of how individual measures are scored according to each method.

On slide 38 we present, again, a scoring exception in payment year 2018 — this is the ICH CAHPS measure. The ICH CAHPS survey measure uses performance in calendar year 2015 as the comparison period for both the achievement and improvement scoring methods. Furthermore, the measure is made up of three composite measures and three global ratings to reflect the NQF-endorsed approach for the measure. Each of these six elements will be scored according to the achievement and improvement methodologies, with the better result applied for that element. Then the six scores will be averaged together to determine the overall score for the measure.

Please be sure to check out the technical specifications for the ICH CAHPS measure as it does differ somewhat from many of the other clinical measures with which you are familiar. Now having identified the 11 clinical measures for payment year 2018, I again turn to Tamyra to discuss the reporting measures for that year.

**Reporting Measures for PY 2018**

Tamyra Garcia: Thank you so much Joel. That required a lot of information to suggest so please — to digest. So please take Joel's suggestion to sort of tap into those resources from previous payment years for additional information.

Now we are going to take a moment to look at the reporting measures for payment year 2018. So, as you all may recall, in payment year 2017, there were three reporting measure, two of which were anemia management and mineral metabolism. In payment year 2018, anemia management is unchanged and mineral metabolism has been modified to accept either serum phosphorus or plasma phosphorus to comply with the measure requirements. ICH CAHPS, the third measure that was in this previous payment year, has actually been expanded into a clinical measure for payment 2018, so it's no longer a part of the reporting measures.

And moving on to slide 41, we are listing the new reporting measures for payment year 2018 that will be added to the list of two — both the anemia management and the mineral metabolism gram measure.

These three new reporting measures represent an enhanced focus on patient well-being and the health of the medical professionals employed by the facility to treat patients. The first of the three —pain assessment and followup —is defined as the report in CROWNWeb, one of six conditions for each qualifying patient once before August 1st, 2016, and once before February 1st, 2017. The second, clinical depression screening and followup, is defined as a report on CROWNWeb, one of six conditions for each qualifying patient, once before February 1st, 2017 and the third NHSN healthcare personnel influenza vaccination is defined as the submission of healthcare personnel influenza vaccination summary reports to NHSN.

Moving on to slide 42, we summarize how these reporting measures will be scored. As in previous years, mineral metabolism and anemia management will be scored according to the formula presented in payment year 2017. The pain assessment and clinical depression and followup measures were initially proposed to be all or nothing measures, just as the ICH CAHPS measure had been. This was actually changed in the final rule to make it possible to obtain points for partial compliance according to the formula presented here, where the number of patients for whom a facility reports one of six conditions are compared to the number of eligible patients.

The NHSN HCP measure remains an all-or-nothing measure. The facility received 10 points for satisfying all of the performance requirements or zero points if they do not.

Next, we will discuss payment year 2018 methods for calculating a total performance score, just as we did for payment year 2017. Although the process of scoring individual clinical and the reporting measures has not changed significantly between these payment years, the way in which the clinical measure scores in particular are used to create a total performance score is quite different for the 2018 program. We'll explore this change in the following section.

In taking a look at slide 44, we are pretty much giving you all time to tell a story using a hypothetical facility score to give you an idea of how these scores are used to create the clinical measure domain score. So if you look on the left-hand side of the slide, there's a list of each measure or measure topic along with hypothetical aid facility score under the measure score column.

On the right-hand side, we have the formulas for each of the three clinical subdomains, with the weight for each score is represented as its portion of the subdomain score. In this example, the facility qualifies for a score on each of the measures —this hypothetical example. The arrows in between the left and right sides of the slides illustrate where each clinical measure score will be used in the formulas. For example, for the clinical measure domain, clinical measures and measure topics will be divided into three subdomain categories. The first, the safety subdomain, will represent 20 percent of the clinical measure domain score. The second, the patient and family engagement/care coordination subdomain, accounts for 30 percent of the clinical measure domain score. And the third, clinical care subdomain, makes up the remaining 50 percent of the clinical domain score.

The weight of the subdomain and the weight of individual measures within those subdomains were selected according to three items:

- The first, the number of measures in each subdomain,
- The second, facility experience with those measures, and

- The third, how closely the measures align with CMS priorities for quality improvement.

In looking at slide 45, we see how each score is populated to the three formulas using the hypothetical facility and the result of each calculation. The safety subdomain formula is related to the NHSN measure while the patient and family engagement and care coordination subdomain formula is related to the ICH CAHPS and SRR measures. The clinical care subdomain formula includes dialysis adequacy, vascular access, hypercalcemia, and standard transfusion ratio.

Moving on to slide 46, the next step is to take each subdomain score and apply the relative weight to each as described earlier. The weighted results are added to calculate the clinical measure domain score. In the hypothetical example we've provided, the score comes out to 91.2, which is quite respectable for this facility. I also want to highlight our desire to align our subdomains with the National Quality Strategy and including the safety, patient and family engagement/care coordination, and clinical subdomain score.

Next, we'd like to move on to how we calculate the total — the facility total performance score, not simply the clinical measures. The measure for calculating the total performance score in the final rule for payment year 2018 has changed as a result of the public comments that we've received from you all, again stressing the importance of those. The finalized scoring method is similar to the approach that we're using in the payment year 2017 program, with the dates changed to account, of course, for the applicable comparison and performance period.

On slide 48 we describe our method for calculating the minimum total performance score for payment year 2018. It's similar to the 2017 program because the standards are based on facility performance throughout 2014. Unfortunately, because they are based on the performance for 2014, we can't calculate the minimum TPS at this time. The applicable performance standard achievement thresholds and benchmarks will be published in the next round of rulemaking, along with the minimum TPS for the payment year. These details will be included in the calendar year 2016 ESRD Prospective Payment System final rule in November of this year.

Slide 49 provides us with information regarding the minimum total performance score for payment year 2018, the payment reduction structure, which remains constant from previous years, as well as the ranges for each reduction percentage category.

Just as we did for payment year '17, slide 50 describes the scoring and payment reduction methodology for payment year 2018. It shows how facilities will be scored, how those scores will translate into a total performance score, and whether a payment reduction will be applied for payment year 2018. It includes the measures, both clinical

and reporting, the subdomain, the domain weights, relevant calculations, and the scale for the payment reduction where applicable.

As we have done throughout the presentation, payment year 2018 new measures are identified with a gold star. You can see all of those there for your information as well.

Finally, in taking a look at slide 51, we'd like to sort of discuss some larger overarching changes that were included in the final rule. The rule identified how CMS will be able to determine whether a measure has topped out progress on the data validation project, efforts to monitor beneficiary access to treatment, and policies clarifying how extraordinary circumstances will impact facility scores on the ERSD QIP.

With that being said, I'd like to turn the presentation over to Brenda Gentles for a discussion about next steps. Brenda?

**Next Steps and Resources**

Brenda Gentles: Great, thank you Tamyra. To recap today's presentation, the final rule for payment year 2017 shares a lot of structure with payment year 2016 but also includes some new measures. The rule — the rule for payment year 2018 in contrast represents an evolution in the program's approach to clinical measure scoring and it covers five of the six domains in the National Quality Strategy. It also includes several new and modified measures. We'll conclude with a review of what's coming up for the program, but we'll begin with an overview of the program from a timeline perspective.

Looking at slide number 53, we'll look at the upcoming ESRD QIP milestone. Given the overlap of rulemaking process and the scoring process, it's easy to see that a lot of activity impacting multiple payment years happens at the same time. To start, let's take a look at the overarching timeline of the program. This graphic illustrates what's going on with the program as we speak.

So right now we're in the midst of the payment implications for payment year 2015. The 30-day preview period for payment year 2016 will begin in early summer. The performance period is underway for payment year 2017, and we don't even have enough room to show that a proposed rule for payment year 2019 will be published in early summer as well, followed by a 60-day comment period. In this way, the ESRD QIP can be seen as a series of multiple year programs.

OK. So moving on to slide number 54, here are some of our website resources. You've heard Joel Andress as well as Tamyra Garcia refer to some of the resources that we have. Listed on slide 54 are those websites that we'd like for you to take a look at. We have information as it relates to MIPPA, the ESRD QIP section page of the cms.gov including the technical specifications for the program are listed there as well as information about the ESRD Network Coordinating Center, the Dialysis Facility Compare, and the final rule itself.

Now on to next steps, here we have about five or so next steps that we would like for you to follow. Starting with the first one, please make sure your facility has posted its payment year 2015 Performance Score Certificate in English and Spanish. Read and comment on payment year 2019, the proposed rule, when posted in early July. Review payment year 2016 preview PSR when available, which should be mid-July and submit any clarifying questions or formal inquiry through the ESRD QIP mailbox. Join us for the National Provider Calls discussing the payment year 2019 proposed rule and payment year 2016 preview period when scheduled in the summer of this year.

Review payment year 2016 final PSR when available in mid-December along with posting the payment year 2016 PSC in both English and Spanish when available, end of December. And then certainly, CMS appreciates your cooperation, your input, and your recommendations.

Again, we would like to thank you for your time and your attention. We are going to proceed now with our question-and-answer session; however, if your question or you are not able to get through with your question, please utilize the ESRD QIP mailbox which you see here, esrdqip@cms.hhs.gov, for any questions that you may have after this presentation.

At this time, I'll turn the presentation back over to Aryeh to proceed with our Q&A session.

## Question-and-Answer Session

Aryeh Langer: Thank you. And as Brenda said, we'll start our question-and-answer session now, where CMS subject matter experts will take your questions. Because this call is being recorded and transcribed, please state your name and the name of the organization before asking your question. In an effort to hear from as many callers as possible, we ask that you — excuse me — we ask that you limit yourself to one question at a time. If you have more than one question, please press star 1 after your first question is answered to get back in the queue and we'll address additional questions as time permits.

Victoria, we are now ready to take our first question please.

**Operator**: Certainly. To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue press – I'm sorry, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question so anything you say or any background noise will be heard into the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Joan Simard.

Joan Simard: Yes, good afternoon everyone. This is Joan Simard from Intermountain Healthcare in Salt Lake City, Utah. My first question is regards to the transfusions. Our facilities, we do not administer blood transfusions to our patients anymore in the center and they usually have to go to an outpatient facility or they receive — or might receive during a hospital admission. How are we going to be able to monitor and keep track of what that is going to be if we don't have access to when those procedures were done outside our facility?

Joel Andress: Good afternoon, this is Joel Andress. So, thank you for your question. So I'll say that, you know, it's not always going to be the case that you're going to know when an event has occurred outside of — outside of your facility. I think the concern of the measure is to know that a transfusion became necessary after a patient you've been treating has been managed for anemia. So the measure is intended to capture the outcome of the anemia management work that your facility has undertaken.

In terms of, you know, tracking, I'm assuming you're meaning for quality improvement purposes. I think that's going to be largely an issue of coordinating with wherever the patient is sent for additional care or for where the transfusion is occurring if that's the result of a hospitalization or some other event. I think that's going to be largely a care coordination, particularly for those facilities do not administer transfusions on site.

Joan Simard: So is that going to be picked up through their Medicare submission or are we going to be — I mean how does that get reported because, a patient goes into the hospital for a cardiac event and has surgery and requires blood during surgery, it may not be relevant to — related to the fact that they were, you know, on ESA therapy but that they had surgery.

Joel Andress: I don't want to get into the details.

Joan Simard: I'm just – how is it going to be, who's going to capture it, that I guess is what I'm going to say?

Joel Andress: So the measure has a number of exclusion criteria for events that, such as surgery, that can take place that, you know, may require blood transfusion but that obviously are not a consequence of poor anemia management. And the specifications delineate what those are. If you have recommendations about what else may need to be incorporated within those exclusion criteria, then we would certainly be happy to take a comment from you to address those. But I would encourage you to go the website and look at the — and look at the specifications and decide whether or not you believe additional comment is necessary.

Joan Simard: If it says data sources are going to be REMUS, CROWNWeb, and other CMS ESRD, well again, I don't know if they've done it, I can't put it in CROWNWeb. So I'm just looking at …

Joel Andress: Right, right. So we don't require additional reporting through CROWNWeb. We have administrative data sources that we use to capture …

Joan Simard: OK.

Joel Andress: To capture transfusions that are — that are — that don't rely on reporting from analysis facility.

Joan Simard: OK.

Joel Andress: We can — and those are actually laid out in the measure specification. I couldn't tell you right off the top of my head what all of them are, but it's not a measure that requires that you be able to capture all of the information and submit the information in CROWNWeb in order for us to calculate it.

Joan Simard: And then is there – will there — would there be a way for us to be able to see what has been submitted at some point in time in the future so that we can see what's happening, you know, other than just when the reports come out? Because when the reports come out, I'm like, who was the patient? Who were they? I mean, is there any way we'll be able to go back and look and see who had the submissions on them?

Joel Andress: So this is an issue that's come up not just for this kind of measure but for others, such as the readmissions measures that we've implemented in a number of programs. In some cases, we simply don't have the capacity to be able to share with you information from another provider. And in that case, I'd say it would be able to call out a patient is really is going to be an issue of care coordination between you and other providers because we don't have the capacity to provide that communication from all of the — all of the providers who the patient may encounter.

Joan Simard: OK. Thank you.

**Operator:** Your next question comes from the line of Debbie Benner.

Debbie Benner: Yes my name is Debbie Benner with DaVita Healthcare Partners and my question relates to the clinical depression screening. The requirement appears that it is — that a screening was conducted and then followup plan is documented if it is positive. What I'm wondering about is, have you determined a specific screening tool, because there's several of them out there?

Tamyra Garcia: Hello Debbie, this is Tamyra Garcia. Thank you so much for your question. So if you take a look at the rule, it pretty much describes that the facility is able to determine the type of tool that they'd like to use and there are also examples

provided in the rules of what could potentially be used to screen depression. Does that help?

Debbie Benner: Yes, that helps.

Tamyra Garcia: OK, thank you.

Debbie Benner: I'm going to find that. OK.

**Operator:** Your next question comes from the line of Philip Calderone.

Aryeh Langer: Hello, your line is open.

**Operator**: Philip, if you're on mute, please unmute your line and proceed with your question.

Moving to the next question, your next question comes from the line of Mohammed Khan.

Mohammed Khan: Yes, hi, my name is Dr. Mohammed Khan from Van Buren Dialysis in Southern California. My question pertains to the standardized readmission ratio. Now is this related to the same diagnosis being readmitted twice or different diagnosis and is it for different providers or same providers? Sometimes patients end up being sent by their primaries, and if it were in my hands in the process, I would not have admitted the patient for that reason.

Joel Andress: This is Joel Andress. Thank you — thank you for your question. So first off, I'll start off by saying the manual specifications are available online and that will — I think will give you some of the details to your question.

In short, the measure is all cause, all conditions. So patients who return to the facility for any reason …

Mohammed Khan: I see.

Joel Andress: It doesn't have to be specifically related to why they were discharged in the first place.

Mohammed Khan: I see.

Joel Andress: We do have exclusions for a number of specific cases, including unplanned readmissions —or I should say planned readmissions. And these are situations in which the event is something that is part of the continuing care of the patient and, therefore, doesn't represent a failure in quality.

That having been said, of course, we're always accepting comments from providers and physicians regarding additional issues that we don't currently exclude from measures. So if you — any circumstances in which you think we may be failing to exclude something that should be excluded, we will certainly be happy to hear from you on that point.

Mohammed Khan: So there will be some time where we can give feedback that these measures should be excluded or these admissions?

Joel Andress: Well, so I should say, the measures themselves undergo an annual payments process.

Mohammed Khan: I see, I see.

Joel Andress: So we accept comments, we can take it either from the QIP help desk, and I believe that's listed on the presentation here, or dialysisdata.org has a help desk, which you could also submit comments on regarding measures.

Mohammed Khan: OK, thank you.

**Operator**: And as a reminder, that is star 1 to ask a question. Your next question comes from the line of Mary Lincoln.

Mary Lincoln: Yes, back with regard to the transfusion. I'm kind of confused on this, too, and I was trying to look at your resources. So where exactly do we find a list of all the exclusions because we've had the same concern, you when patient has GI bleeds, this thing is totally unrelated to dialysis, how does it get measured? How does it get reported? And where do I find all this information and exclusions and …

Joel Andress: Right, well thank you for asking. This is Joel again, obviously.

So again, if this is on the Specifications Manual that is provided on to the CMS website, we have — they'll actually also be submitting the transfusion measure to NQF in the near future so you'll be able to — I think and probably in March, you'll be able to see the specification online at the National Quality Forum website.

In brief, we use a combination of 27/28 data, which we use for risk adjustment. We also make use of claims data to capture certain kinds of events from both inpatient and outpatient claims that would indicate that the transfusion may or probably was not the result of poor anemia management. And that's generally the source of information we use for those particular exclusion criteria.

The details are available online, although I'll say just a quick rundown from the specifications manual. We currently exclude patients with a Medicare claim for one of

the following conditions: hemolytic and aplastic anemia; solid organ cancer, breast, prostate, lung, digestive tract, and others; lymphoma; carcinoma in situ; for ovulation disorders; multiple myeloma, myelodysplastic syndrome and myelofibrosis; leukemia; head and neck cancer; other cancers of connective tissues, skin, and others; metastatic cancer; or sickle cell anemia.

So those are the current exclusions that we have incorporated for Medicare claims. I believe there has been — there has been some questions — some questions about additional exclusions. I'll say that the same — the same that goes true for the standardized readmission ratio. If you believe that we have erred in not including a particular exclusion, we're certain always interested in hearing back from you in the form of a comment.

Mary Lincoln: I believe that that GI bleed has been brought up several times and I can't believe that that's not in there.

Joel Andress: OK. Well, I would say — I would recommend that if you believe strongly that it should be included there, I would ask that you submit a comment, you provide your rationale, any supporting information or evidence that you believe we need to review. And we can take a look at it as part of the review process. As it goes through, at the National Quality Forum, we will also…. Of course, there will also be an opportunity for comments there. And I would recommend that you make a public comment there as well because we'll be expected to respond to those as part of the endorsement process for providers.

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

Julie Williams: Yes, this is Julie Williams, I'm from Branson Dialysis in Missouri. My question is on the Kt/V adequacy and why visiting dialysis patients, the transients, are included if they've had three or more treatments? Why are transients included in our Kt/V measures?

Tamyra Garcia: Julie, thank you so much for your question. Give us 1 second to formulate a response.

So again Julie, thank you for your question. Based upon what you described a few moments ago, we've learned that recently, well, previously there was a two-touch rule associated with the measure and now there's a seven-touch rule. So actually the information that you provided may be a little outdated.

Julie Williams: I'm going off my QIP report card and when I requested my data because of my Kt/V measures being so horrible, I found out it was because my transient patients are included. And when I called the QualityNet help desk, they were — I was told that the measure says any patient with three or more treatments is counted.

Tamyra Garcia: Yes, and that was for payment year 2015. So the change has been updated as of payment year 2017.

(Crosstalk)

Tamyra Garcia: So for payment year 2017, it's now a seven-touch rule.

Julie Williams: Can you explain what that means?

Tamyra Garcia: So in payment year 2015, and the requirements of payment year 2015 vs. payment year 2017 have changed. So now in payment year 2017, there's a seven-touch rule as opposed to previously where there were three.

Julie Williams: OK, if you're saying seven or more treatments?

Tamyra Garcia: Yes, so …

Julie Williams: OK, OK.

Tamyra Garcia: Patients treated at the facility fewer than seven times during the claim month are to be included in the denominator.

Julie Williams: OK, all right, I appreciate that, thank you.

**Operator**: Your next question comes from the line of Philip Calderone.

Philip Calderone: Hi, this is Dr. Calderone, can everybody hear me?

Aryeh Langer: Can you speak a little closer to your phone please?

Philip Calderone: I'm sorry?

Aryeh Langer: Can you speak up a little bit please?

Philip Calderone: I'm sorry?

**Operator**: Philip, if you could just speak up and repeat your question.

Philip Calderone: OK, can everyone hear me?

Aryeh Langer: OK, go ahead sir.

Philip Calderone: OK, my question is a question I've asked for the past 2 years relative to vascular access on nursing home patients. Has anything been addressed relative to the inability to get a fistula into those patients?

Joel Andress: Good afternoon, Dr. Calderon, this is Joel Andress again.

Philip Calderone: Hi, yes, I know. We've spoken quite a bit about this.

Joel Andress: Yes, we have. So in terms of the QIP policy, the QIP Policy still implemented (inaudible) the measure as specified. We have, however, posted — we have posted a call for nominations for a technical expert panel to address vascular access. This is one of the issues that that panel will be taking up. That is currently up and running on the CMS website. So I would recommend that if you're interested or know of anyone you're interested in serving on that TEP, that you submit a nomination either for yourself or for others. And that TEP will be responsible for addressing this as well as other issues with regard to the two-vascular access measures.

Philip Calderone: Great, and I'm sorry because I lost you before — may I ask just a single question? On the readmission ratios basically, is it only based on admissions that are relative to ESRD?

Joel Andress: OK, so the, I'm sorry, you're asking for the standardized readmission ratio. The standardized readmission ratio is regarding all cause, all conditions. So it involves any readmissions from ...

Philip Calderone: For any reason?

Joel Andress: For any reason, yes. If any patient who is discharged …

Philip Calderone: OK, even if it's unrelated to the ESRD?

Joel Andress: … returns to dialysis care and then returns to the hospital within that — within those first 30 days.

Philip Calderone: Right. If they return for appendicitis or pneumonia, that's part of the criteria that are used?

Joel Andress: Yes, yes.

Philip Calderone: OK.

Joel Andress: And the exceptions to that are the planned readmissions, which I mentioned earlier. There are a set of codes which are listed out on the website. There

are a series of claims codes that indicate conditions for the return for which we do not — we do not count the readmissions. It is considered …

Philip Calderone: OK, and nothing has been adjusted relative to 27/28 relative to updating it on a timely basis?

Joel Andress: I'm sorry, can you repeat that, I couldn't hear the question?

Philip Calderone: The 27/28, OK, which is initiated at the initiation of dialysis, ESRD.

Joel Andress: Yes.

Philip Calderone: It has never been updated. Has that been changed?

Joel Andress: As far as I'm aware, it has not, but that's not, that's …

Philip Calderone: No, because comorbid conditions change over 5 years, 10 years or more.

Joel Andress: Are you referring to the standardized readmission ratio?

Philip Calderone: No, I'm — basically I'm referring to everything on the 27/28, vis-à-vis comorbidity.

Joel Andress: OK, no the comorbidities that are listed on the 27/28 are not — are not updated on an ongoing basis.

Philip Calderone: OK, so nothings been done about that either. OK, thank you very much. Appreciate your time.

**Operator**: Your next question comes from the line of Rawle Austin.

Aryeh Langer: Hello, your line is open.

Rawle Austin: I have a question regarding the readmission — oh not readmission, the transfusion. I'd like to get some clarification on determination. Is there a level of like hemoglobin that you are looking at for transfusion and who is the determining factor, the hospital or the nephrologists who is ordering the transfusion? Which one are you guys going with? Because what happens sometimes in hospital a doctor might see a patient, a nephrology patient, and think that patient needs transfusion while the nephrologist is not involved, may go ahead and transfuse the patient. So it needs some clarity here as to what the criteria….

Joel Andress: Thank you. So the criteria are spelled out in the specifications manual. In terms of whether or not we have a hemoglobin level that is spelled out for the measure, no, we do not.

Rawle Austin: OK.

Joel Andress: Transfusions included are not limited by specific hemoglobin UL level with the patient.

Rawle Austin: And the ordering of the transfusion, is it hospital-related or the nephrologists that's involved in the decision-making. Because most of the time the patient goes to the hospital unknowing to the nephrologists and the doctors in the hospital see a low hemoglobin and order a transfusion without drilling down to know that this patient has a nine or eight and in dialysis, they're not going to transfuse the patient with that, but they go ahead and transfuse the patient. So there needs to be some clarity as to what is determine, the reason for transfusion.

Joel Andress: So the answer to that is that the measure is agnostic as to the source of the ordering. If you believe that is something that it needs to be taken out, then we certainly will be willing to take a written comment on it and we can review your concern.

I would state that this is an area where it seems that better coordination between the dialysis provider and the hospital in this instance would be ideal, and that's certainly something we want to encourage. But as for the specific measure specifications, we would need to review your concern more fully before we can actually make a change to them.

Rawle Austin: OK, thank you.

Joel Andress: Thank you.

**Operator**: Your next question comes from the line of Susan Senich.

Susan Senich: Hello, Susan Senich, North Central PA Dialysis. On slide 44, the calculations, the weights — where do we – how do we determine how to weight these measures so that we can maybe kind of do a little calculation?

Tamyra Garcia: Hello Susan, this is Tamyra Garcia and we are formulating a response. Hold for 1 second please.

So again, good afternoon Susan, and to answer your question, what we see in slide 44, it assumes that a facility is eligible for all of the measures. So those — if you as a facility are eligible for all of the measures, you can use those exact weights to sort of estimate

your score, but if there are any measure that you are not eligible for in a particular domain, then the weights will be sort of recalculated in order to account for the excluded measure.

Susan Senich: OK, because I know now that we don't have pediatric. So pediatric Kt/V and pediatric PD Kt/V, we wouldn't have.

Tamyra Garcia: Um-hum.

Susan Senich: Other than that, we would have everything. So can you – do you pull those two out and then recalculate from the 30 percent?

Tamyra Garcia: One second. So because the measures that you identified are considered measured topic scores, the weights will remain the same.

Susan Senich: OK.

Tamyra Garcia: So the weights will not change based on what you see on slide 44.

Susan Senich: Oh, great. OK, thank you.

Tamyra Garcia: Um-hum.

**Operator**: You do have a followup question from the line of Joan Simard.

Joan Simard: Yes, thank you again for taking my question. I've got so many of them. One of the things — and the physician was just speaking about the nursing home patients, are they still looking at the fact that many patients are not a candidate for a fistula or have had failed fistulas and now only require and can manage a graft? They are still functioning without complications. I have some of my facilities with almost 20 percent of the patients that have to use a graft, their fistulas failed or they're not a candidate. And that really has an impact on my overall scoring. But they don't have a catheter, but they just can't get a fistula. Is it going to — are they going to ever address the peripheral access versus a CBC instead?

Joel Andress: This is Joel Andress again. So, as I was explaining to Dr. Calderone, we are reviewing this issue as part of the technical expert panel that's being convened for vascular access. And that's where the issue is being taken up.

In terms of reviewing it from my awareness of the issue, I think what we found is that there's sufficient — there's sufficient question left over as to whether or not — as to what the correct course of action is that it needs to be reviewed in depth as opposed to simply a policy decision from CMS about how to apply the measure. And so that's why

we've chosen to take it up with a panel of experts as opposed to making a decision on our own, and, you know, that's going where that is.

I would say that if you are like some others who've been concerned about this issue, then, of course, we would love to hear from you in the form of a comment. Any additional data or information you could provide to us is, of course, always welcome and we can consider that along with the information currently available to us regarding the appropriateness of a fistula vs. a graft for some patients.

Joan Simard: It's not even a question of appropriateness. Some patients don't have the capabilities or they don't have the peripheral vessels for a fistula and they have — surgeons have to — after unsuccessful fistulas have to create a graft…

Joel Andress: Right.

Joan Simard: And that is the only access that we can use. But we're not using a catheter. Or I have patients that have had grafts that are functioning without complications and we can't justify replacing those and we get, you know, very close to getting dinged every year because, like I say, 20- to 25-percent of my population — it's pretty significant.

Joel Andress: And as I say, that is precisely the kind of information we need to hear — we need to hear in the form of a comment so that we can take that with us to the TEP and say, "These are some of the concerns that have been raised to us about the measure, this is the evidence that we have in the literature, and we need some guidance in terms of how to address this."

Joan Simard: And that's through the ESRD QIP site that you mentioned?

Joel Andress: You can, yes, you can send it to the help desk there or again dialysisdata.org also has a help desk.

Joan Simard: OK.

Joel Andress: Either one will get you to us.

Tamyra Garcia: And to repeat that email, it's esrdqip@cms.hhs.gov.

Joan Simard: Thank you.

**Operator**: Your next question comes from the line of William Poirier.

William Poirier: Hi, William Poirier from Greenfield Health Systems in Detroit. Can you tell us how the weights will be readjusted for home-only programs that don't submit NHSN or the in-center CAHPS surveys for the vascular access?

Tamyra Garcia: Thank you so much for that — thank you so much for your question, William. Again, this is Tamyra. And I'm going to ask that you send that question along to the ESRD QIP mailbox at esrdqip@cms.hhs.gov so that we can address your issue in greater detail because it's quite a complicated response.

William Poirier: Thank you.

Tamyra Garcia: Um-hum.

**Operator**: Your next question comes from the line of Christine Good.

Christine Good: Can you hear me?

Aryeh Langer: Go ahead Christine.

Christine Good: I was just trying to reach in and touch base about the lady that had the question about the vascular accesses and, you know, not being able to get the patient — you know we're being judged on the number of fistulas vs., you know, how many patients are without a catheter. What about — is there ever going to be anything taken into consideration for the patients that we've educated and they just choose not to get the preferred access?

Joel Andress: This is Joel. Thank you for your question. I think — in terms of how it may be addressed for quality measures in the future, I can't say if it will ever be addressed. It's not something that we can currently capture using the data available to us. And the QIP uses claims data and there's not a meaningful means for us to capture that particular piece of information.

So as a concern, I think it's certainly worth bringing it to our attention, but I think we'll need to explore how we could account for that in the first place in addition to whether or not it's something we would want to include within the specifications of the measures.

Christine Good: OK.

Aryeh Langer: Thank you.

**Operator**: You do have a followup question from the line of Debbie Benner.

Debbie Benner: Yes, I just wanted to ask about the ICH CAHPS with regards to the scoring. It says, "a percentage of patient responses to multiple testing tools," and I thought we were just using the ICH CAHPS tool. And then secondly, I'm wondering what that means in terms of when it says "a summation of responses." Does that mean a sum of the number of patients that responded or we — it states, you know, to be a clinical

measure so I was anticipating it was going to move towards what the actual responses were not the numbers of responses. So I'm just curious as to if you could provide more specifics.

Aryeh Langer: Give us one moment, please.

Tamyra Garcia: Hello, and to respond to your question, so the composite score is a combination of many different questions in the survey. And the overall rating is really just a summation sort of those responses, the top box responses, and each of those, each response is given either an achievement or an improvement score, and whichever score reflects better performance, that's the score that's chosen, and then they're averaged. So that's sort of how— how the process works. It's a multilevel process.

Debbie Benner: So you're saying it'll be based upon the top box score.

Tamyra Garcia: Yes.

Debbie Benner: So, for example on the overall, it would overall center, just the 9s and 10s, and it's the number or percent of patients that are scoring as a 9 or 10?

Tamyra Garcia: Yes, or just a 10.

Debbie Benner: And which is a 9 or a 10 or …

Tamyra Garcia: And what we'll do is, please send your question regarding whether or not it's 9 or 10 to the ESRD QIP mailbox and we can provide you with additional information on that.

Aryeh Langer: Thank you. We have time for one more question.

**Operator**: Your next question comes from the line of Katrina Russell.

Katrina Russell: Hi, Katrina Russell, Dialysis Consulting Group in Seattle. And it's another followup question regarding the ICH CAHPS survey. On slide 38 you discuss the fact that it is — the score's based on three composite measures and three global ratings, and I think it would help me and the previous question to you to address what are those composite measures and the global ratings. I looked at the specifications and there's no detail on that, so where can we get the information on what those composite measures and the global ratings are?

Tamyra Garcia: Excuse me. Please give us one moment to take a look to make sure we're pointing you to an accurate source to see what those three composite measures are.

Katrina Russell: Right, thank you.

Tamyra Garcia: OK, so if you take a look at the measure specifications on the CMS website, the composite scores include nephrologists' communication and caring, quality of dialysis center care and operations, and providing information to patients. So those are the three composite score measures. And the three global ratings can actually be found in the rules. Those include the overall rating of the nephrologist and overall rating of the dialysis center staff, and an overall rating of the dialysis facility.

Katrina Russell: OK, thank you. But let me clarify, I see where I can find the global ratings in the rule, but you said the composite measures are supposed to be in the specs, because they are not there.

Tamyra Garcia: No, they're on the CMS website under the finalized payment year 2018 clinical measure. There's a Patient Experience of Care document, and it has the measure description, exclusions, data sources, and any additional information you'd like on the patient — the ICH CAHPS survey.

Katrina Russell: OK.

Tamyra Garcia: And also — I apologize, it's also included in the rule as well directly above the global ratings.

Katrina Russell: All right, thank you.

Tamyra Garcia: Um-hum.

## Additional Information

Aryeh Langer: Thank you. Unfortunately that's all the time we have for questions today. On slide 58 of today's presentation, you'll find information on how to evaluate your experience with today's National Provider Call. Evaluations are anonymous, confidential, and voluntary, and we hope you'll take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Aryeh Langer from the Provider Communications Group here at CMS. I'd like to thank all of our subject matter experts here in the room with us as well as the participants who joined us today for this MLN Connects Call. Have a great day, everybody.

**Operator:** This concludes today's call. Presenters, please hold.

**-END-**