CY 2023 ESRD PPS Final Rule
Presentation Transcript

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Karen Vanbourgondien Hello, everyone. Thank you for joining us. My name is Karen VanBourgondien. Today, we are fortunate to have Golden Horton and Dr. Delia Houseal with us to go over the final rule as it relates to ESRD QIP. Golden is involved in ESRD public reporting, is the interim representative for the ESRD QIP and will be speaking to the final rule content. Delia is the Program Lead for the ESRD QIP and will be available to respond to any questions later in the presentation. We also have Arbor Research available to assist us with answering any measure-specific questions.

Before I hand things over to Golden, let me just cover a few housekeeping items. First, the slides are available on CMS.gov, and I will place the direct link in the chat box. We will have a word-for-word presentation transcript, as well as a recording of this event available shortly. Second, Golden will be going over the finalized proposals in the Calendar Year 2023 ESRD PPS Final Rule as it relates to QIP.

After the presentation portion, we will be taking questions. If you would like to ask a question, please use the Raised Hand feature. To use this feature, you will just click on the hand icon located in the chat box area. During the open discussion portions, we will monitor this feature and call your name to unmute your line, so that, at that point, you may interact with us verbally. Once your question is addressed, please lower your hand to provide opportunity for others. We will make every effort to get to as many people as possible.

Now, without any further delay, let me turn things over to Golden Horton. Golden.

Golden Horton: Greetings. Thank you and welcome to our annual webinar on the Calendar Year 2023 ESRD PPS Final Rule. First, the learning objectives for this presentation are listed here. We will discuss the finalized proposals and the rationale for finalizing them.

As Karen stated, we will be having an open discussion after the presentation of the final rule, and we will wrap things up by providing you with some useful resources. I'd like to make certain that the content covered on today's call should not be considered official guidance. The webinar is only intended to provide information regarding program requirements. Please refer to the final rule, located in the *Federal Register* to clarify and provide a more complete understanding of the modifications and proposals for the program which I will be discussing.

To find the rule, you can access the top link, which will take you directly to the ESRD PPS final rule in the *Federal Register*. For those of you that prefer a PDF version, the second link will take you to that location. The ESRD QIP proposals begin on page 89 of the PDF version.

Let's begin our discussion of the final rule.

Let's begin with flexibilities for the program in response to the Public Health Emergency, or PHE, due to COVID-19 that will impact payment year 2023. In the Calendar Year 2022 ESRD PPS Final Rule, we finalized a measure suppression policy for the duration of the COVID-19 Public Health Emergency. We stated that we identified the need for flexibility in our quality programs to account for the impact of changing conditions that are beyond participating facilities' control. We identified this need because we would like to ensure that facilities are not affected negatively when their quality performance suffers not due to the care provided, but due to external factors, such as the COVID-19 Public Health Emergency. Due to the ongoing impact of the Public Health Emergency, in the Calendar Year 2023 [ESRD] PPS Proposed Rule, we proposed to pause six measures seen here: the SHR clinical measure, SRR clinical measure, ICH CAHPS clinical measure, the Long-Term Catheter Rate clinical measure, PPPW clinical measure, and the Kt/V Dialysis Adequacy Comprehensive clinical measure for payment year 2023.

We proposed to continue providing confidential feedback reports to facilities as a part of program activities to ensure they are made aware of the changes in performance rates that we observe.

We also stated that we intend to publicly report payment year 2023 data where feasible and appropriately caveated. Some of the reasons we proposed to suppress measures was due to significant deviation in national performance on the measure during the COVID-19 Public Health Emergency, which could be significantly better or significantly worse compared to historical performance during the immediately preceding program years; and a national shortage of rapid and unprecedented changes in healthcare personnel or patient case volumes or facility-level case mix. These staff shortages have varied widely geographically, and the shortages experienced by ESRD facilities may be even worse due to the highly specialized nature of the nephrology staff. Although we did not propose to pause the Standardized Fistula Rate measure in the proposed rule, we believe that the Standardized Fistula Rate measure is sufficiently linked to the Long-Term Catheter Rate measure, as I just mentioned.

The circumstances caused by the COVID-19 Public Health Emergency that have significantly affected the Long-Term Catheter Rate clinical measure have also affected the Standardized Fistula Rate clinical measure and resulting performance score. The same barriers to surgical care for catheter reduction also prevented patients from receiving surgical care for AV fistulas.

After considering public comment, we are finalizing to pause the measures seen here, including the Standardized Fistula Rate. We believe that pausing the Standardized Fistula Rate measure in this final rule is appropriate under Measure Suppression Factor 1. There is additional information and tables in the final rule, providing further detail on the finalized pause of the Standardized Fistula Rate clinical measure. In addition to the pause of the seven measures, we will also continue to provide confidential feedback reports to facilities as a part of program activities to ensure they are made aware of the changes in the performance rates that we observe. We also stated our intent to publicly report payment year 2023 data where feasible and appropriately caveated. Our goal is to continue resuming the use of all measure data for scoring and payment adjustment purposes beginning with payment year 2024 ESRD QIP.

We also proposed to update the minimum Total Performance Score and payment reduction scale to reflect our proposal to pause six measures for payment year 2023, which together constitute nearly half of the ESRD QIP measure set. We also proposed to amend policy which will specify that we will calculate a measure rate for each of the paused measures but will not score the facility performance on the paused measures or include them in the facility's TPS for payment year 2023.

We stated that the proposed re-calculated mTPS for payment year 2023 would be 80. We also stated that if one or more of our measures paused proposal is not finalized, then we would revise the mTPS for payment year 2023, so that it includes all measures that we are finalizing for scoring for payment year 2023. Additionally, we proposed to calculate the performance standards for payment year 2023 using calendar year 2019 data, which are the most recently available full calendar year of data we can use to calculate those standards.

We proposed the update in the mTPS due to ongoing effects of the Public Health Emergency due to COVID-19. However, we are not pausing all program measures because our analyses have indicated that some were not significantly impacted by the COVID-19 Public Health Emergency and did not fit within the scope of our measure suppression policy. Scoring a facility on non-paused measures will provide meaningful information to patients and caregivers regarding that facility's performance on these non-paused measures. We believe that it is appropriate to update the mTPS so that it only includes non-paused measures. We also considered the addition of the pausing of the Standardized Fistula Rate clinical measure and its impact on scoring.

After considering public comments, we are finalizing our proposal to update the mTPS for payment year 2023 to include non-paused measures. The re-calculated mTPS will be 83, addressing the addition of the Standardized Fistula Rate Clinical Measure. We will also amend regulation to state that the definition of the mTPS does not apply to payment year 2023.

Additionally, we are finalizing the addition of a new regulation which is different than the original proposal due to our additional pausing of the Standardized Fistula Rate clinical measure for payment year 2023. This will specify that we will calculate a measure rate for each of the paused measures but will not score facility performance on those paused measures or include them in the facility's TPS for payment year 2023. It will also specify that we will score facility performance on each of the non-paused measures. Lastly, we are finalizing our proposal to calculate the performance standards for payment year 2023 using calendar year 2019 data, and we are finalizing our proposal to revise our regulations to reflect this finalized policy.

So, here we can see the calendar year 2023 finalized payment reduction scale, which is also available in the final rule in Table 16. Again, the minimum TPS for payment year 2023 will be 83. Although the recalculated mTPS for payment year 2023 is higher than we proposed in the proposed rule, we estimate that fewer facilities will receive payment reductions for payment year 2023. Although we acknowledge that certain measures may be weighted more heavily due to the reduced measure set, we do not believe this will result in facilities being unfairly penalized for their performance on those measures; our analyses indicated that the facility performance on these measures remains high.

Previously, we finalized a subregulatory process to incorporate technical measure specification updates into the measure specifications we have adopted for the ESRD QIP. In the Calendar Year 2023 ESRD PPS Proposed Rule, we announced that we are updating the technical specifications to revise how we express the results of the SHR and SRR clinical measures. so that those results are expressed as a rate. We noted that interested parties had previously expressed concern that these measures were difficult to interpret and track facility performance over time when expressed as ratios. In light of concerns, we conducted an analysis. Our analysis found that expressing the SHR clinical measure and SRR clinical measure results as rates would reflect the same level of measure performance as expressing those results as ratios.

We stated our belief that expressing the measure results as rates will help providers and patients better understand a facility's performance on the measure and would be more intuitive for a facility to track its performance from year to year. This change will also align with measure result calculation methodology used in the Dialysis Facility Compare Star Rating Program. We will be updating the technical specifications of the SHR clinical measure and SRR clinical measure so that the measure results are expressed as rates instead of ratios beginning with the payment year 2024 ESRD QIP. Additionally, in order to adequately account for patient case mix, we are further modifying the technical measure specifications for the SHR and SRR measures to include a covariate adjustment for patient history of COVID-19 in the 12 months prior to measure eligibility. The inclusion of the covariate adjustment for patient history of COVID-19 would be effective beginning with the payment year 2025 program year for the SHR clinical measure and the SRR clinical measure, and we will also apply this adjustment for purposes of calculating the performance standards for that program year.

We are also considering whether it would be appropriate to add a covariate adjustment for patient history of COVID-19 to the STrR clinical measure, beginning with payment year 2025, and we will announce that technical update, if appropriate, at a later time. Although we considered implementing the technical measure specification updates before payment year 2025, we ultimately concluded that payment year 2025 was the earliest year feasible for including the covariate adjustment due to data collection timelines.

For the payment year 2025, we have several updates to program requirements. In this next section, we will discuss our proposal to adopt the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) reporting measure, our proposal to convert the STrR reporting measure to a clinical measure, and our proposal to convert the Hypercalcemia clinical measure to a reporting measure.

We will begin with the COVID-19 vaccination measure, as COVID-19 has had significant negative health effects—on individuals, communities, and the nation as a whole. To address the COVID-19 pandemic, we proposed to adopt the COVID-19 Vaccination Coverage Among Healthcare Personnel reporting measure to the program beginning with payment year 2025 ESRD QIP.

Some of the reasons we proposed this measure are CMS believes that it is important to incentivize and track HCP vaccination for COVID-19 in dialysis facilities through quality measurement and have finalized proposals to include a COVID-19 HCP vaccination measure in quality reporting programs for other care settings. 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 from which to seek treatment.

Under CMS' Meaningful Measures Framework, 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. The COVID-19 HCP Vaccination measure is a process measure developed by the CDC to track COVID-19 vaccination coverage among HCP in non-long-term care facilities such as dialysis facilities. The denominator is the number of HCP eligible to work in the dialysis facility for at least one day during the reporting period excluding persons with contraindications to COVID-19 vaccination that are described by the CDC. The numerator is the cumulative number of HCP eligible to work in the dialysis facility for at least one day during the reporting period and who have received a complete vaccination course against COVID-19 using the FDA authorized or approved vaccine for COVID-19.

We proposed quarterly reporting deadlines for the ESRD QIP and a 12-month performance period. Facilities would report their measure through the NHSN web-based surveillance system.

Facilities currently use the NHSN web-based system to report two ESRD QIP measures, the NHSN Bloodstream Stream Infection measure clinical measure and the NHSN Dialysis Event reporting measure. To report this measure, we propose that facilities would collect the numerator and denominator for the COVID-19 HCP vaccination measure for at least one self-selected week during each month of the reporting quarter and submit the data to NHSN before the quarterly deadline to meet ESRD QIP requirements. While 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 that data. Thus, in collaboration with the CDC, we determined that data from at least one week of each month would be sufficient to obtain a reliable snapshot of vaccination levels among a facility's healthcare personnel while balancing the costs of reporting.

Each quarter, we proposed that the CDC would calculate a single quarterly COVID-19 HCP vaccination coverage rate for each facility, which would be calculated by taking the average of the data from the three weekly rates submitted by the facility for that quarter. We stated that we would publicly report the most recent quarterly COVID-19 HCP vaccination coverage rate as calculated by the CDC. You can access specifications for this measure by using the link here on the slide.

We welcomed public comment. After considering public comments, we are finalizing our proposal to add the COVID-19 Vaccination Coverage among Health Care Personnel reporting measure to the ESRD QIP measure set beginning with payment year 2025, as proposed. Facilities will collect a numerator and denominator for at least one, self-selected week during each month of the reporting quarter by the deadline as proposed. CMS would publicly report each quarterly rate as calculated by the CDC. Next, we proposed to convert the STrR reporting measure to the revised STrR clinical measure using the revised specifications that were endorsed by the NQF.

In addition, we also proposed to update the scoring methodology so that facilities that meet previously finalized minimum data and eligibility requirements would receive a score on the STrR clinical measure based on the actual clinical values reported by the facility, rather than the successful reporting of the data.

We also proposed to express the proposed STrR clinical measure as a rate, rather than a ratio, and this would begin in payment year 2025. Some of the reasons for this proposal are we feel that by converting the STrR clinical measure to be expressed as a rate will help providers and patients better understand a facility's performance on the measures and would be more intuitive for a facility to track its performance from year to year. Additionally, we stated our belief that expressing STrR measures results as rates would not result in different ESRD QIP scores. This keeps the same ESRD QIP scores. This approach would also align with our technical updates to the SHR clinical measure and the SRR clinical measure.

After considering public comments, we are finalizing our proposal to convert the STrR reporting measure to a clinical measure. We are also finalizing our proposal to update the scoring methodology for the STrR clinical measure so that facilities that meet previously finalized minimum data and eligibility requirements would receive a score on the STrR clinical measure based on the actual clinical values reported by the facility and to express the STrR clinical measure results as rates. This finalized proposal will begin with payment year 2025.

As we discussed in the proposed rule, 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. Taking into account persistent concerns expressed by stakeholders, we are currently examining the continued viability of the Hypercalcemia clinical measure as part of the ESRD QIP measure set. Therefore, we proposed to convert the Hypercalcemia clinical measure to a reporting measure beginning in payment year 2025 while we explore possible replacement measures that would be more clinically meaningful for purposes of quality improvement.

We also proposed to update the scoring methodology so that facilities that meet previously finalized minimum data and eligibility requirements will receive a score on the Hypercalcemia reporting measure based on the successful reporting of the data, rather than the actual clinical values reported by the facility. Facilities would be scored using the equation shown here, beginning in payment year 2025.

So, the rationale behind the proposal is that many stakeholders have indicated that they believe the measure is topped out, pointing out that the NQF 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 to impact patient outcomes. We did receive comment and after considering public comments, and we are finalizing our proposal to convert the Hypercalcemia clinical measure to a reporting measure, part of the Reporting Measure domain beginning with the payment year 2025 ESRD QIP.

CMS is also updating the scoring methodology so that facilities that met previously finalized minimum data and eligibility requirements will receive a score on the Hypercalcemia reporting measure based on the successful reporting of the data rather than the actual clinical values reported by the facility. This proposal is finalized to begin with payment year 2025. We proposed to create a new Reporting Measure domain which would include the four current reporting measures in the ESRD QIP measure set, as well as the proposed COVID-19 HCP Vaccination reporting measure and the proposed Hypercalcemia reporting measure.

The proposed STrR clinical measure would be placed in the Clinical Care Measure domain. We also proposed to update the domain weights and individual measure weights in the Care Coordination domain, Clinical Care domain, and Safety domain accordingly to accommodate the new Reporting Measure domain and individual reporting measures to begin in payment year 2025.

We have reassessed the impact of the ESRD QIP measure domains and domain weights on the TPS, and we believe it is necessary to increase incentives for improving performance by increasing the weights on measures where there is most room for improvement, especially on patient clinical outcomes. We believe this would help to address concerns regarding the impact of individual measure performance on a facility's TPS, while also further incentivizing improvement on clinical measures.

After reviewing comments, we are finalizing our proposal to create a new Reporting domain and to update the domains and measure weights used to calculate the TPS, beginning with payment year 2025. The Care Coordination domain will have the SHR, SRR, and PPPW measures. However, the PPPW weight will increase to 6.0. The Clinical Care Measure domain will decrease to 35 percent and Ultrafiltration will no longer be in that domain. The Safety Measure domain will also decrease to 10 percent and will only contain the NHSN BSI measure. The Patient and Facility Engagement Measure domain's overall weight remains at 15 percent and still contains only ICH CAHPS. The added domain, the Reporting Measure domain, will have a 10 percent weight and contain the Clinical Depression and Follow-Up measure, Hypercalcemia, Ultrafiltration Rate, MedRec, NHSN Dialysis Event, and the new COVID-19 HCP Vaccination measure.

In the Calendar Year 2022 ESRD PPS Final Rule, we set the performance period for the payment year 2025 ESRD QIP as calendar year 2023 and the baseline period as calendar year 2021. We note, for the seven measures we are pausing for the payment year 2023 ESRD QIP, we would continue to use calendar year 2019 data as the baseline period for those measures.

We believe that this is consistent with our established policy to use the prior year's numerical values for the performance standards if the most recent full calendar year's final numerical values are worse. In the proposed rule, we stated our intention to update the mTPS for payment year 2025, as well as the payment reduction ranges for that payment year, in this Calendar Year 2023 ESRD PPS Final Rule.

We have now finalized the payment reductions that will apply to the payment year 2025 ESRD QIP using updated calendar year 2021 data. The mTPS for the payment year 2025 will be 55, and the finalized payment reduction scale is shown here. CMS did request information on topics such as home dialysis, social drivers of health, and healthcare disparities. Please access the final rule for responses to these requests for information. That concludes our presentation.

Karen Vanbourgondien: All right. thank you, Golden. thank you to the panelists who helped answer our questions, MKECC, and Arbor. We are always so glad to have you here to help answer our questions. Next slide, Rachel.

If by some reason, I don't see anything, but if your question did not get answered, please put your question in the Q&A tool. I will put this direct link in the chat box. It's on the slide as well. So, again, thank you for spending time with us, going over the rule. It is always nice to have CMS to keep us up to date on all these important program updates. So, thanks again.

We do have the rest of these resources here that you can see.

Thank you again for all of you in joining us today. Have a great rest of your day. Thank you.