



Centers for Medicare & Medicaid Services

Guide to the Payment Year (PY) 2017 End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) Performance Score Report (PSR)

Version 1.0

08/15/2016

Revision History

Table 1 - Revision History

Version Number	Date	Organization/Point of Contact	Description of Change
1.0	08/15/2016	CMS/Mohammed Baba	Baseline document

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1. Background and Purpose

The purpose of the Centers for Medicare & Medicaid Services (CMS) End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) is to set performance quality standards that improve patient care. Facilities that fail to meet these performance standards may be subject to a payment reduction of up to 2 percent. Congress established ESRD QIP under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008; CMS administers ESRD QIP. The Final Rule outlining the program for payment year (PY) 2017 (CMS-1525-F) was published in the Federal Register on 11/06/2014 (see <https://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26182.pdf>).

Under ESRD QIP PY 2017, CMS applies a formula to award points to facilities based on their performance on a total of 11 quality of care measures. CMS examines facility performance based on eight clinical measures and three reporting measures.

The following PY 2017 clinical measures are continued from PY 2016:

- The vascular access type (VAT) measure topic, made up of the following two measures:
 - Arteriovenous Fistula (AVF)
 - Catheter
- The Kt/V Dialysis Adequacy measure topic, made up of the following three measures:
 - Adult Hemodialysis Adequacy
 - Adult Peritoneal Dialysis Adequacy
 - Pediatric Hemodialysis Adequacy
- National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Outpatients (BSI)
- Hypercalcemia

The Standardized Readmission Ratio (SRR) is a new clinical measure for PY2017.

All three PY 2017 reporting measures are continued from PY 2016. The list below presents the reporting measures:

- Administration of the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) survey
- Anemia management
- Mineral metabolism

CMS compares facility performance during calendar year (CY) 2015 to an established scoring methodology to calculate scores for each measure. The performance measure scores are then weighted and combined to derive the facility Total Performance Score (TPS). Facilities with a TPS of fewer than 60 points (out of 100) will have their Medicare payments for 2017 dialysis services reduced on a sliding scale, with a maximum 2 percent reduction applied to any facility.

The purpose of Guide to the PY 2017 ESRD QIP Performance Score Report (PSR) is to explain in detail the methodology used in the ESRD QIP scoring process, with specific references to elements provided throughout the PSR. The purpose of the PSR is to provide each facility with information regarding each of the following items:

- How Medicare payments to facilities are affected as a result of the TPS
- Performance on each of the 11 quality measures
- The TPS and how the score was calculated

This guide presents information that applies to the Preview PSR, which will be available for download on 08/15/2016, and the Final PSR, which will be available for download in late 2016. In December 2016, a Performance Score Certificate (PSC) based on the data presented in the Final PSR will be available for each facility. All facilities are required by law to print and display their PSC in a prominent area for the duration of CY 2017, even if the facility did not receive a TPS. The downloadable file that contains the PSC will include a version of the certificate in English and in Spanish. Facilities are required to display both the English and Spanish versions of the PSC in a prominent area within the facility.

Table 2 - Important Dates for PY 2017 PSRs presents and describes important dates concerning the PY 2017 PSRs.

Table 2 - Important Dates for PY 2017 PSRs

Date	Description
08/15/2016	<ul style="list-style-type: none"> • The PY 2017 Preview PSR is available to dialysis facilities on the QualityNet Web site (https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier1&cid=1138115987358). • The Preview Period for dialysis facilities opens at 12:01 a.m. Eastern Standard Time (EST)
09/16/2016	<ul style="list-style-type: none"> • The Preview Period for dialysis facilities ends at 5:00 p.m. EST • Reports are available for viewing and download for 3 years after this date.

2. Preview Period and Inquiry Process

During the Preview Period (08/15/2016 - 09/16/2016), facilities may ask clarification questions (CQs) and systemic clarification questions (SCQs) about how the system calculates scores. If a facility believes an error has been made regarding the calculations or data used for the facility's score, the facility may submit a formal inquiry (FI). The facility should provide an explanation and evidence of the possible calculation error. All FIs will be addressed prior to finalizing facility performance scores, finalizing payment reduction percentages, and publishing PSCs. Facilities use the ESRD QIP 2.0.0 system to submit CQs, SCQs, or an FI.

For general questions about the ESRD QIP process or the use of the Web site, review this guide and the frequently asked questions (FAQs) page found at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier1&cid=1138115987358>.

Each facility should designate one person as the ESRD QIP facility point of contact (POC) who can ask CQs and SCQs, request patient-level data (see *Section 2.2 - Patient-Level Data*), and submit an FI. If you wish to submit a CQ, request patient-level data, or make an FI but do not see the options to do so, you may not have the appropriate permission as a facility POC. If you cannot identify your facility's POC, contact the ESRD Help Desk at qnetsupport-esrd@hcqis.org. Please have your facility's CMS Certification Number (CCN) ready.

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

Throughout the Preview Period, facilities can submit CQs. For example, a facility might have questions about how a measure is calculated. CMS strongly encourages facilities to review their scores early and submit any CQs by 08/31/2016.

Facilities also have the opportunity to express a belief that a systemic error occurred regarding the way the system calculates facility scores. For example, a facility POC would submit an SCQ if the facility believed a scoring algorithm for a measure was improperly configured and that scores for all facilities were inaccurate as a result. Facilities are not limited in the number of SCQs they can submit, and all facility scores will be recalculated if a systemic error is identified. CMS strongly encourages facilities to submit any SCQs by 08/31/2016.

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

Although each facility is permitted to submit only one FI, facilities may submit an unlimited number of CQs or SCQs. However, if a facility submits CQs after 08/31/2016, CMS cannot guarantee a response with sufficient time to submit an FI.

CMS will not accept FIs, CQs, or SCQs after 5:00 p.m. EDT on 09/16/2016.

2.1.1 Formal Inquiries: Submit a Formal Inquiry

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

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

See the ESRD QIP PY 2017 Facility User Manual (UM) for details regarding how to submit an FI

(<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier1&cid=1138115987358>).

2.1.2 Clarification Questions: Question about my ESRD QIP Score

If the FAQ or this guide does not fully address a facility's question, the facility POC may submit questions via the ESRD QIP PY 2017 system. See the ESRD QIP PY 2017 Facility UM for details regarding how to submit a CQ

(<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier1&cid=1138115987358>).

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

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

FIs about a facility's Preview PSR must be accompanied with specific evidence or arguments as outlined in this guide. If a facility is uncertain of how to meet the FI requirements, the facility POC is encouraged to submit any concerns as a CQ on or prior to 08/31/2016. The QualityNet Help Desk will help facilities determine whether an FI is appropriate.

2.1.3 Systemic Questions: Question about Multiple ESRD QIP Scores

Facilities can submit SCQs if they suspect logic error(s) in multiple facility score calculations. SCQs are specific questions regarding ESRD QIP scoring methodology.

See the ESRD QIP PY 2017 Facility User Manual (UM) for details regarding how to submit an SCQ

(<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier1&cid=1138115987358>).

2.2 Patient-Level Data

Facilities should conduct a review of the list of patients with Medicare claims data or Consolidated Renal Operations in a Web-Enabled Network (CROWNWeb) data included in the calculations before submitting CQs or FIs. Each facility has access to the Patient List Report; included in this report is the listing of patient names and health care identifiers (IDs), as well as patient information for Kt/V values, serum calcium values, index discharges, readmissions, numerators, denominators, and other patient-level data associated with that facility.

2.3 After the Preview Period

In late 2016, a Final PSR and PSC will be accessible to each facility.

Unless the inquiry process leads to CMS-approved changes, the Final PSR, showing the final results of ESRD QIP PY 2017, will be provided during late 2016 and will reflect the results shown in the Preview PSR.

If an inquiry leads to CMS-approved changes during the Preview Period, the Final PSR for ESRD QIP PY 2017 will reflect those changes.

In late 2016, the PSC will be made available as well. Each facility must download and print its English and Spanish PSC. Even if a facility did not receive a TPS, each ESRD QIP-eligible facility must post both of its PSCs in a prominent area for the duration of CY 2017.

3. Inclusion Criteria

This section describes which data are included in the calculations for each facility.

3.1 Included Medicare Claims and CROWNWeb Data

The Medicare claims underlying the PY 2017 Preview PSR are as of 06/15/2016. The CROWN and CROWNWeb data underlying the PY 2017 Preview PSR are as of 06/12/2016.

Medicare outpatient dialysis facility claims in Final Action status with care provided during the ESRD QIP data window were reviewed for inclusion in the ESRD QIP measures calculations. Eligible facilities were identified using CROWN and the Dialysis Facility Compare (DFC) Web site (<http://www.medicare.gov/dialysisfacilitycompare>) and cross-checked in other CMS sources as of 06/12/2016. Facilities with multiple CCNs were identified and linked using CMS data sources.

A patient's first date of ESRD treatment may be related to a kidney transplant, a Medicare dialysis claim, or another indication of ESRD in CMS data sources (such as a CMS-2728 Form or an admission in CROWNWeb). The first date of ESRD treatment is determined by comparing these data sources and selecting the earliest date.

Each claim must meet each measure's inclusion criteria to be included in the corresponding measure calculation. Different inclusion criteria have been established for each measure. It is possible for a claim to meet the inclusion criteria for one measure but not another.

3.2 Hypercalcemia

The Hypercalcemia clinical measure uses uncorrected serum calcium values reported in CROWNWeb. In order for an uncorrected serum calcium reading to be included in a 3 month rolling average, it must meet the following criteria:

- The patient must be 18 years or older as of the first day of the last month in the 3 month measurement period.
- The patient must be admitted to the facility for at least 30 days (either consecutive or non-consecutive) during the 3 month measurement period.
- The patient must be on ESRD treatment for at least 90 days as of the first day of the last month of the 3 month measurement period.
- The patient must be on ESRD treatment as indicated by a completed CMS-2728 Form, a REMIS/CROWNWeb admission record, or a sufficient volume of dialysis sessions reported in final action outpatient dialysis facility Medicare claims.
- The patient must have at least one uncorrected serum calcium reading within the 3 month measurement period.
- The patient must have at least three uncorrected serum calcium readings during the year in the facility.
- The patient must still be admitted to the facility as of the last day of the 3 month measurement period.

3.3 NHSN

The Standardized Infection Ratio (SIR) is based on facility data reported to the Centers for Disease Control and Prevention (CDC) through the NHSN system. However, both claims and CROWNWeb treatment data are used to determine the number of eligible patients used for the patient count exclusion and the low-volume facility adjustment. A patient at a facility is deemed eligible for the facility's patient count if either or both of the following conditions is true:

- The patient has an in-center hemodialysis claim at the facility during the performance period.
- The patient has a record in CROWNWeb indicating hemodialysis treatment at the facility (either dialysis facility or skilled nursing facility (SNF)) during the performance period.

3.4 Standardized Readmission Ratio

SRR evaluates inpatient hospitalizations based on patient and facility data from Medicare claims and CROWNWeb. Each index discharge included in the SRR measure calculation must meet the following conditions:

- The discharge date occurred during the performance and/or improvement period.
- The hospital was an acute care facility, not a Prospective Payment System (PPS)-exempt, rehab, or long-term care facility.
- The hospitalization was within the first 12 inpatient admissions for the patient during the report period.
- The patient did not die during the hospitalization.
- The patient did not die within 30 days of discharge without a readmission.
- The patient was not transferred to another acute care hospital, discharged against medical advice, or readmitted within 3 days.
- The patient was on ESRD treatment on the index discharge date.
- The patient's primary diagnosis was not cancer, rehabilitation, or a psychiatric condition.

The dialysis facility must have at least 11 eligible index discharges during the reporting period in order to be included in the measure.

3.5 Vascular Access Type Measure Topic

The VAT measure topic area consists of the following two measures:

- The percent of hemodialysis patient-months using an AVF with two needles during last treatment of the month
- The percent of hemodialysis patient-months using a catheter for 90 days or longer prior to last hemodialysis session of the month

In order for a claim to be included in the AVF measure calculation, the claim must meet the following criteria:

- Claims with one V modifier or V modifiers with Catheter+Fistula or Catheter+Graft are included. Claims with Fistula+Graft V modifiers or claims without V modifiers are excluded. If the claim indicated fistula and catheter, only the fistula is counted.
- The last claim of the month is used for the calculation and the patient must have at least 4 months of eligible claims to be included during the comparison/performance period.
- The claim modality must be in-center or home hemodialysis.
- The patient must be 18 years of age or older at the beginning date of the claim.

- The patient must be on ESRD treatment as indicated by a completed CMS-2728 Form, a Renal Management Information System (REMIS)/CROWNWeb admission record, or a sufficient volume of dialysis sessions reported in final action outpatient dialysis facility Medicare claims.
- The primary modality of the month must be in-center or home hemodialysis.

In order for a claim to be included in the catheter measure calculation, the claim must meet the following criteria:

- Claims with one V modifier or V modifiers with Catheter+Fistula or Catheter+Graft are included in the measure calculation. Claims with Fistula+Graft V modifiers or claims without V modifiers are excluded. If the claim indicated fistula and catheter, only the fistula is counted.
- The claim modality must be in-center or home hemodialysis.
- The last claim of the month is used for the calculation. For VAT Catheter, the patient must have claims in the facility for 3 previous months. In the comparison/performance period, the beginning date of the claim for the 3 previous months can occur before the start of the comparison/performance period (e.g., October 2013 through December 2013 for comparison period and October 2014 through December 2014 for performance period).
- The patient must be 18 years+90 days of age or older at the claim's beginning date.
- The patient must be on ESRD treatment as indicated by a completed CMS-2728 Form, a REMIS/CROWNWeb admission record, or a sufficient volume of dialysis sessions reported in final action outpatient dialysis facility Medicare claims.
- The primary modality of the month must be in-center or home hemodialysis.

3.6 Kt/V Dialysis Adequacy Measure Topic

The Kt/V Dialysis Adequacy measure topic comprises the following three dialysis adequacy measures:

- The percentage of adult hemodialysis patient-months with spKt/V greater than or equal to 1.2 (i.e., Adult Hemodialysis Adequacy)
- The percentage of adult peritoneal dialysis patient-months with Kt/V greater than or equal to 1.7 (i.e., Adult Peritoneal Dialysis Adequacy)
- The percentage of pediatric in-center hemodialysis patient-months with spKt/V greater than or equal to 1.2 (i.e., Pediatric Hemodialysis Adequacy)

In order for a claim to be included in the Adult Hemodialysis Adequacy measure calculation, the claim must meet the following criteria:

- Prescribed sessions per week in CROWNWeb must be less than four.
- The claim's beginning date must be at least 90 days after the first date of ESRD treatment for the patient.
- The patient must be 18 years of age or older at the claim's beginning date.
- The patient must have been treated at the facility at least seven times during the claim month.
- The primary modality of the claim must be in-center or home hemodialysis.
- The reported Kt/V value must be between 0.5 and 2.5, or 9.99.
- The reported number of dialysis sessions must be greater than two and less than four times per week for claims greater than 7 days; and the reported number of dialysis sessions must be less than four times for claims with less than or equal to 7 days.

In order for a claim to be included in the Adult Peritoneal Dialysis Adequacy measure calculation, the claim must meet the following criteria:

- The claim's beginning date must be at least 90 days after the first date of ESRD treatment for the patient.
- The patient must be 18 years of age or older at the claim's beginning date.
- The primary modality of the claim must be peritoneal dialysis.
- The reported Kt/V value must be between 0.5 and 5.0, or 9.99.

In order for a claim to be included in the Pediatric In-center Hemodialysis Adequacy measure calculation, the claim must meet the following criteria:

- Prescribed sessions per week in CROWNWeb must be less than five.
- The claim's beginning date must be at least 90 days after the first date of ESRD treatment for the patient.
- The patient must be younger than 18 years of age at the claim's beginning date.
- The patient must have been treated at the facility at least seven times during the claim month.
- The primary modality of the claim must be in-center hemodialysis.
- The reported Kt/V value must be between 0.5 and 2.5, or 9.99.
- The reported number of dialysis sessions must be greater than two and less than five times per week for claims with greater than 7 days; and the reported number of dialysis sessions must be less than five times for claims with less than or equal to 7 days.

3.7 Anemia Management Reporting Measure

In order for a patient to be included in the Anemia Management Reporting measure calculation for a given month, the patient must meet the following criteria:

- For a patient month to be included in the numerator of the measure calculation, the facility must report a valid hemoglobin/hematocrit value for the patient.
- The patient must be on ESRD treatment as indicated by a completed CMS-2728 Form, a REMIS/CROWNWeb record, or a sufficient number of dialysis sessions reported on dialysis facility claims.
- The primary modality for the month must indicate in-center hemodialysis or home dialysis. In-center hemodialysis patients must be treated at the facility seven times or more during the reporting month. Home dialysis patients must have a claim submitted by the facility during the reporting month.

Note: A facility will not be penalized for using the default value of 99.99 for a patient in his/her first month of treatment at that facility

3.8 Mineral Metabolism Reporting Measure

In order for a patient to be included in the Mineral Metabolism Reporting measure calculation for a given month, the patient must meet the following criteria:

- For a patient month to be included in the numerator of the measure calculation, a phosphorus lab value must be reported in CROWNWeb for the patient (the lab value may be reported at a different facility).
- In-center hemodialysis patients must be treated at the facility seven times or more during the reporting month. Home dialysis patients must have a claim submitted during the reporting month.

- The patient must be on ESRD treatment as indicated by a completed CMS-2728 Form, a REMIS/CROWNWeb record, or a sufficient volume of dialysis sessions reported on dialysis facility claims.

3.9 ICH CAHPS

The ICH-CAHPS measure is based on the compliance data and collection of 30 surveys provided to the CAHPS contractor. Facilities that treated 30 or more in-center hemodialysis adult patients during the eligibility period, which is defined as the year prior to the performance period, but are unable to obtain at least 30 completed surveys during the performance period are excluded. Additionally, facilities that attest that they treated fewer than 30 eligible in-center hemodialysis patients during the eligibility period are excluded. Facilities that do not attest that they are ineligible will be considered eligible and will receive a score on the measure, assuming all other eligibility criteria are met.

Eligible patients must meet the following criteria:

- The patient must be 18 years of age or older on the last day of the sampling window for the semiannual survey. The patient must be receiving hemodialysis from the facility for at least 90 days.
- The patient must not be currently residing in an institution such as a residential nursing home, other long-term care facility, jail, or prison.
- The patient must not be receiving hospice care.

3.10 Which Patients are Included?

It is possible for a patient's claims to be used in one measure calculation but not others. For example, a patient may have 5 months of claims which meet the inclusion criteria for the VAT Catheter measure, but the facility may not have at least 11 patients eligible for the Adult Hemodialysis Kt/V Dialysis Adequacy measure. Some patients receive treatment at multiple facilities during a year. Thus, these patients have Medicare claims at more than one facility. These patients are included in any facility for which they had Medicare claims meeting the measure-specific inclusion criteria. For example, a patient with eligible claims for the Adult Hemodialysis Kt/V Dialysis Adequacy measure at Facility A and Facility B would be included in the measure calculation for both facilities. With the exception of the Mineral Metabolism Reporting measure, a patient's data from Facility A would only be used in Facility A's PSR and not in Facility B's PSR. For the Mineral Metabolism Reporting measure, patient lab values reported in CROWNWeb at any facility during the reporting month are used in the measure calculation.

3.11 Which Facilities are Included?

Eligible facilities were identified using CROWNWeb and the DFC Web site (<http://www.medicare.gov/dialysisfacilitycompare>) and cross-checked in other CMS sources as of 06/12/2016. Facilities with multiple CCNs were identified and linked using CMS data sources. To be eligible to receive a TPS, a facility must have at least one clinical measure and at least one reporting measure; nevertheless, all ESRD QIP-eligible facilities will receive a PSR and a PSC.

3.12 Extraordinary Circumstances Exception

Extraordinary Circumstance Exceptions (ECEs) were created to allow facilities to be exempt from all the requirements of the ESRD QIP clinical and reporting measures during the time that a facility was forced to close temporarily due to a natural disaster or other extraordinary circumstance beyond the facility's control.

The ESRD QIP PY 2017 system has been updated to include functionality to exempt facilities from all requirements of the ESRD QIP clinical and reporting measures during the months in which they are forced to close due to a natural disaster or other extraordinary circumstance. If an ECE is approved for a facility, the months covered are listed on page 5 of the PSR for that facility. Furthermore, facilities with at least one approved month will be excluded from the entire NHSN BSI clinical measure because infections are seasonal and 12 months of data are required for the measure.

3.12.1 Extraordinary Circumstances Exception Process

Facilities that experienced an extraordinary circumstance out of their control must submit a CMS Disaster Extension/Exception Request through the ESRD QIP mailbox at ESRDQIP@cms.hhs.gov within 90 calendar days of the date of the disaster or extraordinary circumstance. Upon receipt of the information, CMS reviews whether the facility should be exempt from all ESRD QIP requirements during the period in which the facility was closed. If CMS determines the facility was, in fact, closed for a period of time due to an extraordinary circumstance, then the facility is exempt from scoring during the months in which the facility was closed. For example, if a facility was granted an ECE for the time period between 01/15/2015 and 02/15/2015, then the facility is not required to report, and is not penalized for not reporting data on any ESRD QIP measure for January and February of CY 2015. Since the NHSN BSI clinical measure requires 12 complete months of data, a facility approved for an ECE is not scored on the NHSN BSI measure.

3.13 Feasibility and Pilot Validation Studies

Facilities were randomly selected to participate in the Feasibility and Pilot Validation Studies (FPVSs). The selected facilities were required to provide CMS with the information within 60 days of receiving a request. Facilities that did not provide CMS with the required information within the specified time period received a 10 point deduction from their TPS.

Note: It is possible for a facility to be included in both the FPVSs and therefore possible to have a total of 20 points deducted from its TPS.

3.14 Clinical Measures

For each clinical measure, facilities must have at least 11 patients who meet the patient criteria, or in the case of SRR, 11 eligible index discharges. If only one of the two VAT measures or only one or two of the Kt/V Dialysis Adequacy measures have 11 or more patients, the measure topic score will reflect only the measure(s) that meet the applicable case minimum. For example, if a facility has 9 eligible patients for the catheter measure and 12 eligible patients for the fistula measure, then the VAT measure topic is based only on the fistula measure.

It is possible for a facility to have enough patients to calculate one measure but not others. For example, a facility may have 15 patients who meet the inclusion criteria for the VAT Catheter measure but only 10 patients who meet the inclusion criteria for the Hypercalcemia measure.

Facilities that do not qualify for at least one clinical measure and one reporting measure will not receive a TPS, but these facilities will still receive a Preview PSR indicating insufficient data.

3.15 Reporting Measures

In order to be scored for the ICH CAHPS reporting measure, a facility must meet the following criteria:

- Offer in-center hemodialysis.
- Treat 30 or more qualifying patients during the eligibility period, which is defined as the year prior to the performance period.
- Obtain at least 30 completed surveys during the performance period. For ICH CAHPS, a facility will be considered to have met the 30 patient threshold unless it attests in CROWNWeb that it treated 29 or fewer qualifying patients.
- Have a certification date on or before 01/01/2015.

For the Mineral Metabolism and Anemia Management reporting measures, facilities with a certification date before 07/01/2015 and at least 11 eligible patients will receive a score.

4. Calculation Process

This section describes the calculation process used to obtain the results for each facility.

4.1 Clinical Measures

The annual facility performance calculation for clinical measures used patient summaries at each facility and included the following information:

- The number of adult hemodialysis patient-months with Kt/V greater than or equal to 1.2
- The number of adult patient 3 month rolling averages of uncorrected serum calcium greater than 10.2 mg/dL
- The number of patient-months with AVF
- The number of patient-months with catheter in use for at least 90 days
- The number of pediatric hemodialysis patient-months with Kt/V greater than or equal to 1.2
- The number of peritoneal dialysis patient-months with Kt/V greater than or equal to 1.7
- The ratio of actual to expected unplanned hospital readmissions, or SRR
- The Standardized Infection Ratio (SIR) for hemodialysis outpatients

4.1.1 Vascular Access Type

For each adult patient, the number of eligible Medicare in-center or home hemodialysis months was added during the measurement period (comparison or performance). AVF use was determined by adding the number of eligible patient-months in which an AVF with two needles was in use during the last hemodialysis treatment of the month. Catheter use was determined by adding the number of eligible patient-months in which an intravenous catheter was in use for 90 days or longer.

4.1.2 Kt/V Dialysis Adequacy (Kt/V Greater than or Equal to 1.2 for Hemodialysis (Adult and Pediatric) and Kt/V Greater than or Equal to 1.7 for Peritoneal Dialysis)

For each adult patient, the number of eligible Medicare in-center or home hemodialysis months with a Kt/V value greater than or equal to 1.2, but not 9.99 or missing, were added for hemodialysis. More specifically, the Kt/V value was measured within 4 months of the claim through date for home hemodialysis claims and measured during the reporting month for in-center hemodialysis claims. Otherwise, the number of eligible Medicare peritoneal dialysis months with a Kt/V value greater than or equal to 1.7, but not 9.99 or missing, and measured within 4 months of the claim through date were added for peritoneal dialysis. For each pediatric patient, the number of eligible Medicare in-center hemodialysis months with a Kt/V value greater than or equal to 1.2, but not 9.99 or missing, and measured within the reporting month were added.

4.1.3 Hypercalcemia Clinical Measure

For each adult patient, the number of eligible months with a 3 month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL was added.

4.1.4 NHSN Bloodstream Infection in Hemodialysis Outpatients

For each facility, the ratio of the observed number of hemodialysis outpatients with positive blood cultures divided by the risk-adjusted expected number was calculated.

4.1.5 Standardized Readmission Ratio

For each facility, SRR was calculated as the number of observed unplanned hospital readmissions divided by the risk-adjusted expected number of hospital readmissions.

4.2 Small-Facility Adjustment

A small facility adjustment was applied to each clinical measure if a facility had 11 to 25 eligible patients or, in the case of SRR, if a facility had between 11 - 41 eligible index discharges. The small facility adjustment uses the facility size (number of patients eligible for the measure, or number of index discharges eligible for the SRR measure), the unadjusted measure rate at the facility, and the benchmark value (90th percentile) calculated using the performance period data for the measure. The adjustment factor is added to measures where a higher value indicates better care and subtracted from measures where a lower value indicates better care. Therefore, the adjustment is always applied in favor of the facility. The small facility adjustment is only applied to the performance period scores (CY 2015).

4.3 Clinical Measure Scoring

A facility's score for all clinical measures is based on the higher of the achievement score (performance period rate compared to national rate) and the improvement score (performance period rate compared to facility's own comparison period rate).

To determine the achievement score, facilities receive points along an achievement range. The achievement threshold is the 15th percentile during the comparison period. The benchmark is the 90th percentile during the comparison period. The achievement range is a 10 point scale that runs from the achievement threshold to the benchmark. *Figure 1 - Achievement Score Formula* presents the achievement score formula.

$$9 \times \left(\frac{\text{Facility Rate during Performance Period} - \text{Achievement Threshold}}{\text{Benchmark} - \text{Achievement Threshold}} \right) + 0.5$$

Figure 1 - Achievement Score Formula

To determine the improvement score, facilities receive points along an improvement range. The improvement threshold is the individual facility's performance during the comparison period. The benchmark is the 90th percentile for all facilities during the comparison period. The improvement range (on a scale from 0 - 9 points) runs between the improvement threshold and the benchmark. *Figure 2 - Improvement Score Formula* presents the improvement score formula.

$$10 \times \left(\frac{\text{Facility Rate during Performance Period} - \text{Facility Rate during Comparison Period}}{\text{Benchmark} - \text{Facility Rate during Comparison Period}} \right) - 0.5$$

Figure 2 - Improvement Score Formula

The above achievement (or improvement) score formula is only used if the facility's performance falls within the achievement (or improvement) range. If a facility's performance rate is equal to or better than the benchmark, the facility earns 10 points for the measure. A

performance rate worse than the achievement threshold and worse than the improvement threshold earns 0 points.

4.4 Reporting Measures

4.4.1 ICH CAHPS Administration

To earn the maximum 10 points on the ICH CAHPS reporting measure, facilities must complete the following tasks:

- Arrange for a CMS-approved vendor to conduct the ICH CAHPS survey twice yearly.
- Collect and submit at least 30 surveys across the two 6 month survey collection periods.
- Ensure their vendor submits survey data to CMS before 01/28/2016.
- Register on the <https://ichcahps.org> Web site to authorize the vendor.

A facility with 30 or fewer eligible patients during the eligibility period must attest via CROWNWeb that they are ineligible for the measure by 01/30/2016 in order to be excluded from the measure calculation. If a facility's certification date is on or after 01/01/2015, the facility attested in CROWNWeb, did not offer in-center hemodialysis, or submitted fewer than 30 completed surveys, then the facility will not receive a score for this measure.

4.4.2 Mineral Metabolism

To earn the maximum 10 points on the Mineral Metabolism reporting measure, a facility must successfully report phosphorus values for the eligible patients for each month the facility was eligible in 2015. For each month of the performance period, the percentage of patients with phosphorus lab values reported by a facility was compared to 97%, which was determined to be the lesser of the system default threshold (97%) and facility-level median percentage calculated using CY 2014 data. Facilities received one point for each month the facility reported phosphorus lab values at or above 97%. For each month a facility fails to report eligible patient phosphorus lab values at this rate, the facility receives a score of 0. The scores for each month are added and divided by the number of months a facility was eligible in the performance period. This number is multiplied by 12, and then 2 is subtracted from the score. This results in a score between 0 and 10.

4.4.3 Anemia Management

To earn the maximum 10 points on the Anemia Management reporting measure, a facility must successfully report Erythropoietin Stimulating Agent (ESA) dosage (as applicable) and Hgb/hematocrit values for the eligible patients for each month the facility is eligible in 2015. For each month of the performance period, the percentage of eligible patients with ESA dosage (as applicable) and Hgb/hematocrit values reported by a facility was compared to 99%, which was determined to be the lesser of the system default threshold (99%) and facility-level median percentage calculated using CY 2014 data. Facilities were not penalized for patients with an Hgb/hematocrit value of 99.99 reported during the first month of treatment at the facility. If the facility's percentage of patients meets or exceeds 99%, the facility receives a score of 1 for the month. For each month a facility fails to report eligible patients' ESA dosage (as applicable) and Hgb/hematocrit values at this rate, the facility receives a score of 0. The scores for each month are added and divided by the number of months a facility was eligible in the performance period. This number is multiplied by 12, and then 2 is subtracted from the score. This results in a score between 0 and 10.

4.5 Measure Topic Scores

Measure topic scores were calculated for the VAT and Dialysis Adequacy measures. The VAT topic score was calculated using the two VAT measures (Catheter and Fistula), which were scored separately according to the achievement and improvement methodology. These two measures were combined into the VAT topic score by averaging the measure scores and weighting each measure score based on each measure's patient count. Likewise, the Dialysis Adequacy topic score was calculated using the three Dialysis Adequacy measures (Adult Hemodialysis, Adult Peritoneal Dialysis, and Pediatric Hemodialysis), which were scored separately according to the achievement and improvement methodology. These three measures were combined into the Dialysis Adequacy topic score by averaging the measure scores and weighting each measure score based on each measure's patient count.

Only the measures that get a score are included in the calculation of the topic scores.

4.6 Total Performance Score

The clinical measure scores for which a facility is eligible are weighted equally, with the exception of the Hypercalcemia clinical measure, which has two-thirds the weight of the other clinical measures. These weighted scores are combined to comprise 75 percent of the facility TPS.

Each reporting measure for which a facility is eligible is equally weighted to comprise 25% of the TPS.

A facility must have a score for at least one clinical measure and one reporting measure in order to have a TPS calculated. Facilities can obtain a TPS of up to 100 points.

4.7 Payment Reduction Percentage

The TPS is used to assign the appropriate payment reduction to the facility. The payment reduction indicates the reduction percentage that will be applied to the facility's reimbursement of all Medicare dialysis claims for services delivered during all of CY 2017.

The following list presents the facility payment reduction scale:

- No reduction for a TPS of 60 to 100 or if a TPS cannot be calculated due to insufficient data
- A 0.5% reduction for a TPS of 50 to 59
- A 1.0% reduction for a TPS of 40 to 49
- A 1.5% reduction for a TPS of 30 to 39
- A 2.0% reduction for a TPS of 0 to 29

As noted, if a TPS cannot be calculated, the facility will not receive a payment reduction. However, all facilities eligible for ESRD QIP receive a PSR and PSC.

5. Contents of the Performance Score Report

This section describes the facility-specific results presented in the PSR. Information in the Preview PSR is subject to change as a result of the Preview Period (08/15/2016 through 09/16/2016). Information in the Final PSR will incorporate any changes from the preview and inquiry process.

When certain rows are populated with N/A, subsequent rows will be populated with N/A as well. For example, if a facility performs the same as or better than the benchmark for a measure, then rows pertaining to the achievement and improvement score calculations for that measure will be populated with N/A, because the facility automatically receives 10 points for the measure. Please note directions for skipping rows for assistance in navigating the PSR.

5.1 Table 1. Performance Score Overview

Table 1 shows an overview of the facility's ESRD QIP PY 2017 results. The projected payment reduction percentage is listed first. This will be the reduction percentage applied to the reimbursement of Medicare dialysis claims submitted by this facility throughout CY 2017.

Table 1 also shows the facility TPS. As described in *Section 4 - Calculation Process*, this is a number between 0 and 100 that is calculated as a weighted sum of the eight clinical measure scores and the three reporting measure scores. The facility's individual measure scores are also given in Table 1. For all measures, the measure score is a number between 0 and 10. See *Section 4 - Calculation Process* for additional details regarding the calculation of these values.

5.2 Facility Information

Facility information on record with CMS is provided for review. The information includes facility names, addresses, and CCNs. This section also lists other CCNs associated with the facility in various CMS data sources linked during the ESRD QIP calculation process.

If any of the facility identification information is incorrect, submit a CQ in the ESRD QIP 2.0.0 system.

5.2.1 Extraordinary Circumstances Exception

For PY 2017 and future payment years, the ESRD QIP system has been updated to include functionality to exempt facilities from all requirements of the ESRD QIP clinical and reporting measures during the months in which they are forced to close due to a natural disaster or other extraordinary circumstance. If an ECE is approved for a facility, the months covered are listed on page 5 of the PSR for that facility.

5.3 Table 2. Projected Payment Reduction Percentage

Table 2 shows the range of TPSs that correspond with each payment reduction. In addition, an arrow to the right of the table indicates which payment reduction applies to the facility.

5.4 Table 3. Kt/V Adult Hemodialysis

Table 3 shows the performance measure score calculation for the Kt/V Dialysis Adequacy Adult Hemodialysis measure. Lines 3a through 3d show the calculation of the facility rate for the 2015 performance period. Lines 3e through 3g show the calculation of the facility improvement threshold for the 2014 comparison period. Lines 3h and 3i show the national achievement threshold and benchmark. Line 3j shows whether the facility performance rate is equal to or better than the benchmark. Lines 3k through 3m show the calculation of the achievement score. Lines 3n through 3q show the calculation of the improvement score. Finally, lines 3r and 3s show the performance measure score. Each line in this table is discussed below.

5.4.1 3a-3d. Facility Rate Calculation for Performance Period

3a. This indicates the number of patient-months that meet the Adult Hemodialysis inclusion criteria with a spKt/V of at least 1.2 at this facility during the performance period.

3b. This indicates the number of patient-months that meet the Adult Hemodialysis inclusion criteria at this facility during the performance period.

3c. This calculation gives the percentage of patient-months with spKt/V of at least 1.2. When 0 - 10 patients are eligible for the measure, no score is calculated.

3d. This indicates the performance rate for facilities with 11 - 25 eligible patients after applying the small facility adjustment. Values are not reported for facilities that do not receive a small facility adjustment.

5.4.2 3e-3g. Facility Improvement Threshold

3e. This indicates the number of patient-months that meet the Adult Hemodialysis inclusion criteria with a spKt/V of at least 1.2 at this facility during the comparison period.

3f. This indicates the number of patient-months that meet the Adult Hemodialysis inclusion criteria at this facility during the comparison period.

3g. This calculation gives the percentage of patient-months with spKt/V of at least 1.2 during the comparison period. When 0 - 10 patients are eligible for the measure, no score is calculated.

5.4.3 3h-3i. National Achievement Threshold and Benchmark

3h. This indicates the national achievement threshold used for the Adult Hemodialysis performance measure.

3i. This indicates the national benchmark used for the Adult Hemodialysis performance measure.

5.4.4 3j. Facility Performance Measure Score Calculation

3j. This indicates whether the facility performance rate meets or surpasses the benchmark. If so, the facility receives 10 points for achievement and skips to the performance measure score. If not, an achievement score is determined for the facility.

5.4.5 3k-3m. Achievement Score Calculation

3k. This indicates whether the facility performance rate is less than the achievement threshold. If so, the facility receives 0 points for achievement and skips to the improvement score calculation.

3l. This calculation gives an achievement score if the facility performance rate meets the following criteria:

- The facility performance rate does not fall below the achievement threshold.
- The facility performance rate does not meet or exceed the benchmark.

3m. This indicates the achievement score.

5.4.6 3n-3q. Improvement Score Calculation

3n. This indicates whether the facility performance rate is less than the facility improvement threshold. If so, the facility receives 0 points for improvement and skips to the performance measure score.

3o. This indicates whether the facility performance rate surpasses the benchmark and/or the facility improvement threshold is greater than or equal to the benchmark. If so, the facility skips to the performance measure score.

3p. This calculation gives an improvement score if the facility performance rate/threshold meets the following criteria:

- The facility performance rate does not fall below the facility improvement threshold.
- The facility performance rate does not meet or exceed the benchmark.
- The facility performance threshold does not meet or exceed the benchmark.

3q. This indicates the improvement score.

5.4.7 3r-3s. Performance Measure Score

3r. This indicates which performance score calculation was applied. The higher of the achievement or improvement scores is applied.

3s. This indicates the facility score for this performance measure.

5.5 Table 4. Kt/V Adult Peritoneal Dialysis

Table 4 shows the performance measure score calculation for the Kt/V Dialysis Adequacy Adult Peritoneal Dialysis measure. Lines 4a through 4d show the calculation of the facility rate for the 2014 performance period. Lines 4e through 4g show the calculation of the facility improvement threshold for the 2014 comparison period. Lines 4h and 4i show the national achievement threshold and benchmark. Line 4j shows whether the facility performance rate is equal to or better than the benchmark. Lines 4k through 4m show the calculation of the achievement score. Lines 4n through 4q show the calculation of the improvement score. Finally, lines 4r and 4s show the performance measure score. Each line in this table is discussed below.

5.5.1 4a-4d. Facility Rate Calculation for Performance Period

4a. This indicates the number of patient-months that meet the Adult Peritoneal Dialysis inclusion criteria with a Kt/V of at least 1.7 at this facility during the performance period.

4b. This indicates the number of patient-months that meet the Adult Peritoneal Dialysis inclusion criteria at this facility during the performance period.

4c. This calculation gives the percentage of patient-months with Kt/V of at least 1.7. When 0 - 10 patients are eligible for the measure, no score is calculated.

4d. This indicates the performance rate for facilities with 11 - 24 eligible patients after applying the small facility adjustment. Values are not reported for facilities that do not receive a small facility adjustment.

5.5.2 4e-4g. Facility Improvement Threshold

4e. This indicates the number of patient-months that meet the Adult Peritoneal Dialysis inclusion criteria with a Kt/V of at least 1.7 at this facility during the comparison period.

4f. This indicates the number of patient-months that meet the Adult Peritoneal Dialysis inclusion criteria at this facility during the comparison period.

4g. This calculation gives the percentage of patient-months with Kt/V of at least 1.7 during the comparison period. When 0 - 10 patients are eligible for the measure, no score is calculated.

5.5.3 4h-4i. National Achievement Threshold and Benchmark

4h. This indicates the national achievement threshold used for the Adult Peritoneal Dialysis performance measure.

4i. This indicates the national benchmark used for the Adult Peritoneal Dialysis performance measure.

5.5.4 4j. Facility Performance Measure Score Calculation

4j. This indicates whether the facility performance rate meets or surpasses the benchmark. If so, the facility receives 10 points for achievement and skips to the performance measure score. If not, an achievement score is determined for the facility.

5.5.5 4k-4m. Achievement Score Calculation

4k. This indicates whether the facility performance rate is less than the achievement threshold. If so, the facility receives 0 points for achievement and skips to the improvement score calculation.

4l. This calculation gives an achievement score if the facility performance rate meets the following criteria:

- The facility performance rate does not fall below the achievement threshold.
- The facility performance rate does not meet or exceed the benchmark.

4m. This indicates the achievement score.

5.5.6 4n-4q. Improvement Score Calculation

4n. This indicates whether the facility performance rate is less than the facility improvement threshold. If so, the facility receives 0 points for improvement and skips to the performance measure score.

4o. This indicates whether the facility performance rate surpasses the benchmark and/or the facility improvement threshold is greater than or equal to the benchmark. If so, the facility skips to the performance measure score.

4p. This calculation gives an improvement score if the facility performance rate/threshold meets the following criteria:

- The facility performance rate does not fall below the facility improvement threshold.
- The facility performance rate does not meet or exceed the benchmark.
- The facility performance threshold does not meet or exceed the benchmark.

4q. This indicates the improvement score.

5.5.7 4r-4s. Performance Measure Score

4r. This indicates which performance score calculation was applied. The higher of the achievement or improvement scores is applied.

4s. This indicates the facility score for this performance measure.

5.6 Table 5. Kt/V Pediatric Hemodialysis

Table 5 shows the performance measure score calculation for the Kt/V Dialysis Adequacy Pediatric Hemodialysis measure. Lines 5a through 5d show the calculation of the facility rate for the 2015 performance period. Lines 5e through 5g show the calculation of the facility improvement threshold for the 2014 comparison period. Lines 5h and 5i show the national achievement threshold and benchmark. Line 5j shows whether the facility performance rate is equal to or better than the benchmark. Lines 5k through 5m show the calculation of the achievement score. Lines 5n through 5q show the calculation of the improvement score. Finally, lines 5r and 5s show the performance measure score. Each line in this table is discussed below.

5.6.1 5a-5d. Facility Rate Calculation for Performance Period

5a. This indicates the number of patient-months that meet the Pediatric Hemodialysis inclusion criteria with a spKt/V of at least 1.2 at this facility during the performance period.

5b. This indicates the number of patient-months that meet the Pediatric Hemodialysis inclusion criteria at this facility during the performance period.

5c. This calculation gives the percentage of patient-months with spKt/V of at least 1.2. When 0 - 10 patients are eligible for the measure, no score is calculated.

5d. This indicates the performance rate for facilities with 11 - 25 eligible patients after applying the small facility adjustment. Values are not reported for facilities that do not receive a small facility adjustment.

5.6.2 5e-5g. Facility Improvement Threshold

5e. This indicates the number of patient-months that meet the Pediatric Hemodialysis inclusion criteria with a spKt/V of at least 1.2 at this facility during the comparison period.

5f. This indicates the number of patient-months that meet the Pediatric Hemodialysis inclusion criteria at this facility during the comparison period.

5g. This calculation gives the percentage of patient-months with spKt/V of at least 1.2 during the comparison period. When 0 - 10 patients are eligible for the measure, no score is calculated.

5.6.3 5h-5i. National Achievement Threshold and Benchmark

5h. This indicates the national achievement threshold used for the Pediatric Hemodialysis performance measure.

5i. This indicates the national benchmark used for the Pediatric Hemodialysis performance measure.

5.6.4 5j. Facility Performance Measure Score Calculation

5j. This indicates whether the facility performance rate meets or surpasses the benchmark. If so, the facility receives 10 points for achievement and skips to the performance measure score. If not, an achievement score is determined for the facility.

5.6.5 5k-5m. Achievement Score Calculation

5k. This indicates whether the facility performance rate is less than the achievement threshold. If so, the facility receives 0 points for achievement and skips to the improvement score calculation.

5l. This calculation gives an achievement score if the facility performance rate meets the following criteria:

- The facility performance rate does not fall below the achievement threshold.
- The facility performance rate does not meet or exceed the benchmark.

5m. This indicates the achievement score.

5.6.6 5n-5q. Improvement Score Calculation

5n. This indicates whether the facility performance rate is less than the facility improvement threshold. If so, the facility receives 0 points for improvement and skips to the performance measure score.

5o. This indicates whether the facility performance rate surpasses the benchmark and/or the facility improvement threshold is greater than or equal to the benchmark. If so, the facility skips to the performance measure score.

5p. This calculation gives an improvement score if the facility performance rate/threshold meets the following criteria:

- The facility performance rate does not fall below the facility improvement threshold.
- The facility performance rate does not meet or exceed the benchmark.
- The facility performance threshold does not meet or exceed the benchmark.

5q. This indicates the improvement score.

5.6.7 5r-5s. Performance Measure Score

5r. This indicates which performance score calculation was applied. The higher of the achievement or improvement scores is applied.

5s. This indicates the facility score for this performance measure.

5.7 Table 6. Combining Kt/V Dialysis Adequacy Measures into a Measure Topic Score

Table 6 combines the Kt/V Adult Hemodialysis measure score from 3s, the Kt/V Adult Peritoneal Dialysis measure score from 4s, and the Kt/V Pediatric Hemodialysis measure score from 5s to calculate a performance measure score for Kt/V Dialysis Adequacy. Each line in this table is discussed below.

5.7.1 6a-6c. Clinical Measure Scores

6a. This indicates the Kt/V Adult Hemodialysis measure score from 3s.

6b. This indicates the Kt/V Adult Peritoneal Dialysis measure score from 4s.

6c. This indicates the Kt/V Pediatric Hemodialysis measure score from 5s.

5.7.2 6d-6g. Measure Weight Calculation

6d. This indicates the number of patients included in the calculation of the Kt/V Adult Hemodialysis measure score.

6e. This indicates the number of patients included in the calculation of the Kt/V Adult Peritoneal Dialysis measure score.

6f. This indicates the number of patients included in the calculation of the Kt/V Pediatric Hemodialysis measure score.

6g. This calculation gives the total number of patients in all three Kt/V measures for use as the weighting denominator.

5.7.3 6h-6l. Measure Topic Score Calculation

6h. This calculates the weighted score of the Kt/V Adult Hemodialysis measure score.

6i. This calculates the weighted score of the Kt/V Adult Peritoneal Dialysis measure score.

6j. This calculates the weighted score of the Kt/V Pediatric Hemodialysis measure score.

6k. This calculates the weighted scores of the three Kt/V measure scores.

6l. This indicates the facility's Kt/V Dialysis Adequacy measure topic score.

5.8 Table 7. Treatment with Arteriovenous Fistula Measure Calculation

Table 7 shows the performance measure score calculation for the Treatment with AVF measure. Lines 7a through 7d show the calculation of the facility rate for the 2015 performance period. Lines 7e through 7g show the calculation of the facility improvement threshold for the 2014 comparison period. Lines 7h and 7i show the national achievement threshold and benchmark. Line 7j shows whether the facility performance rate is equal to or better than the benchmark. Lines 7k through 7m show the calculation of the achievement score. Lines 7n through 7q show the calculation of the improvement score. Finally, lines 7r and 7s show the performance measure score. Each line in this table is discussed below.

5.8.1 7a-7d. Facility Rate Calculation for Performance Period

7a. This indicates the number of patient-months that meet the AVF inclusion criteria with an AVF in use during a month's final treatment at this facility during the performance period.

7b. This indicates the number of patient-months that meet the AVF inclusion criteria at this facility during the performance period.

7c. This calculation gives the percentage of patient-months where patients with an AVF received treatment at this facility during the performance period. When 0 - 10 patients are eligible for the measure, no score is calculated.

7d. This indicates the performance rate for facilities with 11 - 25 eligible patients after applying the small facility adjustment. Values are not reported for facilities that do not receive a small facility adjustment.

5.8.2 7e-7g. Facility Improvement Threshold

7e. This indicates the number of patient-months that meet the AVF inclusion criteria with an AVF in use during the final treatment of each month at this facility during the comparison period.

7f. This indicates the number of patient-months that meet the AVF inclusion criteria at this facility during the comparison period.

7g. This calculation gives the percentage of patient-months where patients with an AVF received treatment at this facility during the comparison period. When 0 - 10 patients are eligible for the measure, no score is calculated.

5.8.3 7h-7i. National Achievement Threshold and Benchmark

7h. This indicates the national achievement threshold used for the AVF performance measure.

7i. This indicates the national benchmark used for the AVF performance measure.

5.8.4 7j. Facility Performance Measure Score Calculation

7j. This indicates whether the facility performance rate meets or exceeds the benchmark. If so, the facility receives 10 points for achievement and skips to the performance measure score. If not, an achievement score is determined.

5.8.5 7k-7m. Achievement Score Calculation

7k. This indicates whether the facility performance rate is less than the achievement threshold. If so, the facility receives 0 points for achievement and skips to the improvement score calculation.

7l. This calculation gives an achievement score if the facility performance rate meets the following criteria:

- The facility performance rate does not fall below the achievement threshold.
- The facility performance rate does not meet or exceed the benchmark.

7m. This indicates the achievement score.

5.8.6 7n-7q. Improvement Score Calculation

7n. This indicates whether the facility performance rate is less than the facility improvement threshold. If so, the facility receives 0 points for improvement and skips to the performance measure score.

7o. This indicates whether the facility performance rate surpasses the benchmark and/or the facility improvement threshold is greater than or equal to the benchmark. If so, the facility skips to the performance measure score.

7p. This calculation gives an improvement score if the facility performance rate/threshold meets the following criteria:

- The facility performance rate does not fall below the facility improvement threshold.
- The facility performance rate does not meet or exceed the benchmark.
- The facility performance threshold does not meet or exceed the benchmark.

7q. This indicates the improvement score.

5.8.7 7r-7s. Performance Measure Score

7r. This indicates which performance score calculation was applied. The higher of the achievement or improvement scores is applied.

7s. This indicates the facility score for this performance measure.

5.9 Table 8. Treatment with Catheter Measure Calculation

Table 8 shows the performance measure score calculation for the Treatment with Catheter measure. Lines 8a through 8d show the calculation of the facility rate for the 2015 performance period. Lines 8e through 8g show the calculation of the facility improvement threshold for the 2014 comparison period. Lines 8h and 8i show the national achievement threshold and benchmark. Line 8j shows whether the facility performance rate is equal to or better than the benchmark. Lines 8k through 8m show the calculation of the achievement score. Lines 8n through 8q show the calculation of the improvement score. Finally, lines 8r and 8s show the performance measure score. Each line in this table is discussed below.

5.9.1 8a-8d. Facility Rate Calculation for Performance Period

8a. This indicates the number of patient-months that meet the Treatment with Catheter inclusion criteria where patients with a catheter in use for at least 90 days received treatment at this facility during the performance period.

8b. This indicates the number of patient-months that meet the Treatment with Catheter inclusion criteria at this facility during the performance period.

8c. This calculation gives the percentage of patient-months where patients with a catheter in use for at least 90 days received treatment at this facility during the performance period. When 0 - 10 patients are eligible for the measure, no score is calculated.

8d. This indicates the performance rate for facilities with 11 - 25 eligible patients after applying the small facility adjustment. Values are not reported for facilities that do not receive a small facility adjustment.

5.9.2 8e-8g. Facility Improvement Threshold

8e. This indicates the number of patient-months that meet the Treatment with Catheter inclusion criteria where patients with a catheter in use for at least 90 days received treatment at this facility during the comparison period.

8f. This indicates the number of patient-months that meet the Treatment with Catheter inclusion criteria at this facility during the comparison period.

8g. This calculation gives the percentage of patient-months where patients with a catheter in use for at least 90 days received treatment at this facility during the comparison period. When 0 - 10 patients are eligible for the measure, no score is calculated.

5.9.3 8h-8i. National Achievement Threshold and Benchmark

8h. This indicates the national achievement threshold used for the Treatment with Catheter performance measure.

8i. This indicates the national benchmark used for the Treatment with Catheter performance measure.

5.9.4 8j. Facility Performance Measure Score Calculation

8j. This indicates whether the facility performance rate meets or falls below the benchmark. If so, the facility receives 10 points for achievement and skips to the performance measure score. If not, an achievement score is determined.

5.9.5 8k-8m. Achievement Score Calculation

8k. This indicates whether the facility performance rate surpasses the achievement threshold. If so, the facility receives 0 points for achievement and skips to the improvement score calculation.

8l. This calculation gives an achievement score if the facility performance rate meets the following criteria:

- The facility performance rate does exceed the achievement threshold.
- The facility performance rate does not meet or fall below the benchmark.

8m. This indicates the achievement score.

5.9.6 8n-8q. Improvement Score Calculation

8n. This indicates whether the facility performance rate surpasses the facility improvement threshold. If so, the facility receives 0 points for improvement and skips to the performance measure score.

8o. This indicates whether the facility performance rate is less than the benchmark and/or the facility improvement threshold is less than or equal to the benchmark. If so, the facility skips to the performance measure score.

8p. This calculation gives an improvement score if the facility performance rate/threshold meets the following criteria:

- The facility performance rate does not exceed the facility improvement threshold.
- The facility performance rate does not fall below the benchmark.
- The facility performance threshold does not meet or fall below the benchmark.

8q. This indicates the improvement score.

5.9.7 8r-8s. Performance Measure Score

8r. This indicates which performance score calculation was applied. The higher of the achievement or improvement scores is applied.

8s. This indicates the facility score for this performance measure.

5.10 Table 9. Combining Vascular Access Type Measures into a Measure Topic Score

Table 9 combines the AVF measure score from 7s and the Treatment with Catheter measure score from 8s to calculate a performance measure score for VAT. Each line in this table is discussed below.

5.10.1 9a-9b. Clinical Measure Scores

9a. This indicates the VAT Fistula measure score from 8s.

9b. This indicates the VAT Catheter measure score from 9s.

5.10.2 9c-9i. Measure Weight Calculation

9c. This indicates the number of patients included in the VAT Fistula measure score calculation.

9d. This indicates the number of patients included in the VAT Catheter measure score calculation.

9e. This calculation gives the total number of patients in the two VAT measures for use as the weighting denominator.

5.10.3 9f-9i. Measure Topic Score Calculation

9f. This calculates the weighted score of the VAT Fistula measure score.

9g. This calculates the weighted score of the VAT Catheter measure score.

9h. This calculates the weighted scores of the two VAT measure scores the weighted measure scores.

9i. This indicates the facility VAT measure topic score.

5.11 Table 10. Performance Measure Score Calculation: NHSN Bloodstream Infection in Hemodialysis Outpatients

Table 10 shows the performance measure score calculation for the NHSN Bloodstream Infection in Hemodialysis Outpatients measure. This measure is scored via the achievement and improvement methods using performance period data in CY 2015 compared to data from CY 2014 for achievement and improvement scores. Lines 10a through 10e show the calculation of the facility rate for the performance period. Lines 10f, 10g, and 10h show the calculation of the facility rate for the comparison period. Lines 10i and 10j show the national achievement threshold and benchmark, which were determined using CY 2014 data. Lines 10k through 10m show facility information used to calculate the facility measure score. Lines 10n through 10q show the calculation of the achievement score. Lines 10r through 10u show the calculation of the improvement score. Finally, lines 10v through 10w show the performance measure score. Each line in this table is discussed below.

5.11.1 10a-10e. Facility Rate Calculation for Performance Period

10a. This indicates the observed number of hemodialysis outpatients with positive blood cultures.

10b. This indicates the predicted (risk-adjusted) number of hemodialysis outpatients with positive blood cultures.

10c. This indicates the actual patient-month denominator. This is not used in calculating the score of this clinical measure.

10d. This calculation gives the standardized number of hemodialysis outpatients with positive blood cultures per 100 hemodialysis patient-months. When 0 - 10 patients are eligible for the measure, no score is calculated.

10e. This indicates the performance rate for facilities with 11 - 25 eligible patients after applying the small facility adjustment. Values are not reported for facilities that do not receive a small facility adjustment.

5.11.2 10f-10h. Facility Improvement Threshold

10f. This indicates the observed number of hemodialysis outpatients with positive blood cultures.

10g. This indicates the predicted (risk-adjusted) number of hemodialysis outpatients with positive blood cultures.

10h. This calculation gives the standardized number of hemodialysis outpatients with positive blood cultures per 100 hemodialysis patient-months. When 0 - 10 patients are eligible for the measure, no score is calculated.

5.11.3 10i-10j. National Achievement Threshold and Benchmark

10i. This calculation gives the national achievement threshold.

10j. This calculation gives the national benchmark.

5.11.4 10k-10n Facility Performance Measure Score Calculation

10k. This indicates whether the facility CCN open (certification) date is after 01/01/2015. If yes, the facility receives a performance measure score of N/A.

10l. This indicates whether the facility offers in-center hemodialysis. If no, the facility receives a performance measure score of N/A.

10m. This indicates whether the facility submitted 12 months of data according to NHSN protocol. If no, the facility receives a performance measure score of 0. Additionally, if the facility has an approved ECE, the performance measure score is N/A.

10n. This indicates whether the facility performance rate meets or falls below the benchmark.

5.11.5 10o-10q. Achievement Score Calculation

10o. This indicates whether the facility performance rate surpasses the achievement threshold. If so, the facility receives 0 points for achievement and skips to the performance measure score.

10p. This calculation gives an achievement score if the facility meets the following criteria:

- The facility certification date is on or before 01/01/2015.
- The facility performance rate does not exceed the achievement threshold.
- The facility performance rate does not meet or fall below the benchmark.
- The facility submitted 12 months of data, according the NHSN protocols.
- The facility was not approved for an ECE.

10q. This indicates the achievement score.

5.11.6 10r-10u. Improvement Score Calculation

10r. This indicates whether the facility performance rate surpasses (i.e., is higher than) the improvement threshold (row 10h) If yes, the facility receives 0 points for the improvement score.

10s. This indicates whether the facility performance rate falls below the benchmark, and/or the facility improvement threshold meets or falls below the benchmark. If yes to either, no improvement score is calculated. If no to both, an improvement score is calculated.

10t. This calculation gives an improvement score if the facility meets the following criteria:

- The facility certification date is on or before 01/01/2015.
- The facility improvement threshold does not meet or fall below the benchmark.
- The facility performance rate does not exceed the performance threshold.
- The facility performance rate does not meet or fall below the benchmark.
- The facility submitted 12 months of data, according the NHSN protocols.

10u. This indicates the facility improvement score.

5.11.7 10v-10w. Performance Measure Score

10v. This indicates whether the facility performance score is based on its achievement score or improvement score, or if it is N/A. The higher of the achievement and improvement score is assigned.

10w. This indicates the facility performance score for this measure.

5.12 Table 11. Performance Measure Score Calculation: Hypercalcemia

Table 11 shows the performance measure score calculation for the Hypercalcemia measure. Lines 11a through 11d show the calculation of the facility rate for the 2015 performance period. Lines 11e through 11g show the calculation of the facility improvement threshold for the 2014 comparison period. Lines 11h and 11i show the national achievement threshold and benchmark. Line 11j shows whether the facility performance rate is equal to the benchmark. Lines 11k through 11m show the calculation of the achievement score. Lines 11n through 11q show the calculation of the improvement score. Finally, lines 11r and 11s show the performance measure score. Each line in this table is discussed below.

5.12.1 11a-11d. Facility Rate Calculation for Performance Period

11a. This indicates the number of patient-months that meet the Hypercalcemia inclusion criteria with a 3 month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL at this facility during the performance period.

11b. This indicates the number of patient-months that meet the Hypercalcemia inclusion criteria at this facility during the performance period.

11c. This calculation gives the percentage of patient-months with a 3 month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL at this facility during the performance period. When 0 - 10 patients are eligible for the measure, no score is calculated.

11d. This indicates the performance rate for facilities with 11 - 25 eligible patients after applying the small facility adjustment. Values are not reported for facilities that do not receive a small facility adjustment.

5.12.2 11e-11g. Facility Improvement Threshold

11e. This indicates the number of patient-months that meet the Hypercalcemia inclusion criteria with a 3 month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL at this facility during the comparison period.

11f. This indicates the number of patient-months that meet the Hypercalcemia inclusion criteria at this facility during the comparison period.

11g. This calculation gives the percentage of patient-months with a 3 month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL at this facility during the comparison period. When 0 - 10 patients are eligible for the measure, no score is calculated.

5.12.3 11h-11i. National Achievement Threshold and Benchmark

11h. This indicates the national achievement threshold used for the Hypercalcemia performance measure.

11i. This indicates the national benchmark used for the Hypercalcemia performance measure.

5.12.4 11j. Facility Performance Measure Score Calculation

11j. This indicates whether the facility performance rate is equal to the benchmark. If so, the facility receives 10 points for achievement and skips to the performance measure score. If not, an achievement score is determined.

5.12.5 11k-11m. Achievement Score Calculation

11k. This indicates whether the facility performance rate surpasses the achievement threshold. If so, the facility receives 0 points for achievement and skips to the improvement score calculation.

11l. This calculation gives an achievement score if the facility performance rate meets the following criteria:

- The facility performance rate does not exceed the achievement threshold.
- The facility performance rate does not meet the benchmark.

12m. This indicates the achievement score.

5.12.6 11n-11q. Improvement Score Calculation

11n. This indicates whether the facility performance rate surpasses the facility improvement threshold. If so, the facility receives 0 points for improvement and skips to the performance measure score.

11o. This indicates whether the facility performance rate meets the benchmark and/or if the facility improvement threshold meets the benchmark.

11p. This calculation gives an improvement score if the facility performance rate/threshold meets the following criteria:

- The facility performance rate does not exceed the facility improvement threshold.
- The facility performance rate does not meet the benchmark.
- The facility performance threshold does not meet the benchmark.

11q. This indicates the improvement score.

5.12.7 11r-11s. Performance Measure Score

11r. This indicates which performance score calculation was applied. The higher of the achievement or improvement scores is applied.

11s. This indicates the facility score for this performance measure.

5.13 Table 12. Performance Measure Score Calculation: Standardized Readmission Ratio

Table 12 shows the performance measure scoring calculation for the SRR measure. Lines 12a through 12d show the calculation of the facility rate for the 2015 performance period. Lines 12e through 12g show the calculation of the facility improvement threshold for the 2014 comparison period. Lines 11h and 11i show the national achievement threshold and benchmark. Line 11j shows whether the facility performance rate is equal to the benchmark. Lines 11k through 11m show the calculation of the achievement score. Lines 11n through 11q show the calculation of

the improvement score. Finally, lines 11r and 11s show the performance measure score. Each line in this table is discussed below.

5.13.1 12a-12d. Facility Rate Calculation for Performance Period

12a. This indicates the observed number of unplanned hospital readmissions during the performance period.

12b. This indicates the expected number of unplanned readmissions in the facility for the performance period.

12c. This calculates the risk-adjusted standardized hospital readmissions ratio of the number of observed unplanned readmissions to the number of expected unplanned readmissions for the performance period.

Note: When fewer than 11 index hospital discharges are eligible for the measure, no score is calculated.

12d. This indicates the performance rate for facilities when 11 - 41 index discharges are included in the calculation.

5.13.2 12e-12g. Facility Improvement Threshold

12e. This indicates the observed number of unplanned hospital readmissions during the comparison period.

12f. This indicates the expected number of unplanned readmissions in the facility for the comparison period.

12g. This calculates the risk-adjusted standardized hospital readmissions ratio of the number of observed unplanned readmissions to the number of expected unplanned readmissions for the comparison period.

Note: When fewer than 11 index hospital discharges are eligible for the measure, no score is calculated.

5.13.3 12h-12i. National Achievement Threshold and Benchmark

12h. This indicates the national achievement threshold used for the SRR measure.

12i. This indicates the national benchmark used for the SRR measure.

5.13.4 12j. Facility Performance Measure Score Calculation

12j. This indicates whether the facility performance rate meets or falls below the benchmark. If yes, 10 points are awarded for the measure.

5.13.5 12k-12m. Achievement Score Calculation

12k. This indicates whether the facility performance rate surpasses (i.e. is higher than) the achievement threshold. If yes, 0 points are awarded for the achievement score.

12l. This calculation gives an achievement score if the facility performance rate meets the following criteria:

- The facility performance rate does not exceed the achievement threshold.
- The facility performance rate does not meet the benchmark.

12m. This indicates the achievement score.

5.13.6 12n-12q. Improvement Score Calculation

12n. This indicates whether the facility performance rate surpasses (i.e. is higher than) the facility improvement threshold. If yes, 0 points are awarded for the improvement score.

12o. This indicates whether the facility performance rate falls below the benchmark, and/or does the facility improvement threshold meet or fall below the benchmark. If yes to either, an improvement score is calculated.

12p. This calculation gives an improvement score if the facility performance rate/threshold meets the following criteria:

- The facility improvement threshold does not meet the benchmark.
- The facility performance rate does not exceed the facility improvement threshold.
- The facility performance rate does not meet the benchmark.

12q. This indicates the improvement score.

5.13.7 12r-12s. Performance Measure Score

12r. This indicates which performance score calculation was applied. The higher of the achievement or improvement scores is applied.

12s. This indicates the facility score for this performance measure.

5.14 Table 13. Performance Measure Score Calculation: Anemia Management Reporting

Table 13 shows the performance measure scoring calculation for the Anemia Management Reporting measure. Lines 13a through 13e provide the facility information used to calculate the measure score. Line 13f shows the performance measure score. Each line in this table is discussed below.

5.14.1 13a-13e. Reporting Measure Score Calculation

13a. This indicates whether the facility's certification date is after 06/30/2015. If so, the facility receives a score of N/A for the measure.

13b. This indicates whether the facility treated fewer than 11 eligible patients during 2015. If so, the facility receives a score of N/A for the measure.

13c. This indicates how many months the facility was eligible for the measure based on the facility certification date. For facilities certified in 2015, the month in which the facility was certified is not counted.

13d. This indicates the number of months the facility reported hemoglobin or hematocrit values and any ESA dosage on Medicare claims for at least 99% of eligible patients in 2015.

13e. This calculation gives the equation for the performance measure score calculation.

5.14.2 13f. Performance Measure Score

13f. This indicates the facility score for this performance measure.

5.15 Table 14. Performance Measure Score Calculation: Patient Experience of Care Survey

Table 14 shows the performance measure score calculation for the Patient Experience of Care Survey measure. Lines 14a through 14e provide the facility information used to calculate the performance measure score. Line 14f shows the performance measure score. Each line in this table is discussed below.

5.15.1 14a-14d. Reporting Measure Score Calculation

14a. This indicates whether the facility certification date is after 01/01/2015. If so, the facility measure performance score is N/A.

14b. This indicates whether the facility provided in-center hemodialysis. If not, the facility measure performance score is N/A.

14c. This indicates whether the facility attested in CROWNWeb that it treated fewer than 30 eligible patients during the eligibility period (CY 2014). If so, the facility measure performance score is N/A.

14d. This indicates whether the facility received at least 30 completed surveys during the performance period. If not, the facility measure performance score is N/A.

14e. This indicates whether the facility's third-party vendor successfully administered two ICH CAHPS surveys and delivered the results before 01/28/2016. If so, the facility measure performance score is 10. If not, 0 points are awarded.

5.15.2 14f. Performance Measure Score

14f. This indicates the facility score for this performance measure.

5.16 Table 15. Performance Measure Score Calculation: Mineral Metabolism Reporting

Table 15 shows the performance measure score calculation for the Mineral Metabolism reporting measure. Lines 15a through 15d provide the facility information used to calculate the measure score. Line 15f shows the performance measure score. Each line in this table is discussed below.

5.16.1 15a-15e. Reporting Measure Score Calculation

15a. This indicates whether the facility certification date is after 06/30/2015. If so, the facility performance measure score is N/A.

15b. This indicates whether the facility treated fewer than 11 eligible patients during 2015. If so, the facility measure performance score is N/A.

15c. This indicates the number of months for which the facility was eligible for the measure based on the facility certification date. For facilities certified in 2015, the month in which the facility was certified is not counted.

15d. This indicates the number of months the facility reported serum phosphorus levels via CROWNWeb for at least 97% of eligible patients in 2015.

15e. This calculation gives the equation for the facility performance measure score.

5.16.2 15f. Performance Measure Score

15f. This indicates the facility score for this performance measure.

5.17 Table 16. Calculation of Relative Weights Applied to Measure Scores

Table 16 shows how the weights were calculated and applied for each measure. Lines 16a through 16e show the calculation of the overall measure category weighting. Lines 16f and 16g show the calculation of the clinical measure weights. Finally, line 16h shows the calculation of the reporting measure weights. Each line in this table is discussed below.

5.17.1 16a-16e. Overall Measure Category Weighting

16a. This indicates the number of clinical measures (other than Hypercalcemia) with a score for this facility.

16b. This indicates whether the facility received a score for the Hypercalcemia measure.

16c. This indicates the number of scored reporting measures for this facility.

16d. This indicates the overall weight for clinical measures for this facility.

16e. This indicates the overall weight for reporting measures for this facility.

5.17.2 16f-16g. Clinical Measures Weight Calculation

16f. This calculation gives the weight applied to each clinical measure score (other than Hypercalcemia).

16g. This calculation gives the weight applied to the Hypercalcemia clinical measure score.

5.17.3 16h. Reporting Measures Weight Calculation

16h. This indicates the weight applied to each reporting measure score.

5.18 Table 17. Total Performance Score Calculation

Table 17 shows the calculations of measures and weighted measures used to determine the facility TPS. The facility TPS can range from 0 to 100. This total is then translated to a payment reduction percentage (or no payment reduction), as indicated in Table 2. Each line in this table is discussed below.

5.18.1 17a-17c. Measure Weights

17a. This indicates the relative weight applied to each clinical measure (other than Hypercalcemia) from 16f.

17b. This indicates the relative weight applied to the Hypercalcemia measure from 16g.

17c. This indicates the relative weight applied to each reporting measure from 16h.

5.18.2 17d-17e. Kt/V Dialysis Adequacy Measure Topic

17d. This indicates the score given to the Kt/V Dialysis Adequacy measure from 6l.

17e. This calculation gives the weighted score for the Kt/V Dialysis Adequacy measure.

5.18.3 17f-17g. Vascular Access Type Measure Topic

17f. This indicates the score given to the VAT measure from 9i.

17g. This calculation gives the weighted score for the VAT measure.

5.18.4 17h-17i. NHSN Bloodstream Infection in Hemodialysis Outpatients

17h. This indicates the score given to the VAT measure from 10w.

17i. This calculation gives the weighted score for the NHSN Bloodstream Infection in Hemodialysis Outpatients measure.

5.18.5 17j-17k. Hypercalcemia

17j. This indicates the score given to the Hypercalcemia measure from 11s.

17k. This calculation gives the weighted score for the Hypercalcemia measure.

5.18.6 17l-17m. Standardized Readmission Ratio

17l. This indicates the score given to the SRR measure from 12s.

17m. This calculation gives the weighted score for the SRR measure.

5.18.7 17n-17o. Anemia Management Reporting

17n. This indicates the score given to the Anemia Management reporting measure from 13f.

17o. This calculation gives the weighted score for the Anemia Management reporting measure.

5.18.8 17p-17q. Patient Experience of Care Survey Reporting

17p. This indicates the score given to the Patient Experience of Care Survey measure from 14f.

17q. This calculation gives the weighted score for the Patient Experience of Care Survey measure.

5.18.9 17r-17s. Mineral Metabolism Reporting

17r. This indicates the score given to the Mineral Metabolism reporting measure from 15f.

17s. This calculation gives the weighted score for the Mineral Metabolism reporting measure.

5.18.10 17t-17w. Total Performance Score

17t. This calculation gives the total weighted measure scores.

17u. This calculation gives the total weighted measure scores a value of 0 - 100.

17v. This indicates the TPS for the facility before applicable deductions from 17u.

5.19 Table 18. Total Performance Score Reductions

Table 18 shows the calculations for the TPS reduction. Each line in this table is discussed below.

18a. This indicates whether the facility was selected to participate in the CROWNWeb pilot validation study, and failed to provide CMS with the requisite medical records within 60 days of receiving the request. If yes, the facility receives a 10 point reduction in their TPS. A value of N/A is reported for facilities not selected to participate in the pilot validation study.

18b. This indicates whether the facility was selected to participate in the NHSN feasibility study, and failed to provide CMS with the requisite lists of positive blood cultures or the requisite medical records within 60 days of receiving the request. If yes, the facility receives a 10 point reduction in their TPS. A value of N/A is reported for facilities not selected to participate in the feasibility study.

18c. This calculation gives the total reduction by adding 18a and 18b.

18d. This calculation gives the TPS by subtracting 18c from 17v.

18e. This indicates the payment reduction for the facility.