

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Room 352-G  
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## FACT SHEET

FOR IMMEDIATE RELEASE

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### **CMS Finalizes Quality Incentive Program Policies For End-Stage Renal Disease Prospective Payment System For Payment Year 2016**

**Overview:** The Centers for Medicare & Medicaid Services (CMS) issued the final rule for the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) for Payment Year (PY) 2016. The ESRD QIP promotes high-quality services 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. The ESRD QIP will reduce payments to ESRD facilities that do not meet or exceed certain performance standards.

As a major payer of healthcare services, CMS is a critical force for the continual improvement of health and healthcare for all Americans. Complementing existing CMS quality improvement initiatives, the ESRD QIP is designed to incentivize better clinical outcomes and to increase the quality of care for patients on dialysis.

**Background:** Established in accordance with section 153(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), the ESRD QIP is designed to encourage high-quality care for dialysis patients. As a result of performance on quality measures, eligible dialysis facilities that earn a performance score that does not meet or exceed the minimum Total Performance Score (TPS) are subject to a payment reduction of up to two percent on in their payment rates under the ESRD PPS during the payment year. This final rule establishes payment reductions that will be applied in PY 2016, based on facility performance in 2014.

**Final PY 2016 ESRD QIP:** The final rule for PY 2016 expands the scope of clinical and reporting measures included in the ESRD QIP. CMS has finalized eight clinical measures and

three reporting measures encompassing anemia management, dialysis adequacy, vascular access type, patient experience of care, infections, and mineral metabolism management.

### **Clinical Measures**

The PY 2016 final rule includes eight clinical measures. Five measures are captured in two clinical measure “topics” or categories (Kt/V Dialysis Adequacy and Vascular Access Type). The National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Outpatients and Hypercalcemia measures are new; the Kt/V Dialysis Adequacy measure topic, Vascular Access Type measure topic, and the Anemia Management measure remain unchanged from PY 2015. With the exception of the Hypercalcemia measure, individual scores for clinical measures and measure topics that apply to a given facility will be weighted equally to make up 75 percent of the facility’s TPS. The Hypercalcemia measure will have lesser weight (two-thirds) than the other clinical measures.

### **Reporting Measures**

The final rule modifies three reporting measures that were part of ESRD QIP PY 2015: Anemia Management, Mineral Metabolism, and the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Patient Satisfaction Survey. The Anemia Management and Mineral Metabolism measures have been revised to include home peritoneal dialysis patients. The ICH CAHPS measure has been expanded; facilities are now required to submit the results of the survey to CMS. Individual scores for the reporting measures that apply to a given facility will be weighted equally to make up 25% of the facility’s TPS.

### **Scoring Structure**

The PY 2016 scoring structure is similar to that established for PY 2015. Each facility could receive a TPS between 0 to 100 points. CMS determined that the minimum TPS required to avoid a payment reduction for PY 2016 is 54 points. This minimum TPS would be achieved by a facility if it:

- Scored zero points for the NHSN Bloodstream Infection clinical measure;
- Met the national performance standard for each of the remaining clinical measures; and
- Scored half the total possible points for each of the reporting measures

As a general matter, facilities will earn points on applicable clinical measures by comparing its performance during 2014 either to: (1) a national standard based on 2012 data (the “achievement score”); or (2) its own performance during 2013 (the “improvement score”). CMS will apply the better of the two scores when computing the TPS. Facilities will only be scored on the basis of achievement if CMS is unable to calculate an improvement score due to insufficient baseline data.

For purposes of calculating clinical measure topic scores for the TPS, the individual measure score(s) applicable to a given facility will be weighted according to the number of eligible patients in each component measure. Weighted scores will then be combined to create a single score for the measure topic.

Facilities will be scored on reporting measures according to a point system established for each measure. Facilities will receive a TPS as long as they are eligible for at least one clinical measure and at least one reporting measure.

The final rule encompasses program elements in addition to the scoring of PY 2016 performance. The rule also discusses elements involved in continuing CMS's data-validation pilot program, refining public-reporting requirements, and adding facilities operating in the Pacific Rim to the PY 2016 ESRD QIP.

### **National Provider Call—Payment Year 2016 Final Rule**

On January 15, 2014, CMS will hold a National Provider Call to help facilities and other stakeholders in the ESRD community understand the final rule. The discussion will be recorded and made available at [www.cms.gov/live](http://www.cms.gov/live).

For more information about the program, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/index.html>

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