Outpatient Quality Program Systems and Stakeholder Support Team

CY 2023 ESRD PPS Final Rule

Question and Answer Summary Document

Moderator:
Karen VanBourgondien, RN, BSN
Outpatient Quality Program Systems and Stakeholder Support Team

Speaker(s):
Golden M. Horton, MS
Health Insurance Specialist
Center for Clinical Standards and Quality (CCSQ)
Quality Measurement and Value-Based Incentive Group (QMVIG)
Digital Quality Management (DQM)
Centers for Medicare & Medicaid Services (CMS)

Delia Houseal, PhD, MPH
End-Stage Renal Disease Quality Incentive Program (ESRD QIP) Program Lead
Division of Value, Incentives & Quality Reporting (DVIQR)
Centers for Medicare & Medicaid Services (CMS)

January 19, 2023
2 p.m. Eastern Time (ET)

DISCLAIMER: This presentation question-and-answer summary document was current at the time of publication and/or upload onto the *Quality Reporting Center* and *QualityNet* websites. Medicare policy changes frequently. Any links to Medicare online source documents are for reference use only. In the case that Medicare policy, requirements, or guidance related to these questions and answers change following the date of posting, these questions and answers will not necessarily reflect those changes; given that they will remain as an archived copy, they will not be updated. The written responses to the questions asked during the presentation were prepared as a service to the public and are not intended to grant rights or impose obligations.

Any references or links to statutes, regulations, and/or other policy materials included are provided as summary information. No material contained therein is intended to take the place of either written laws or regulations. In the event of any conflict between the information provided by the question-and-answer session and any information included in any Medicare rules and/or regulations, the rules and regulations shall govern. The specific statutes, regulations, and other interpretive materials should be reviewed independently for a full and accurate statement of their contents.

Subject-matter experts researched and answered the following questions during the live webinar. The questions may have been edited for grammar.

Question 1: **Why is CMS not adding the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure until program year (PY) 2025? Will the measure be useful by then?**

We believe the COVID-19 Vaccination reporting measure will continue to be useful in the PY 2025 End-Stage Renal Disease Quality Incentive Program (ESRD QIP). Facilities will begin reporting measure data in calendar year (CY) 2023, which we believe is the earliest that we can begin requiring facilities to report for scoring and payment purposes.

Question 2: **Why is CMS pausing measures in the ESRD QIP?**

We have determined that circumstances caused by the Public Health Emergency (PHE) for COVID-19 continue to significantly affect certain measures and the resulting quality scores in CY 2021. We believe that pausing certain measures is a short-term necessity to ensure that the PY 2023 ESRD QIP does not reward or penalize facilities based on factors that the Program's measures were not designed to accommodate.

Question 3: **Why is CMS pausing the Standardized Fistula Rate clinical measure f or PY 2023?**

Although we initially considered pausing the Standardized Fistula Rate clinical measure in the proposed rule, we concluded that the measure would not be eligible for pausing based on data available at the time of the proposed rule. However, we believe that pausing the Standardized Fistula Rate clinical measure for PY 2023 is now appropriate based on our updated analyses. These analyses show significant deviation in national fistula rates in CY 2021 compared to CY 2019, as well as significant decline in national fistula rates over the course of CY 2021. We believe this aligns with COVID-19 surges throughout that year. Our analyses also showed that, as catheter rates increased in CY 2021, fistula rates correspondingly decreased.

We determined that COVID-19 PHE circumstances significantly affected the Long-term Catheter Rate clinical measure and significantly impacted the Standardized Fistula Rate clinical measure and resulting performance score, and we believe that justifies pausing both vascular access type measures for PY 2023. We note that interested parties, through public comments, recommend pausing the Standardized Fistula Rate clinical measure for PY 2023 because performance on that measure is closely tied to performance on the Long-Term Catheter Rate clinical measure.

Question 4: **Why is CMS updating the performance standards for PY 2023?**

Due to the exclusion of CY 2020 data from ESRD QIP scoring, we believe that it is appropriate to use CY 2019 data to set performance standards. Currently, CY 2021 is the performance period and CY 2020 is the baseline period for the PY 2023 ESRD QIP. Under the nationwide Extraordinary Circumstance Exception (ECE) that CMS granted in response to the PHE, first and second quarter data for CY 2020 are excluded from scoring for purposes of the ESRD QIP. We are concerned that it would be difficult to assess performance standards for PY 2023 using a baseline period based on partial year data. Therefore, we are finalizing our proposal to use pre-pandemic data from CY 2019 as the baseline period for the PY 2023 ESRD QIP.

Question 5: **Why is CMS updating the Standardized Hospitalization Ratio (SHR) clinical measure and the Standardized Readmission Ratio (SRR) clinical measure?**

We believe that expressing these measure results as rates will help providers and patients better understand a facility's performance on the measures. We also believe rates are a more intuitive way for a facility to track its performance from year to year.

Question 6: **Why is CMS updating the Standardized Transfusion Ratio (STrR) reporting measure?**

In the CY 2020 ESRD Prospective Payment System (PPS) Final Rule, we converted the STrR clinical measure to a reporting measure to examine validity concerns and to ensure that dialysis facilities were not adversely affected in the interim. Since then, the National Quality Forum (NQF), the current Consensus Based Endorsement Entity, performed an ad hoc review, revised the measure's specifications to address coding and validity concerns, and renewed its endorsement of the STrR clinical measure. In light of the NQF endorsement, we are converting the STrR reporting measure to the revised STrR clinical measure. We believe that previous validity concerns have been adequately examined and addressed and that the finalized STrR clinical measure more closely aligns with NQF measure specifications.

Question 7: **Why is CMS updating the Hypercalcemia clinical measure?**

Based on our previously adopted methodology, we do not consider the Hypercalcemia clinical measure as topped out. However, we believe that it is very close to being topped out based on the available data, and we are

concerned that small differences in measure performance may disproportionately impact a facility's score on the measure.

In recent years, we have received numerous public comments expressing concern about the role and weight of the Hypercalcemia clinical measure in the ESRD QIP. Many interested parties have indicated that they believe the measure is topped out, pointing out that the NQF, the current Consensus Based Endorsement Entity, has placed the measure in Reserve Status because of high facility performance and minimal room for improvement. As a result, the ability to distinguish meaningful differences in performance between facilities is substantially reduced because small random variations in measure rates can result in different scores. Others have expressed concern about whether the Hypercalcemia clinical measure is the best measure in the bone mineral metabolism domain to impact patient outcomes. Considering these ongoing stakeholder concerns, we are examining the continued viability of the Hypercalcemia clinical measure as part of the ESRD QIP measure set.

Question 8: **Why is CMS updating the ESRD QIP measure domains?**

Currently, ESRD QIP measures are weighted and distributed across four measure domains: Patient & Family Engagement, Care Coordination, Clinical Care, and Safety. Based on changes to the measure set since PY 2021, CMS has reassessed the impact of the ESRD QIP measure domains and domain weights on Total Performance Scores (TPSs). We believe it is necessary to increase incentives for improving performance by increasing the weights on measures where there is the most room for improvement, especially on patient clinical outcomes. Therefore, we are finalizing our proposal to create a new Reporting Measure domain that includes the four current reporting measures in the ESRD QIP measure set, the finalized COVID-19 HCP Vaccination reporting measure, and the finalized Hypercalcemia reporting measure. We are also updating the domain weights and individual measure weights in the Care Coordination, Clinical Care, and Safety domains to accommodate the new Reporting Measure domain and its individual reporting measures. We did not propose any changes to the Patient & Family Engagement domain. CMS will continue to weigh it at 15 percent of a facility's TPS. As the ESRD QIP measure set has evolved over the years, we believe this would help to address concerns regarding the impact of individual measure performance on a facility's TPS, while further incentivizing improvement on clinical measures.

Question 9: **How is ESRD QIP addressing health equity in this final rule?**

CMS is committed to addressing persistent inequities in health outcomes in the United States by improving data collection to better measure and analyze disparities across programs and policies. In the CY 2023 ESRD PPS Proposed Rule, we sought input via a request for information (RFI) on overarching principles in measuring healthcare quality disparities in quality reporting programs and value-based purchasing programs. We sought and received comment on key considerations in five specific areas that could inform our approach: identification of goals and approaches for measuring healthcare disparities and using measure stratification across CMS quality programs; guiding principles for selecting and prioritizing measures for disparity reporting across CMS quality programs; principles for social risk factor and demographic data selection and use; identification of meaningful performance differences; and guiding principles for reporting disparity results. Although we do not respond to these public comments in the CY 2023 ESRD PPS Final Rule, we have summarized the comments we received in the final rule and will use the comments to inform future rulemaking and policy development.

We also requested information through public comment on two social drivers of health measures for possible future inclusion in the ESRD QIP: Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health. These complementary measures would encourage facilities to address health-related social needs (HRSNs) in patients during treatment. The measures would screen for HRSNs in five core domains that have been directly associated with disparate health outcomes, specifically among racial and ethnic minority groups: food insecurity; housing instability, transportation needs, utility assistance needs, and interpersonal safety. Although we do not respond to these public comments in the CY 2023 ESRD PPS Final Rule, we have summarized the comments we received in the final rule and will use the comments to inform future rulemaking and policy development.

Question 10: **Why is the ESRD QIP requiring us to report vaccination rates among our staff?**

This measure has also been included in other quality reporting programs for other care settings. The addition of the COVID-19 HCP Vaccination measure would address the quality priority of "Promoting Effective Prevention and Treatment of Chronic Disease" through the Meaningful Measures Area of "Preventive Care."

CMS believes that it is important to incentivize and track healthcare personnel vaccination for COVID-19 in dialysis facilities through quality measurement.

We also believe that publishing the HCP vaccination rates would be helpful to many patients, including those who are at high-risk for developing serious complications from COVID-19, such as dialysis patients as they choose facilities for treatment.

Question 11: **For the COVID-19 Vaccination HCP reporting measure, will we report weekly data?**

No. Although it would be ideal to have HCP vaccination data for every week of each month, we are mindful of the time and resources that facilities would need to report the data. Thus, in collaboration with the Centers for Disease Control and Prevention (CDC), we determined that data from at least one self-selected week of each month would be sufficient to obtain a reliable snapshot of vaccination levels.

Question 12: **Why doesn't CMS remove the Hypercalcemia measure form the ESRD QIP?**

We are considering the long-term viability of the Hypercalcemia measure and examining possible alternative measures to replace the Hypercalcemia measure in the ESRD QIP. If we do propose to remove the Hypercalcemia measure from the ESRD QIP measure set in future rulemaking, we will also propose to replace it with a different bone mineral metabolism measure.

Question 13: **We are concerned about the new reporting measure domain and the re-weighting of the existing domains. Shouldn't CMS aim to reduce the number of measures in the program and weight the remaining measures to align with clinical value and importance to patients, so they are meaningful?**

Yes, weights should reflect clinical value and meaningfulness to patients, which we took into account. We believe that the measure domains and weights will provide facilities with more meaningful incentives to improve performance on measures that align with clinical value and importance to patients. Although we aim to minimize facility burden as much as feasible, we do not agree that reducing the number of measures in the ESRD QIP should be a goal.

We have developed the ESRD QIP measure set specifically to ensure that facilities focus on the most relevant clinical topics that will lead to improved quality of care and better outcomes for patients.

Question 14: **We disagree with the conversion of the STrR reporting measure to a clinical measure. We are concerned that we will be unfairly penalized as a result of this conversion because hospitals may code non-ESRD transfusions in error.**

We believe the recent NQF, the current Consensus Based Endorsement Entity, endorsed revisions to the STrR clinical measure will mitigate these concerns. For hospital inpatients, the previous version of the STrR clinical measure relied on a restricted transfusion event identification algorithm. The measure utilized only those reported transfusion events that include International Classification of Diseases (ICD) procedure codes, ICD procedure codes with revenue center codes, or value codes. For the revised STrR clinical measure, inpatient transfusion events are identified using a broader definition that includes revenue center codes only, ICD procedure codes (alone or with revenue codes), or value codes alone or in combination. This revision will result in identification of a greater number of inpatient transfusion events compared to the currently implemented STrR.