

§ 413.178

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under this subpart for services provided in a subsequent payment year.

[76 FR 646, Jan. 5, 2011, as amended at 83 FR 57068, Nov. 14, 2018; 86 FR 62020, Nov. 8, 2021]

§ 413.178 ESRD quality incentive program.

(a) *Definitions.* As used in this section:

(1) *Achievement threshold* means the 15th percentile of national ESRD facility performance on a clinical measure during the baseline period for a payment year.

(2) *Baseline period* means, with respect to a payment year, the time period used to calculate the performance standards, benchmark, improvement threshold and achievement threshold that apply to each clinical measure for that payment year.

(3) *Benchmark* means, with respect to a payment year, the 90th percentile of national ESRD facility performance on a clinical measure during the baseline period that applies to the measure for that payment year.

(4) *Clinical measure* means a measure that is scored for a payment year using the methodology described in paragraphs (e)(1)(i) through (v) of this section.

(5) *End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP)* means the program authorized under section 1881(h) of the Social Security Act.

(6) *ESRD facility* means an ESRD facility as defined in § 413.171.

(7) *Improvement threshold* means an ESRD facility's performance on a clinical measure during the baseline period that applies to the measure for a payment year.

(8) *Minimum total performance score (mTPS)* means, with respect to a payment year except payment year 2023, the total performance score that an ESRD facility would receive if it performed at the 50th percentile of national ESRD facility performance on all clinical measures during the baseline period, and it performed at the median of national ESRD facility performance on all reporting measures using data from the most recently available year before the performance period.

(9) *Payment reduction* means the reduction, as specified by CMS, to each

payment that would otherwise be made to an ESRD facility under § 413.230 for a calendar year based on the TPS earned by the ESRD facility for the corresponding payment year that is lower than the mTPS score established for that payment year.

(10) *Payment year* means the calendar year for which a payment reduction, if applicable, is applied to the payments otherwise made to an ESRD facility under § 413.230.

(11) *Performance period* means the time period during which data are collected for the purpose of calculating an ESRD facility's performance on measures with respect to a payment year.

(12) *Performance standards* are, for a clinical measure, the performance levels used to award points to an ESRD facility based on its performance on the measure, and are, for a reporting measure, the levels of data submission and completion of other actions specified by CMS that are used to award points to an ESRD facility on the measure.

(13) *Reporting measure* means a measure that is scored for a payment year using the methodology described in paragraph (e)(1)(vi) of this section.

(14) *Total performance score (TPS)* means the numeric score ranging from 0 to 100 awarded to each ESRD facility based on its performance under the ESRD QIP with respect to a payment year.

(b) *Applicability of the ESRD QIP.* The ESRD QIP applies to ESRD facilities as defined at § 413.171 beginning the first day of the month that is 4 months after the facility CMS Certification Number (CCN) effective date.

(c) *ESRD QIP measure selection, retention, and removal*—(1) *ESRD QIP measure selection.* CMS specifies measures for the ESRD QIP for a payment year and groups the measures into domains. The measures for a payment year include:

(i) Measures on anemia management that reflect the labeling approved by the Food and Drug Administration for such management;

(ii) Measures on dialysis adequacy;

(iii) To the extent feasible, a measure (or measures) of patient satisfaction;

(iv) To the extent feasible, measures on iron management, bone mineral metabolism, and vascular access (including for maximizing the placement of arterial venous fistula);

(v) Beginning with the 2016 payment year, measures specific to the conditions treated with oral-only drugs and that are, to the extent feasible, outcomes-based; and

(vi) Other measures that CMS specifies.

(2) *Use of endorsed measures*—(i) *General rule.* Measures specified by CMS under paragraph (c)(1) of this section will be endorsed by the entity with a contract under section 1890(a) of the Social Security Act, unless the exception in paragraph (c)(2)(ii) of this section applies.

(ii) *Exception.* CMS may specify a measure under paragraph (c)(1) of this section that does not meet the requirement in paragraph (c)(2)(i) of this section if:

(A) CMS has determined that a specified area or medical topic is appropriate for inclusion in the ESRD QIP;

(B) CMS has not identified a feasible and practical measure with respect to that specified area or medical topic that has been endorsed by the entity with a contract under section 1890(a) of the Social Security Act; and

(C) CMS has given due consideration to measures that have been endorsed or adopted by a consensus organization.

(3) *Updating of measure specifications.* CMS uses rulemaking to make substantive updates to the specifications of measures used in the ESRD QIP. CMS announces technical measure specification updates through the QualityNet website (<https://qualitynet.cms.gov>) and listserv announcements.

(4) *Measure retention.* All measures specified for the ESRD QIP measure set remain in the measure set unless CMS, through rulemaking, removes or replaces them.

(5) *Measure removal factors*—(i) *General rule.* CMS may remove or replace a measure based on one or more of the following factors:

(A) *Factor 1.* Measure performance among the majority of ESRD facilities is so high and unvarying that meaning-

ful distinctions in improvements or performance can no longer be made.

(B) *Factor 2.* Performance or improvement on a measure does not result in better or the intended patient outcomes.

(C) *Factor 3.* A measure no longer aligns with current clinical guidelines or practice.

(D) *Factor 4.* A more broadly applicable (across settings, populations, or conditions) measure for the topic or a measure that is more proximal in time to desired patient outcomes for the particular topic becomes available.

(E) *Factor 5.* A measure that is more strongly associated with desired patient outcomes for the particular topic becomes available.

(F) *Factor 6.* Collection or public reporting of a measure leads to negative or unintended consequences.

(G) *Factor 7.* It is not feasible to implement the measure specifications.

(H) *Factor 8.* The costs associated with a measure outweigh the benefit of its continued use in the program.

(ii) *Exception.* CMS may retain a measure that meets one or more of the measure removal factors described in paragraph (c)(5)(i) of this section for reasons including, but not limited to, that the measure addresses a gap in quality that is so significant that removing the measure would lower the quality of care furnished by facilities, or that the measure is statutorily required.

(iii) *Patient safety exception.* Upon a determination by CMS that the continued requirement for facilities to submit data on a measure raises specific patient safety concerns, CMS may elect to immediately remove the measure from the ESRD QIP measure set. CMS will, upon removal of the measure—

(A) Provide notice to facilities and the public at the time CMS removes the measure, along with a statement of the specific patient safety concerns that would be raised if facilities continued to submit data on the measure; and

(B) Provide notice of the removal in the FEDERAL REGISTER.

(d) *Data submission requirement.* (1) Except as provided in paragraph (d)(3)

and (4) of this section, and for a payment year, facilities must submit to CMS data on each measure specified by CMS under paragraph (c) of this section. Facilities must submit these data in the form, manner, and at a time specified by CMS.

(2) For purposes of paragraph (d)(1) of this section, the baseline period that applies to each of payment year 2023 and payment year 2024 is calendar year 2019 for purposes of calculating the achievement threshold, benchmark and minimum total performance score, and calendar year 2019 for purposes of calculating the improvement threshold. The baseline period that applies to payment year 2025 is calendar year 2021 for purposes of calculating the achievement threshold, benchmark and minimum total performance score, and calendar year 2022 for purposes of calculating the improvement threshold, and the performance period that applies to payment year 2025 is calendar year 2023. Beginning with payment year 2026, the performance period and corresponding baseline periods are each advanced 1 year for each successive payment year.

(3) A facility may request and CMS may grant exceptions to the reporting requirements under paragraph (d)(1) of this section for one or more calendar days, when there are certain extraordinary circumstances beyond the control of the facility.

(4) A facility may request an exception within 90 days of the date that the extraordinary circumstances occurred by submitting the Extraordinary Circumstances Exception request form, which is available on the QualityNet website (<https://www.qualitynet.org/>), to CMS via email to the ESRD QIP mailbox at ESRDQIP@cms.hhs.gov. Facilities must provide the following information on the form:

- (i) Facility CCN.
- (ii) Facility name.
- (iii) CEO name and contact information.
- (iv) Additional contact name and contact information.
- (v) Reason for requesting an exception.
- (vi) Dates affected.

(vii) Date the facility will start submitting data again, with justification for this date.

(viii) Evidence of the impact of the extraordinary circumstances, including but not limited to photographs, newspaper, and other media articles.

(5) CMS will not consider an exception request unless the facility requesting such exception has complied with the requirements in paragraph (d)(4) of this section.

(6) CMS may grant exceptions to facilities without a request if it determines that one or more of the following has occurred:

(i) An extraordinary circumstance affects an entire region or locale.

(ii) An unresolved issue with a CMS data system affected the ability of a facility to submit data in accordance with paragraph (d)(1) of this section and CMS was unable to provide the facility with an alternative method of data submission.

(7) With the exception of first and second quarter 2020 ESRD QIP data for which CMS granted an exception under paragraph (d)(6) of this section, a facility that has been granted an exception to the data submission requirements under paragraph (d)(6) of this section may notify CMS that it will continue to submit data under paragraph (d)(1) of this section by sending an email signed by the CEO or another designated contact to the ESRD QIP mailbox at ESRDQIP@cms.hhs.gov. Upon receipt of an email under this clause, CMS will notify the facility in writing that CMS is withdrawing the exception it previously granted to the facility. With respect to fourth quarter 2019 ESRD QIP data for which CMS granted an exception under paragraph (d)(6) of this section, a facility is deemed to have met the requirements of this paragraph if the facility actually submitted the data by the March 31, 2020 submission deadline but did not notify CMS that it would do so.

(e) *Performance scoring under the ESRD QIP.* (1) CMS will award points to an ESRD facility based on its performance on each clinical measure for which the ESRD facility reports the applicable minimum number of cases during the performance period for a payment year, and based on the degree

to which the ESRD facility submits data and completes other actions specified by CMS for a reporting measure during the performance period for a payment year.

(i) CMS will award from 1 to 9 points for achievement on a clinical measure to each ESRD facility whose performance on that measure during the applicable performance period meets or exceeds the achievement threshold but is less than the benchmark specified for that measure.

(ii) CMS will award 0 points for achievement on a clinical measure to each ESRD facility whose performance on that measure during the applicable performance period falls below the achievement threshold specified for that measure.

(iii) CMS will award from 0 to 9 points for improvement on a clinical measure to each ESRD facility whose performance on that measure during the applicable performance period meets or exceeds the improvement threshold but is less than the benchmark specified for that measure.

(iv) CMS will award 0 points for improvement on a clinical measure to each ESRD facility whose performance on that measure during the applicable performance period is below the improvement threshold specified for that measure.

(v) CMS will award 10 points to each ESRD facility whose performance on a clinical measure during the applicable performance period meets or exceeds the benchmark specified for that measure.

(vi) CMS will award from 0 to 10 points to each ESRD facility on a reporting measure based on the degree to which, during the applicable performance period, the ESRD facility reports data and completes other actions specified by CMS with respect to that measure.

(2) CMS calculates the TPS for an ESRD facility for a payment year as follows:

(i) CMS calculates a domain score for each domain based on the total number of points the ESRD facility has earned under paragraph (e)(1) of this section for each measure in the domain and the weight that CMS has assigned to each measure.

(ii) CMS weights each domain score in accordance with the domain weight that CMS has established for the payment year.

(iii) The sum of the weighted domain scores is the ESRD facility's TPS for the payment year.

(f) *Public availability of ESRD QIP performance information.* (1) CMS will make information available to the public regarding the performance of each ESRD facility under the ESRD QIP on the Dialysis Facility Compare website, including the facility's TPS and scores on individual measures.

(2) Prior to making the information described in paragraph (f)(1) of this section available to the public, CMS will provide ESRD facilities with an opportunity to review that information, technical assistance to help them understand how their performance under the ESRD QIP was scored, and an opportunity to request and receive responses to questions that they have about the ESRD QIP.

(3) CMS will provide each ESRD facility with a performance score certificate on an annual basis that describes the TPS achieved by the facility with respect to a payment year. The performance score certificate must be posted by the ESRD facility within 15 business days of the date that CMS issues the certificate to the ESRD facility, with the content unaltered, in an area of the facility accessible to patients.

(g) *Limitation on review.* There is no administrative or judicial review of the following:

(1) The determination of the amount of the payment reduction under section 1881(h)(1) of the Act.

(2) The specification of measures under section 1881(h)(2) of the Act.

(3) The methodology developed under section 1881(h)(3) of the Act that is used to calculate TPSs and performance scores for individual measures.

(4) The establishment of the performance standards and the performance period under section 1881(h)(4) of the Act.

(h) *Special rule for payment year 2022.*

(1) CMS will calculate a measure rate for all measures specified by CMS under paragraph (c) of this section for the PY 2022 ESRD QIP but will not score facility performance on any of

those measures or calculate a TPS for any facility under paragraph (e) of this section.

(2) CMS will not establish a mTPS for PY 2022.

(i) *Special rules for payment year 2023.*

(1) CMS will calculate a measure rate for, but will not score facility performance on or include in the TPS for any facility under paragraph (e) of this section, the following measures: Standardized Hospitalization Ratio (SHR) clinical measure, Standardized Readmission Ratio (SRR) clinical measure, Long-Term Catheter Rate clinical measure, Standardized Fistula Rate clinical measure, ICH CAHPS clinical measure, Percentage of Prevalent Patients Waitlisted (PPPW) clinical measure, and Kt/V Dialysis Adequacy clinical measure.

(2) The mTPS for payment year 2023 is the total performance score that an ESRD facility would receive if, during the calendar year 2019 baseline period, it performed at the 50th percentile of national ESRD facility performance on Hypercalcemia clinical measure, NHSN Blood Stream Infection (BSI) clinical measure, and the median of national ESRD facility performance on Clinical Depression Screening and Follow-Up reporting measure, Standardized Transfusion Ratio (STrR) reporting measure, Ultrafiltration Rate reporting measure, NHSN Dialysis Event reporting measure, and Medication Reconciliation (MedRec) reporting measure.

[83 FR 57068, Nov. 14, 2018, as amended at 84 FR 60803, Nov. 8, 2019; 85 FR 54872, Sept. 2, 2020; 86 FR 62020, Nov. 8, 2021; 87 FR 67302, Nov. 7, 2022; 88 FR 76504, Nov. 6, 2023]

§ 413.180 Procedures for requesting exceptions to payment rates.

(a) *Outpatient maintenance dialysis payments.* All payments for outpatient maintenance dialysis furnished at or by facilities are made on the basis of prospective payment rates.

(b) *Criteria for requesting an exception.* If a pediatric ESRD facility projects on the basis of prior year costs and utilization trends that it has an allowable cost per treatment higher than its prospective rate set under § 413.174, and if these excess costs are attributable to one or more of the factors in § 413.182,

the facility may request, in accordance with paragraph (e) of this section, that CMS approve an exception to that rate and set a higher prospective payment rate.

(c) *Application of deductible and coinsurance.* The higher payment rate is subject to the application of deductible and coinsurance in accordance with § 413.176.

(d) *Payment rate exception request.* Effective October 1, 2002, CMS may approve exceptions to a pediatric ESRD facility's updated prospective payment rate, if the pediatric ESRD facility did not have an approved exception rate as of October 1, 2002. A pediatric ESRD facility may request an exception to its payment rate at any time after it is in operation for at least 12 consecutive months.

(e) *Documentation for a payment rate exception request.* If the facility is requesting an exception to its payment rate, it must submit to CMS its most recently completed cost report as required under § 413.198 and whatever statistics, data, and budgetary projections as determined by CMS to be needed to adjudicate each type of exception. CMS may audit any cost report or other information submitted. The materials submitted to CMS must—

(1) Separately identify elements of cost contributing to costs per treatment in excess of the facility's payment rate;

(2) Show that the facility's costs, including those costs that are not directly attributable to the exception criteria, are allowable and reasonable under the reasonable cost principles set forth in this part;

(3) Show that the elements of excessive cost are specifically attributable to one or more conditions specified in § 413.182;

(4) Specify the amount of additional payment per treatment the facility believes is required for it to recover its justifiable excess costs; and

(5) Specify that the facility has compared its most recently completed cost report with cost reports from (at least 2) prior years. The facility must explain any material statistical data or cost changes, or both, and include an explanation with the documentation supporting the exception request.