U.S. Department of Health & Human Services

Centers for Medicare & Medicaid Services

Payment Year 2015
End-Stage Renal Disease
Quality Incentive Program

Preview Performance Score Report

July 15, 2014

Payment Year 2015 ESRD QIP Preview Performance Score Report

NKC SEATAC KIDNEY CENTER

CMS Certification Number: **502509** CCN Certification Date: **07/18/1988**

Background

The purpose of the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) is to improve patient care by setting performance standards for quality of care. Facilities failing to meet these standards may be subject to a payment reduction of up to 2%. The ESRD QIP was established by Congress under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and is administered by the Centers for Medicare & Medicaid Services (CMS). The Final Rule outlining the program for Payment Year (PY) 2015 (CMS-1352-F) was published in the *Federal Register* on November 9, 2012.

Scoring

Your facility's **Total Performance Score (TPS) is 90 points** out of a total of 100 possible points. Table 1 summarizes your facility's performance in each measure. Information on how these scores are calculated is provided later in this document. Clinical measures account for 75% of the TPS, and reporting measures make up 25% of that total.

Not all measures apply to all populations. If your facility does not meet the case minimum for a measure in the performance period (i.e., 11 cases meeting the criteria for the measure), or if a measure does not apply to your facility, then your facility is not scored on that measure (appearing as a "N/A" result).

A complete explanation of the ESRD QIP performance rate calculations, including inclusion criteria for each measure, can be found in the *Guide to the PY 2015 ESRD QIP Performance Score Report*, available at http://www.DialysisReports.org. You may want to use this document to help answer patients' questions about your facility's Performance Score Certificate (PSC).

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Your facility will **incur no payment reduction** as a result of your ESRD QIP TPS in PY 2015.

Table 1. Performance Score Overview

PROJECTED* PAYMENT REDUCTION PERCENTAGE:	**NO REDUCTION**	
Performance Measures	**Measure Score**	**Measure Weight**
Clinical Measures		***Total of 75%***
Hemoglobin > 12g/dL Percent of patients with mean hemoglobin greater than 12 g/dL	10	25.00%
Kt/V Dialysis Adequacy measure topic Three measures for separate populations	10	25.00%
Percentage of adult hemodialysis patient-months with spKt/V greater than or equal to 1.2	10	
Percentage of adult peritoneal dialysis patient-months with Kt/V greater than or equal to 1.7	N/A	
Percentage of pediatric in-center hemodialysis patient-months with spKt/V greater than or equal to 1.2	N/A	
Vascular Access Type (VAT) measure topic Two measures for different access types	6	25.00%
Percent of hemodialysis patient-months using arteriovenous (AV) fistula with two needles during last treatment of the month	6	
Percent of hemodialysis patient-months with catheter in use for 90 days or longer prior to last hemodialysis session	6	
Reporting Measures		***Total of 25%***
Anemia Management Reporting Number of months for which facility reports hemoglobin/hematocrit values and ESA dosage, if applicable, on Medicare claims	10	6.25%
NHSN Dialysis Event Reporting Number of months for which facility reports NHSN dialysis events to the CDC	10	6.25%
Patient Experience of Care Survey Attestation Attest to successful administration of In-Center Hemodialysis Consumer Assessment of Health Providers and Systems (ICH CAHPS) survey	10	6.25%
Mineral Metabolism Reporting Number of months for which facility reports serum calcium and phosphorus levels of all patients to CROWNWeb	10	6.25%
Total Performance Score‡	**90**	

*The payment reduction percentage is currently **projected** based on current scores and weighting in this report**.** The Preview Period is your chance to submit clarification questions, as well as **a single formal inquiry** regarding the accuracy of the score calculations for your facility.

‡ **Note**: The **Measure Scores** were translated to a **Weighted Score** by multiplying them by the **Measure Weight**. Those Weighted Scores were added together and multiplied by 10 to calculate the **Total Performance Score**. See Table 16 for more details.

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Introduction

The purpose of this document, the **Performance Score Report (PSR)**, is to provide your facility with information regarding:

- Your performance on the quality measures during the Performance Period
- Information regarding the quality measures
- Your ESRD QIP TPS, and how your score was calculated
- Information regarding how Medicare payments to your facility will be affected as a result of your TPS.

During the Preview Period (*July 15, 2014, through August 15, 2014*), your facility has the opportunity to preview your performance scores and communicate with CMS through the http://www.DialysisReports.org website. You may submit two types of communications.

- **Clarification Question(s):** Your facility has the opportunity to ask as many questions as necessary to fully understand how your scores were calculated. For example, you might have questions about how a performance rate is calculated or what data was included in your facility's calculations.
- **Formal Inquiry** (limited to one per facility)**:** If you believe that there is an error in your facility's score calculation, you have an opportunity to provide CMS with a specific explanation or evidence of why you believe there was an error. A facility may only submit **one** formal inquiry during the Preview Period.

CMS will address your formal inquiry prior to finalizing your facility's performance score, finalizing your payment reduction percentage, and publishing your PSC. Use the following website to submit clarification questions and/or **one** formal inquiry: http://www.DialysisReports.org

CMS recommends that you submit your clarification questions prior to August 1 to ensure that you receive a response with enough time to submit a formal inquiry, if desired.

> **Important:** Your facility has until **August 15, 2014,** to review this report and ask questions. Only clarification questions and the one formal inquiry submitted during the Preview Period (*July 15 – August 15, 2014*) will receive a response.

Scores

In December of 2014, your **performance rates and TPS,** as well as those scores of other dialysis facilities, will be finalized. They will be made available to the public in January of 2015 on the Dialysis Facility Compare (DFC) website at: http://www.medicare.gov/dialysis/home.asp

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Performance Score Certificate

In December of 2014, your **PSCs** will be made available for you to download and post at your facility by the first business day of 2015.

Important:

All facilities are required by law to print and display their English and Spanish PSCs prominently in a public area for the duration of calendar year 2015, even if the facility did not receive a Total Performance Score.

Each facility's name and address will be included in the certificate, and this information must be accurate. Please review your facility's information listed below; if you notice any errors, please update your facility information with CMS as soon as possible. Please contact your Network for additional information and directions on how to properly update your facility's information.

NKC SEATAC KIDNEY CENTER
17900 INTERNATIONAL BOULEVARD SUITE 301
SEATAC, WA 98188

CMS Certification Number (CCN): 502509
Alternate CCN(s) Used by Facility:

Facilities with a TPS less than 60 will receive a payment reduction on Medicare dialysis claims for services delivered during all of calendar year 2015 (referred to as PY 2015). Table 2 shows how payment reductions are determined.

Table 2. Projected Payment Reduction Percentage*

Total Performance Score	Payment Reduction	
100 – 60 points	No reduction	←This facility
50 – 59 points	0.5%	
40 – 49 points	1.0%	
30 – 39 points	1.5%	
29 points or fewer	2.0%	
No score calculated	No reduction	

*** Applies to services delivered January 1, 2015, through December 31, 2015.**

Key Achievement and Improvement Scoring Definitions

The following table defines key achievement and improvement scoring terms.

Term	Definition
Achievement threshold	The 15th percentile of performance rates nationally during 2011
Benchmark	The 90th percentile of performance rates nationally during 2011
Improvement threshold	Your facility's performance rate during 2012
Performance period	All of calendar year 2013
Performance standard (Clinical Measures)	The 50th percentile of performance rates nationally during 2011
Facility performance rate	The percentage of a facility's patients either meeting or falling short of a measure's requirements during the performance period

Calculating Your Clinical Measure Scores

CMS calculates your facility's score for each clinical measure using the achievement and improvement scoring methodology. Your score for each clinical measure is calculated based on your facility's performance rate during the performance period compared to two ranges.

- The **achievement range** is the scale running from the achievement threshold to the benchmark.
  - Each facility can earn 0–10 points for achievement.
- The **improvement range** is the scale running from the improvement threshold to the benchmark.
  - Each facility can earn 0–9 points for improvement.

Your scores for achievement and improvement are based on where your facility's performance rate falls on the achievement and improvement ranges, respectively. Your score for each measure will be based on the higher of your achievement or improvement score for that measure.

If your facility does not have sufficient data to calculate a measure rate during 2012 but does have sufficient information to calculate a measure rate during 2013, then your facility score for that measure is based solely on achievement.

If your facility does not meet the case minimum for a clinical measure in the performance period (i.e., 11 cases meeting the criteria for the measure), your facility is not scored on that measure. If your facility has 11 – 25 eligible cases for a clinical measure, then the rate may be subject to an adjustment for low-volume facilities. The small sample size in these facilities puts them at risk for having one or two challenging patients dramatically alter their measure rates and ESRD QIP performance scores. The ESRD QIP therefore applies a favorable adjustment to measure rates for facilities with 11 – 25 cases, effectively giving these facilities the "benefit of the doubt." A complete explanation of the ESRD QIP performance rate calculations, including inclusion criteria for each measure, can be found in the *Guide to the PY 2015 ESRD QIP Performance Score Report*, available at http://www.DialysisReports.org.

Calculating Your Reporting Measure Scores

CMS calculates your facility's score for each reporting measure by awarding points for satisfying requirements for applicable measures. Satisfying these requirements involves recording specific data on your facility's Medicare claim forms, to CROWNWeb, and to the National Healthcare Safety Network (NHSN). If your facility does not meet the eligibility for a particular reporting measure, then your facility will not be scored on that

measure. If your facility does not meet the case minimum for a reporting measure in the performance period (i.e., 11 cases meeting the criteria for the measure), your facility is not scored on that measure.

Calculating Your Total Performance Score

CMS calculates your facility's TPS by weighting the measure scores and translating those weighted scores into a 0–100 range. Your Payment Reduction Percentage is then determined by comparing your TPS to the score ranges shown in Table 2.

Please Note:

For the Hemoglobin > 12g/dL and VAT Catheter measures, a *lower* percentage indicates a better performance rate.

For the Kt/V Dialysis Adequacy and VAT Fistula measures, a *higher* percentage indicates a better performance rate.

For detailed information about how your TPS was calculated, please see the appendix to this PSR, "Measure Eligibility, Scoring, and Calculation Information."

Facility Score Calculations

The following tables show the step-by-step calculations used to determine your scores for each PY 2015 ESRD QIP measure.

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Table 3. Performance Measure Score Calculation: Hemoglobin > 12 g/dL

#	Calculation Definition	Value
	Facility Rate Calculation for Performance Period *Performance period: All of calendar year 2013*	
3a	Number of patients with average hemoglobin greater than 12 g/dL	0
3b	Total number of patients included in calculation	98
3c	**Facility Performance Rate:** *Divide 3a by 3b and round* Percent of patients with hemoglobin greater than 12 g/dL *Note: When fewer than 11 patients are eligible for the measure, no score is calculated.*	0%
3d	**Adjusted Performance Rate for Low-Volume Facilities** Applies when 11 – 25 patients are included in the calculation	N/A
	Facility Improvement Threshold *Comparison period: All of calendar year 2012*	
3e	Number of patients with average hemoglobin greater than 12 g/dL	0
3f	Total number of patients included in calculation	99
3g	**Facility Improvement Threshold:** *Divide 3e by 3f and round* Percent of patients with hemoglobin greater than 12 g/dL *Note: When fewer than 11 patients are eligible for the measure, no score is calculated.*	0%
	National Achievement Threshold and Benchmark	
3h	**Achievement Threshold**	5%
3i	**Benchmark**	0%
	Facility Performance Measure Score Calculation	
3j	Does the Facility Performance Rate meet or fall below the Benchmark? *Is 3c or 3d equal to or less than 3i?* *If Yes, 10 points awarded for achievement (skip to 3r).* *If No, proceed to 3k.*	Yes
	Achievement Score Calculation	
3k	Does the Facility Performance Rate exceed the Achievement Threshold? *Is 3c or 3d greater than 3h?* *If Yes, 0 points awarded for achievement (skip to 3n).* *If No, proceed to 3l.*	N/A
3l	**Achievement Score Calculation** *Calculate 9 x [(3c or 3d – 3h) ÷ (3i – 3h)] + 0.5, then round.*	N/A
3m	**Achievement Score** *(from 3j, 3k, or 3l)*	10

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#	Calculation Definition	Value
	Improvement Score Calculation	
3n	Does the Facility Performance Rate exceed the Facility Improvement Threshold? *Is 3c or 3d greater than 3g?* *If Yes, 0 points awarded for improvement (skip to 3r).* *If No, proceed to 3o.*	N/A
3o	Does the Facility Performance Rate fall below the Benchmark, and/or does the Facility Improvement Threshold meet or fall below the Benchmark? *Is 3c or 3d less than 3i, and/or is 3g less than or equal to 3i?* *If Yes to either, no improvement score is calculated (skip to 3r).* *If No to both, proceed to 3p.*	N/A
3p	**Improvement Calculation** *Calculate 10 x [(3c or 3d – 3g) ÷ (3i – 3g)] – 0.5, then round.*	N/A
3q	**Improvement Score** *(from 3n, 3o, or 3p)*	N/A
	Performance Measure Score	
3r	Performance Score Calculation Applied *Assign the higher of Achievement (3m) or Improvement (3q).*	Achievement
3s	**Performance Measure Score**	**10**

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Tables 4 – 7: Performance Measure Score Calculation: Kt/V Dialysis Adequacy Measure Topic

Table 4. Adult Hemodialysis

#	Calculation Definition	Value
	Facility Rate Calculation for Performance Period *Performance Period: All of calendar year 2013*	
4a	Number of patient-months with spKt/V of at least 1.2	1067
4b	Total number of patient-months included in calculation	1090
4c	**Facility Performance Rate:** *Divide 4a by 4b and round* Percent of patient-months with spKt/V of at least 1.2 *Note: When fewer than 11 patients are eligible for the measure, no score is calculated.*	98%
4d	**Adjusted Performance Rate for Low-Volume Facilities** Applies when 11 – 25 patients are included in the calculation	N/A
	Facility Improvement Threshold *Comparison Period: All of calendar year 2012*	
4e	Number of patient-months with spKt/V of at least 1.2	1003
4f	Total number of patient-months included in calculation	1038
4g	**Facility Improvement Threshold:** *Divide 4e by 4f and round* Percent of patient-months with spKt/V of at least 1.2 *Note: When fewer than 11 patients are eligible for the measure, no score is calculated.*	97%
	National Achievement Threshold and Benchmark	
4h	**Achievement Threshold**	86%
4i	**Benchmark**	97%
	Facility Performance Measure Score Calculation	
4j	Does the Facility Performance Rate meet or exceed the Benchmark? *Is 4c or 4d equal to or greater than 4i?* *If Yes, 10 points awarded for Achievement (skip to 4r).* *If No, proceed to 4k.*	Yes
	Achievement Score Calculation	
4k	Does the Facility Performance Rate fall below the Achievement Threshold? *Is 4c or 4d less than 4h?* *If Yes, 0 points awarded for Achievement (skip to 4n).* *If No, proceed to 4l.*	N/A
4l	**Achievement Score Calculation** *Calculate 9 x [(4c or 4d – 4h) ÷ (4i – 4h)] + 0.5, then round.*	N/A
4m	**Achievement Score** *(from 4j, 4k, or 4l)*	10

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#	Calculation Definition	Value
	Improvement Score Calculation	
4n	Does the Facility Performance Rate fall below the Facility Improvement Threshold? *Is 4c or 4d less than 4g?* *If Yes, 0 points awarded for Improvement (skip to 4r).* *If No, proceed to 4o.*	N/A
4o	Does the Facility Performance Rate exceed the Benchmark, and/or does the Facility Improvement Threshold meet or exceed the Benchmark? *Is 4c or 4d greater than 4i, and/or is 4g greater than or equal 4i?* *If Yes to either, no Improvement score is calculated (skip to 4r).* *If No to both, proceed to 4p.*	N/A
4p	**Improvement Calculation** *Calculate 10 x [(4c or 4d – 4g) ÷ (4i – 4g)] – 0.5, then round.*	N/A
4q	**Improvement Score** *(from 4n, 4o, or 4p)*	N/A
	Performance Measure Score	
4r	**Performance Score Calculation Applied** *Assign the higher of Achievement (4m) or Improvement (4q).*	Achievement
4s	**Kt/V Adult Hemodialysis Measure Score**	**10**

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Table 5. Adult Peritoneal Dialysis

#	Calculation Definition	Value
	Facility Rate Calculation for Performance Period *Performance Period: All of calendar year 2013*	
5a	Number of patient-months with Kt/V of at least 1.7	0
5b	Total number of patient-months included in calculation	0
5c	**Facility Performance Rate:** *Divide 5a by 5b and round* Percent of patient-months with Kt/V of at least 1.7 *Note: When fewer than 11 patients are eligible for the measure, no score is calculated.*	Insufficient data
5d	**Adjusted Performance Rate for Low-Volume Facilities** Applies when 11 – 25 patients are included in the calculation	N/A
	Facility Improvement Threshold *Comparison Period: All of calendar year 2012*	
5e	Number of patient-months with Kt/V of at least 1.7	0
5f	Total number of patient-months included in calculation	0
5g	**Facility Improvement Threshold:** *Divide 5e by 5f and round* Percent of patient-months with Kt/V of at least 1.7 *Note: When fewer than 11 patients are eligible for the measure, no score is calculated.*	Insufficient data
	National Achievement Threshold and Benchmark	
5h	**Achievement Threshold**	63%
5i	**Benchmark**	94%
	Facility Performance Measure Score Calculation	
5j	Does the Facility Performance Rate meet or exceed the Benchmark? *Is 5c or 5d equal to or greater than 5i?* *If Yes, 10 points awarded for Achievement (skip to 5r).* *If No, proceed to 5k.*	N/A
	Achievement Score Calculation	
5k	Does the Facility Performance Rate fall below the Achievement Threshold? *Is 5c or 5d less than 5h?* *If Yes, 0 points awarded for Achievement (skip to 5n).* *If No, proceed to 5l.*	N/A
5l	**Achievement Score Calculation** *Calculate 9 x [(5c or 5d – 5h) ÷ (5i – 5h)] + 0.5, then round.*	N/A
5m	**Achievement Score** *(from 5j, 5k, or 5l)*	N/A

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#	Calculation Definition	Value
	Improvement Score Calculation	
5n	Does the Facility Performance Rate fall below the Facility Improvement Threshold? *Is 5c or 5d less than 5g?* *If Yes, 0 points awarded for Improvement (skip to 5r).* *If No, proceed to 5o.*	N/A
5o	Does the Facility Performance Rate exceed the Benchmark, and/or does the Facility Improvement Threshold meet or exceed the Benchmark? *Is 5c or 5d greater than 5i, and/or is 5g greater than or equal to 5i?* *If Yes to either, no Improvement Score is calculated (skip to 5r).* *If No to both, proceed to 5p.*	N/A
5p	**Improvement Calculation** *Calculate 10 x [(5c or 5d – 5g) ÷ (5i – 5g)] – 0.5, then round.*	N/A
5q	**Improvement Score** *(from 5n, 5o, or 5p)*	N/A
	Performance Measure Score	
5r	**Performance Score Calculation Applied** *Assign the higher of Achievement (5m) or Improvement (5q).*	N/A
5s	**Kt/V Adult Peritoneal Dialysis Measure Score**	**No Score Calculated**

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Table 6. Pediatric Hemodialysis

#	Calculation Definition	Value
	Facility Rate Calculation for Performance Period *Performance Period: All of calendar year 2013*	
6a	Number of patient-months with spKt/V of at least 1.2	0
6b	Total number of patient-months included in calculation	0
6c	**Facility Performance Rate:** *Divide 6a by 6b and round* Percent of patient-months with spKt/V of at least 1.2 *Note: When fewer than 11 patients are eligible for the measure, no score is calculated.*	Insufficient data
6d	**Adjusted Performance Rate for Low-Volume Facilities** Applies when 11 – 25 patients are included in the calculation	N/A
	Facility Improvement Threshold *Comparison Period: All of calendar year 2012*	
6e	Number of patient-months with spKt/V of at least 1.2	0
6f	Total number of patient-months included in calculation	0
6g	**Facility Improvement Threshold:** *Divide 6e by 6f and round* Percent of patient-months with spKt/V of at least 1.2 *Note: When fewer than 11 patients are eligible for the measure, no score is calculated.*	Insufficient data
	National Achievement Threshold and Benchmark	
6h	**Achievement Threshold**	83%
6i	**Benchmark**	97%
	Facility Performance Measure Score Calculation	
6j	Does the Facility Performance Rate meet or exceed the Benchmark? *Is 6c or 6d equal to or greater than 6i?* *If Yes, 10 points awarded for Achievement (skip to 6r).* *If No, proceed to 6k.*	N/A
	Achievement Score Calculation	
6k	Does the Facility Performance Rate fall below the Achievement Threshold? *Is 6c or 6d less than 6h?* *If Yes, 0 points awarded for Achievement (skip to 6r).* *If No, proceed to 6l.*	N/A
6l	**Achievement Score Calculation** *Calculate 9 x [(6c or 6d – 6h) ÷ (6i – 6h)] + 0.5, then round.*	N/A
6m	**Achievement Score** *(from 6j, 6k, or 6l)*	N/A

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#	Calculation Definition	Value
	Improvement Score Calculation	
6n	Does the Facility Performance Rate fall below the Facility Improvement Threshold? *Is 6c or 6d less than 6g?* *If Yes, 0 points awarded for Improvement (skip to 6r).* *If No, proceed to 6o.*	N/A
6o	Does the Facility Performance Rate exceed the Benchmark, and/or does the Facility Improvement Threshold meet or exceed the Benchmark? *Is 6c or 6d greater than 6i, and/or is 6g greater than or equal to 6i?* *If Yes to either, no Improvement Score is calculated (skip to 6r).* *If No to both, proceed to 6p.*	N/A
6p	**Improvement Calculation** *Calculate 10 x [(6c or 6d – 6g) ÷ (6i – 6g)] – 0.5, then round*	N/A
6q	**Improvement Score** *(from 6n, 6o, or 6p)*	N/A
	Performance Measure Score	
6r	Performance Score Calculation Applied *Assign the higher of Achievement (6m) or Improvement (6q).*	N/A
6s	**Kt/V Pediatric Hemodialysis Measure Score**	**No Score Calculated**

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Table 7. Combining Kt/V Dialysis Adequacy Measures into a Measure Topic Score

#	Calculation Definition	Value
	Clinical Measure Scores	
7a	Kt/V Adult Hemodialysis Measure Score *(from 4s)*	10
7b	Kt/V Adult Peritoneal Dialysis Measure Score *(from 5s)*	No Score Calculated
7c	Kt/V Pediatric Hemodialysis Measure Score *(from 6s)*	No Score Calculated
	Measure Weight Calculation	
7d	Number of patients included in Kt/V Adult Hemodialysis Measure Score calculation	130
7e	Number of patients included in Kt/V Adult Peritoneal Dialysis Measure Score calculation	N/A
7f	Number of patients included in Kt/V Pediatric Hemodialysis Measure Score calculation	N/A
7g	Determine total number of patients for weighting denominator *Add 7d + 7e + 7f*	130
	Measure Topic Score Calculation	
7h	Weight the Kt/V Adult Hemodialysis Measure Score *Calculate 7a x (7d ÷ 7g)*	10.0000
7i	Weight the Kt/V Adult Peritoneal Dialysis Measure Score *Calculate 7b x (7e ÷ 7g)*	N/A
7j	Weight the Kt/V Pediatric Hemodialysis Measure Score *Calculate 7c x (7f ÷ 7g)*	N/A
7k	Combine Measure Scores *Add 7h + 7i + 7j and round*	10
7l	**Kt/V Dialysis Adequacy Measure Topic Score (from 7k)**	**10**

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Tables 8 – 10. Performance Measure Calculation: Vascular Access Type Measure Topic

Table 8. Treatment with Arteriovenous Fistula Measure Calculation

#	Calculation Definition	Value
	Facility Rate Calculation for Performance Period *Performance Period: All of calendar year 2013*	
8a	Number of patient-months with fistula used for last treatment of the month	766
8b	Total number of patient-months included in calculation	1209
8c	**Facility Performance Rate:** *Divide 8a by 8b and round* Percent of patient-months receiving treatment with fistula *Note: When fewer than 11 patients are eligible for the measure, no score is calculated.*	63%
8d	**Adjusted Performance Rate for Low-Volume Facilities** Applies when 11 – 25 patients are included in the calculation	N/A
	Facility Improvement Threshold *Comparison Period: All of calendar year 2012*	
8e	Number of patient-months with fistula used for last treatment of the month	736
8f	Total number of patient-months included in calculation	1050
8g	**Facility Improvement Threshold:** *Divide 8e by 8f and round* Percent of patient-months receiving treatment with fistula *Note: When fewer than 11 patients are eligible for the measure, no score is calculated.*	70%
	National Achievement Threshold and Benchmark	
8h	**Achievement Threshold**	47%
8i	**Benchmark**	75%
	Facility Performance Measure Score Calculation	
8j	Does the Facility Performance Rate meet or exceed the Benchmark? *Is 8c or 8d equal to or greater than 8i?* *If Yes, 10 points awarded for Achievement (skip to 8r).* *If No, proceed to 8k.*	No
	Achievement Score Calculation	
8k	Does the Facility Performance Rate fall below the Achievement Threshold? *Is 8c or 8d less than 8h?* *If Yes, 0 points awarded for Achievement (skip to 8n).* *If No, proceed to 8l.*	No
8l	**Achievement Score Calculation** *Calculate 9 x [(8c or 8d – 8h) ÷ (8i – 8h)] + 0.5, then round.*	9 x [(63 - 47) ÷ (75 - 47)] + 0.5
8m	**Achievement Score** *(from 8j, 8k, or 8l)*	6

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#	Calculation Definition	Value
	Improvement Score Calculation	
8n	Does the Facility Performance Rate fall below the Facility Improvement Threshold? *Is 8c or 8d less than 8g?* *If Yes, 0 points awarded for Improvement (skip to 8r).* *If No, proceed to 8o.*	Yes
8o	Does the Facility Performance Rate exceed the Benchmark, and/or does the Facility Improvement Threshold meet or exceed the Benchmark? *Is 8c or 8d greater than 8i, and/or is 8g greater than or equal to 8i?* *If Yes to either, no Improvement Score is calculated (skip to 8r).* *If No to both, proceed to 8p.*	N/A
8p	**Improvement Calculation** *Calculate 10 x [(8c or 8d – 8g) ÷ (8i – 8g)] – 0.5, then round.*	N/A
8q	**Improvement Score** *(from 8n, 8o, or 8p)*	0
	Performance Measure Score	
8r	**Performance Score Calculation Applied** *Assign the higher of Achievement (8m) or Improvement (8q).*	Achievement
8s	**VAT Fistula Performance Measure Score**	**6**

Table 9. Treatment with Catheter Measure Calculation

#	Calculation Definition	Value
	Facility Rate Calculation for Performance Period *Performance Period: All of calendar year 2013*	
9a	Number of patient-months with catheter in use for at least 90 days	138
9b	Total number of patient-months included in calculation	1115
9c	**Facility Performance Rate:** *Divide 9a by 9b and round* Percent of patient-months with catheter in use for at least 90 days *Note: When fewer than 11 patients are eligible for the measure, no score is calculated.*	12%
9d	**Adjusted Performance Rate for Low-Volume Facilities** Applies when 11 – 25 patients are included in the calculation	N/A
	Facility Improvement Threshold *Comparison Period: All of calendar year 2012*	
9e	Number of patient-months with catheter in use for at least 90 days	88
9f	Total number of patient-months included in calculation	973
9g	**Facility Improvement Threshold:** *Divide 9e by 9f and round* Percent of patient-months with catheter in use for at least 90 days *Note: When fewer than 11 patients are eligible for the measure, no score is calculated.*	9%
	National Achievement Threshold and Benchmark	
9h	**Achievement Threshold**	22%
9i	**Benchmark**	5%
	Facility Performance Measure Score Calculation	
9j	Does the Facility Performance Rate meet or fall below the Benchmark? *Is 9c or 9d equal to or less than 9i?* *If Yes, 10 points awarded for Achievement (skip to 9r).* *If No, proceed to 9k.*	No
	Achievement Score Calculation	
9k	Does the Facility Performance Rate exceed the Achievement Threshold? *Is 9c or 9d greater than 9h?* *If Yes, 0 points awarded for Achievement (skip to 9n).* *If No, proceed to 9l.*	No
9l	**Achievement Score Calculation** *Calculate 9 x [(9c or 9d – 9h) ÷ (9i – 9h)] + 0.5, then round.*	9 x [(12 - 22) ÷ (5 - 22)] + 0.5
9m	**Achievement Score** *(from 9j, 9k, or 9l)*	6

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#	Calculation Definition	Value
	Improvement Score Calculation	
9n	Does the Facility Performance Rate exceed the Facility Improvement Threshold? *Is 9c or 9d greater than 9g?* *If Yes, 0 points awarded for Improvement (skip to 9r).* *If No, proceed to 9o.*	Yes
9o	Does the Facility Performance Rate fall below the Benchmark, and/or does the Facility Improvement Threshold meet or fall below the Benchmark? *Is 9c or 9d less than 9i, and/or is 9g less than or equal to 9i?* *If Yes to either, no Improvement Score is calculated (skip to 9r).* *If No to both, proceed to 9q.*	N/A
9p	**Improvement Calculation** *Calculate 10 x [(9c or 9d – 9g) ÷ (9i – 9g)] – 0.5, then round*	N/A
9q	**Improvement Score** *(from 9n, 9o, or 9p)*	0
	Performance Measure Score	
9r	**Performance Score Calculation Applied** *Assign the higher of Achievement (9m) or Improvement (9q).*	Achievement
9s	**VAT Catheter Performance Measure Score**	**6**

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Table 10. Combining Vascular Access Type Measures

#	Calculation Definition	Value
	Clinical Measure Scores	
10a	VAT Fistula Measure Score *(from 8s)*	6
10b	VAT Catheter Measure Score *(from 9s)*	6
	Measure Weight Calculation	
10c	Number of patients included in VAT Fistula Measure Score calculation	118
10d	Number of patients included in VAT Catheter Measure Score calculation	125
10e	Determine total number of patients for weighting denominator *Add 10c and 10d*	243
	Measure Topic Score Calculation	
10f	Weight the VAT Fistula Measure Score *Calculate 10a x (10c ÷ 10e)*	2.9136
10g	Weight the VAT Catheter Measure Score *Calculate 10b x (10d ÷ 10e)*	3.0864
10h	Combine Measure Scores *Add 10f + 10g and round*	6
10i	**Vascular Access Type Measure Topic Score (from 10h)**	**6**

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Table 11. Performance Measure Score Calculation: Anemia Management Reporting

#	Calculation Definition	Value
	Reporting Measure Score Calculation	
11a	Did the facility receive a CCN after June 30, 2013? *If Yes, measure is N/A (skip to 11f).* *If No, proceed to 11b.*	No
11b	Did the facility attest on CROWNWeb that it has treated fewer than 11 eligible patients during 2013? *If Yes, the measure is N/A (skip to 11f).** *If No, continue to 11c.*	No
11c	For how many eligible calendar months in 2013 did the facility have its CCN? *For facilities certified in 2013, the month in which the facility was certified should not be counted.*	12
11d	For how many months did the facility report hemoglobin or hematocrit values and any ESA dosage for the requisite percentage of patients on Medicare claims in 2013?	12
11e	Performance Measure Calculation *Calculate [(11d ÷ 11c) x 12] – 2, then round.*	[(12 ÷ 12) x 12] - 2
11f	**Performance Measure Score**	**10**

**In circumstances where the facility attested that the measure does not apply but claims data indicate that the measure applies, data in this row reflects the facility's attestation ["Yes" response] but the score is calculated based on the claims data received.*

Table 12. Performance Measure Score Calculation: NHSN Dialysis Event Reporting

#	Calculation Definition	Value
	Reporting Measure Score Calculation	
12a	Did the facility receive a CCN after January 1, 2013? *If Yes, measure is N/A (skip to 12f).* *If No, proceed to 12b.*	No
12b	Did the facility attest on CROWNWeb that it has treated fewer than 11 in-center hemodialysis patients during 2013? *If Yes, the measure is N/A (skip to 12f).* *If No, continue to 12c.*	No
12c	Did the facility report dialysis event data to NHSN for every month in 2013? *If Yes, 10 points awarded (skip to 12f).* *If No, proceed to 12d.*	Yes
12d	For how many months did the facility report dialysis event data to NHSN in 2013? *If fewer than 6 months, 0 points awarded. Skip to 12f.*	N/A
12e	Performance Measure Calculation *Calculate (12d ÷ 12) x 10, then round.*	N/A
12f	**Performance Measure Score**	**10**

Table 13. Performance Measure Score Calculation: Patient Experience of Care Survey Attestation

#	Calculation Definition	Value
	Reporting Measure Score Calculation	
13a	Did the facility receive a CCN after June 30, 2013? *If Yes, measure is N/A (skip to 13d).* *If No, proceed to 13b.*	No
13b	Did the facility attest on CROWNWeb that it has treated fewer than 11 eligible patients during 2013? *If Yes, the measure is N/A (skip to 13d).* *If No, continue to 13c.*	No
13c	Did the facility attest on CROWNWeb to successfully administering the ICH CAHPS survey during the performance period? *If Yes, 10 points awarded.* *If No, 0 points awarded.*	Yes
13d	**Performance Measure Score**	**10**

Table 14. Performance Measure Score Calculation: Mineral Metabolism Reporting

#	Calculation Definition	Value
	Reporting Measure Score Calculation	
14a	Did the facility receive a CCN after June 30, 2013? *If Yes, measure is N/A (skip to 14f).* *If No, proceed to 14b.*	No
14b	Did the facility attest on CROWNWeb that it has treated fewer than 11 eligible patients during 2013? *If Yes, the measure is N/A (skip to 14f).** *If No, continue to 14c.*	No
14c	For how many eligible calendar months in 2013 did the facility have its CCN? *For facilities certified in 2013, the month in which the facility was certified should not be counted.*	12
14d	For how many months did the facility report serum calcium and serum phosphorus levels for the requisite percentage of patients in 2013 via CROWNWeb?	12
14e	Performance Measure Calculation *Calculate [(14d ÷ 14c) x 12] – 2, then round.*	[(12 ÷ 12) x 12] - 2
14f	**Performance Measure Score**	**10**

**In circumstances where the facility attested that the measure does not apply but claims data indicate that the measure applies, data in this row reflects the facility's attestation ["Yes" response] but the score is calculated based on the claims data received.*

Total Performance Score Calculations

Following the calculations noted in Tables 3 – 14, the performance measure scores are weighted and combined to create the TPS. Table 15 shows how the weighting was applied to each measure for your facility.

Table 15. Calculation of Relative Weights Applied to Measure Scores

#	Calculation Definition	Value
Overall Measure Category Weighting		
15a	Number of clinical measures/measure topics with scores calculated *Count numerical scores from 3s, 7l, and 10i.*	3
15b	Number of reporting measures with scores calculated *Count numerical scores from 11f, 12f, 13d, and 14f.*	4
15c	Overall weight for clinical measures	75%
15d	Overall weight for reporting measures	25%
Clinical Measures Weight Calculation		
15e	Weight applied to each of the clinical measure/measure topic scores *Divide 15c by 15a.*	25.00%
Reporting Measures Weight Calculation		
15f	Weight applied to each of the reporting measure scores *Divide 15d by 15b.*	6.25%

A facility's TPS will range from 0 to 100. Table 16 shows the step-by-step calculations used to determine the TPS. This total is then translated to a payment reduction percentage (or no payment reduction), as indicated in Table 2. If your facility did not have at least one clinical and one reporting measure, then the scores you see in this document are the raw, unweighted scores that have no payment reduction implications.

Table 16. Total Performance Score Calculation

#	Calculation Definition	Value
Measure Weights		
16a	Relative weight for each clinical measure/measure topic score *(from 15e)*	25.00%
16b	Relative weight for each reporting measure (*from 15f)*	6.25%
Weighted Score Calculations: Clinical Measures		
Hemoglobin > 12 g/dL		
16c	Measure score (*from 3s)*	10
16d	Weighted measure score (*multiply 16c by 16a)*	2.5000

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#	Calculation Definition	Value
	Kt/V Dialysis Adequacy Measure Topic	
16e	Measure Topic score (*from 7l)*	10
16f	Weighted measure score (*multiply 16e by 16a)*	2.5000
	Vascular Access Type Measure Topic	
16g	Measure Topic score (*from 10i)*	6
16h	Weighted measure score (*multiply 16g by 16a)*	1.5000
	Weighted Score Calculations: Reporting Measures	
	Anemia Management Reporting	
16i	Measure score (*from 11f)*	10
16j	Weighted measure score (*multiply 16i by 16b)*	0.6250
	NHSN Dialysis Event Reporting	
16k	Measure score (*from 12f)*	10
16l	Weighted measure score (*multiply 16k by 16b)*	0.6250
	Patient Experience of Care Survey Attestation	
16m	Measure score (*from 13d)*	10
16n	Weighted measure score (*multiply 16m by 16b)*	0.6250
	Mineral Metabolism Reporting	
16o	Measure score (*from 14f)*	10
16p	Weighted measure score (*multiply 16o by 16b)*	0.6250
	Total Performance Score	
16q	Sum of weighted measure scores *Add 16d + 16f + 16h + 16j + 16l + 16n + 16p*	9.0000
16r	Scale weighted score to 0 – 100 scale *Multiply 16q by 10, then round.*	90
16s	**Total Performance Score** *(from 16r)*	**90**
16t	**Payment reduction at this facility** *(compare 16s to Table 2)*	**NO REDUCTION**

For Additional Help

For additional information on this report, to ask clarification questions about how your scores were calculated, request a patient list, or to submit a formal inquiry for CMS to address concerns related to your score, please visit the http://www.DialysisReports.org website. There you will find instructions for how to submit clarification questions and/or a formal inquiry. Only questions or an inquiry submitted during the Preview Period will receive a response.

Key Terms

Term	Definition
Achievement Range	In calculating clinical measure scores, a scale that runs from the achievement threshold to the benchmark.
Achievement Score	Compares the facility's performance during the performance period to the performance of all other facilities during a comparison period.
Achievement Threshold	The 15th percentile of performance rates nationally during a comparison period.
Benchmark	In calculating clinical measure scores, the 90th percentile of performance rates nationally during a comparison period.
Certificate or Performance Score Certificate (PSC)	An annual document produced for each facility that summarizes for the general public the facility's ESRD QIP performance information. The certificate must be posted in a location visible to the facility's patients for all of CY 2015.
Clarification Question(s)	An opportunity to request information that allows a facility to fully understand how its scores were calculated.
Clinical Measure	A measure that scores facilities based on the quality of services provided to patients with ESRD with regard to anemia management, dialysis adequacy, and vascular access. Clinical measures are scored based on facility achievement and improvement alike.
CMS Certification Number (CCN)	A number assigned to a facility for billing and administrative purposes. Each facility has a primary CCN but may potentially submit claims under alternate CCNs. The CCN is sometimes referred to as the billing number or provider number.

Term	Definition
Comparison Period	Range of time (usually a full year) used to gather data and determine the rates against which a facility's rates during the performance period are compared for purposes of measure scoring. The periods may differ for different scoring elements (e.g., achievement and improvement). For PY 2015, the comparison period for the achievement thresholds, benchmarks, and performance standards is CY 2011; the comparison period for the improvement thresholds is CY 2012.
Facility	Medicare-certified entity that provides outpatient dialysis for ESRD beneficiaries.
Formal Inquiry	An opportunity to provide CMS with a specific explanation or evidence of why you believe there was an error with your score. A facility may only submit ONE formal inquiry during the Preview Period.
Kt/V	A measure of dialysis adequacy where K = dialyzer clearance of urea; t = dialysis time; and V = patient's total body water. The measure also is known as "single pool" Kt/V (spKt/V), as it assumes that excess water and urea are removed from only one body compartment, and does not reflect rebound of water and waste products contributed by other body compartments.
Improvement Range	In calculating clinical measure scores, a scale running between the facility's improvement threshold and the benchmark.
Improvement Score	Compares the facility's performance on a clinical measure during the performance period to its own performance during a comparison period.
Improvement Threshold	The *individual* facility's performance during a comparison period.
Low-Volume Adjustment	An adjustment to the clinical performance rates and improvement thresholds for facilities that treat 11 – 25 eligible patients. The small sample size in these facilities puts them at risk for having one or two challenging patients dramatically alter their measure rates and ESRD QIP performance scores. The ESRD QIP therefore applies a favorable adjustment to measure rates for facilities with 11 – 25 cases. The adjustment can only improve a measure score; it will never penalize a facility.

Term	Definition
Measure	The high-level CMS definition of how quality of care is assessed. Ten measures are used for the PY 2015 ESRD QIP (six clinical measures and four reporting measures).
Measure Rate	The raw value of a facility's performance, expressed as a percentage. This number is used to calculate each clinical measure score. (Also referred to as the Performance Rate.)
Measure Score	The value that a facility earns for its performance on a measure. This score is used to calculate the Total Performance Score.
MIPPA	Medicare Improvements for Patients and Providers Act of 2008, providing the legislative authority for the ESRD QIP.
Payment Reduction Percentage	A percentage reduction in Medicare payments, resulting from a failure to meet a minimum Total Performance Score, that is applied to dialysis services provided by that facility during the applicable payment year. Payment reductions range from 0.5% to 2%.
Payment Year (PY)	The calendar year in which a facility's scores are publicly reported and payment reductions are applied. The performance period for which a facility is assessed occurs *prior to* the payment year.
Performance Period	The range of time in which a facility's performance on clinical and reporting measures is evaluated to determine measure rates and scores.
Performance Rate	See Measure Rate.
Performance Standard	The rate against which a facility's individual performance period rate is compared. The relevant standard(s) are defined in each rulemaking for the applicable PY.
Preview Period	The 30-day period when facilities may review calculations related to their performance scores and projected payment reduction percentage and submit questions to CMS about these calculations. A facility may submit one **formal inquiry** to address concerns about its score(s), **clarification questions** to better understand how its score(s) were calculated, and **requests for technical assistance** in using the website.

Term	Definition
Reporting Measure	A measure that scores facilities based on whether they provided particular data during the performance period with regard to anemia management, infections, the administration of patient-satisfaction surveys, and mineral metabolism. Reporting measures in the ESRD QIP are designed to provide data upon which the program can establish future clinical measures, including the calculation of performance standards, benchmarks, and achievement thresholds.
spKt/V	See Kt/V.
Total Performance Score (TPS)	The aggregate, weighted score of all measure scores. The Total Performance Score is calculated using a weighting system that reflects the facility's performance on the measures as well as CMS's judgment regarding the importance of each measure.

Appendix: Measure Eligibility, Scoring, and Calculation Information

The following chart illustrates measure eligibility for adult and pediatric facilities alike.

Clinical Measures						
	Adult			Pediatric		
Measure	In-Center HD	PD	Home HD	In-Center HD	PD	Home HD
Anemia Management	X	X	X			
Kt/V – Adult HD	X		X			
Kt/V – Adult PD		X				
Kt/V – Pediatric Dialysis				X		
VAT – AVF	X		X			
VAT – Catheter	X		X			
Reporting Measures						
	Adult			Pediatric		
Measure	In-Center HD	PD	Home HD	In-Center HD	PD	Home HD
Anemia Management	X		X	X		X
NHSN Dialysis Event	X			X		
Mineral Metabolism	X		X	X		X
ICH CAHPS Survey	X					

Calculating Your Clinical Measure Scores (see Tables 3 – 10)

The following diagram illustrates **an example** of the achievement and improvement ranges. The achievement range runs from the achievement threshold to the benchmark, and the improvement range runs from the facility's performance in a comparison period (the improvement threshold) to the benchmark. In this example, the facility earns 3 points for achievement, and 5 points for improvement. Since the improvement score is higher, the facility in this example earns 5 points for this measure.

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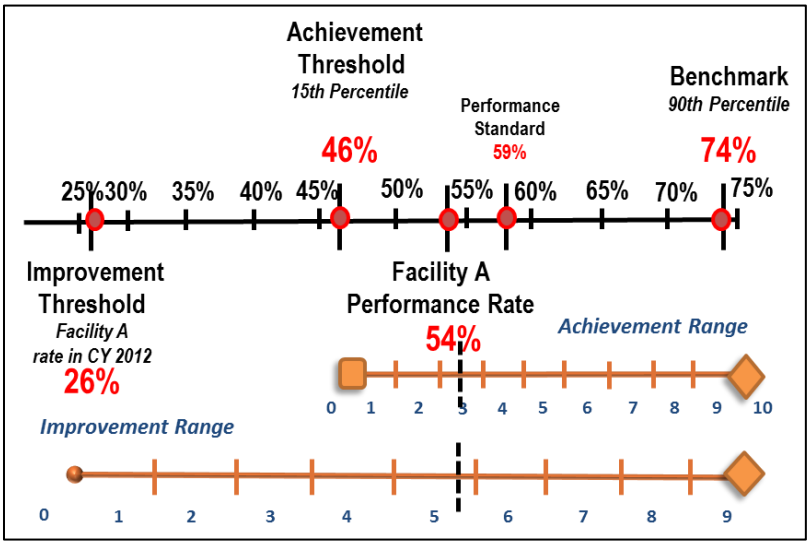
Example of Measure Score Calculation



Your facility receives the higher of either your *achievement* or *improvement* score.

Calculating Your Achievement Score

If your facility's rate falls *within* the achievement range, the following equation is used to calculate your facility's achievement score:

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

The score is then rounded to the nearest integer, with half rounding up. This equation is only applied if your facility's performance rate falls *within* the achievement range.

- If your facility's performance is above the achievement range, your facility receives 10 points for achievement.
- If your facility's performance rate is below the achievement range, your facility receives 0 points for achievement.
- If your facility's performance rate falls within the achievement range between the achievement threshold and the benchmark, your facility score is calculated using the equation above, resulting in an achievement score of 1 to 10.

Calculating Your Improvement Score

If your facility's rate falls *within* the improvement range, the following equation is used to calculate your facility's improvement score:

$$10 \times \left(\frac{\text{Facility's Performance Period Rate} - \text{Improvement Threshold}}{\text{Benchmark} - \text{Improvement Threshold}} \right) - 0.5$$

The score is then rounded to the nearest integer, with half rounding up. This equation is only applied if your facility's performance rate falls *within* the improvement range.

- If your facility's performance rate is above the improvement range, your facility already receives the maximum 10 points for achievement, as noted earlier.
- If your facility's performance rate is below the improvement range, your facility receives 0 points for improvement.
- If your facility's performance rate falls between the improvement threshold and the benchmark, your facility score is calculated using the equation above, resulting in an improvement score of 0 to 9.

Special note on scoring the Measure Topics:
Two measure topics (Kt/V Dialysis Adequacy and Vascular Access Type) consist of more than one measure. The scores for these measure topics are calculated using the following steps.

- A score is calculated independently for each measure using the above scoring methodology.
- The measure scores are weighted and combined (as described in Table 7 and Table 10, respectively) to determine your score on the overall measure.

Special note on adjusting the rates of low-volume facilities:
CMS has determined that the clinical performance rates for "low-volume facilities" (those that report between 11 and 25 cases during the 12-month performance period) may not reflect the quality of the care they provide. For that reason, low-volume facilities will be scored based on their raw performance rate plus a favorable adjustment. This adjustment will account for a possible unfavorable skew in the measure rate due to small sample size. Please see the *Guide to the PY 2015 ESRD QIP Performance Score Report*, available at http://www.DialysisReports.org, for details about how this calculation is made.

Calculating Your Reporting Measure Scores (see Tables 11 – 14)

Your facility's score for the reporting measures is based on whether your facility meets the specified reporting requirements. The requirements for each measure are outlined here.

Note: When fewer than 11 patients are eligible for a measure, no score is calculated. *In circumstances where the facility attested that the measure does not apply but claims data indicate that the Anemia Management (Table 11) or Mineral Metabolism (Table 14) measure applies, data in Row B of the table reflects the facility's attestation ["Yes" response] but the score is calculated based on the claims data received.*

Special note on "eligibility" and CCN issuance:
For purposes of determining "eligible months" for a reporting measure, CMS uses the date on which the facility was issued its CMS Certification Number (CCN).

- If the facility's Certification Date was prior to January 1, 2013, then "eligible months" refers to the entirety of the performance period (i.e., all 12 months in 2013).

- If the facility's Certification Date was between January 1, 2013, and June 30, 2013, then "eligible months" begins on the first day after the month in which the facility receives its CCN. For example, if the facility receives its CCN in March of 2013, then reporting requirements begin on April 1, and the facility is "eligible" to report nine months' worth of data. Note that such facilities would be ineligible from the NHSN measure, which requires a CCN prior to January 1, 2013.
- If the facility's Certification Date was after June 30, 2013, then the facility is exempt from all reporting measures and will not receive a Total Performance Score.

Important:
Facilities with a Certification Date after June 30, 2013, are exempt from reporting measures and will not receive a Total Performance Score.

Special note on "eligibility" and "eligible patients" for Anemia Management and Mineral Metabolism Reporting Measures:
With regard to the Anemia Management and Mineral Metabolism reporting measures, an "eligible month" is one in which a facility has at least one "eligible patient" (in addition to a CCN). "Eligible patients" are (i) in-center hemodialysis Medicare patients who have been treated at least seven times by the facility during the reporting month; and (ii) home hemodialysis Medicare patients for whom the facility submits a claim during the reporting month.

- If the facility has at least one "eligible patient" each month (and its Certification Date was prior to January 1, 2013), then "eligible months" refers to the entirety of the performance period (i.e., all 12 months in 2013).
- If the facility has no "eligible patients" during one or more months in the performance period (and the facility's Certification Date was prior to January 1, 2013), then "eligible months" refers to the months during which the facility had at least one "eligible patient." For example, if the facility had no "eligible patients" for three months of the reporting period, then the facility is "eligible" to report nine months' worth of data.
- If the facility has no "eligible patients" during one or more months in the performance period and the facility's Certification Date was between January 1, 2013, and June 30, 2013, then "eligible months" are those that are both: (i) on or after the first day after the month of the facility's Certification Date; and (ii) during which the facility has at least one eligible patient. For example, if the facility's Certification Date is in March of 2013, and if it has no "eligible patients" in November of 2013, then reporting requirements begin on April 1, 2013, and November 2013 is not considered an "eligible month." Thus, the facility is "eligible" to report eight months' worth of data (for April, May, June, July, August, September, October, and December of 2013).

Special note on "requisite percentage of patients" for Anemia Management and Mineral Metabolism Reporting Measures:

With regard to the Anemia Management and Mineral Metabolism reporting measures, facilities are required to report, on a monthly basis, for the "requisite percentage of patients."

For the Anemia Management reporting measure, the "requisite percentage of patients" is the lower of the following:

- The 50th percentile of facility reporting in CY 2012
- 99% of eligible patients

For the Mineral Metabolism reporting measure, the "requisite percentage of patients" is the lower of the following:

- The 50th percentile of facility reporting in CY 2012
- 97% of eligible patients

Anemia Management Reporting Measure:

- Facility reports hemoglobin and hematocrit values and any ESA dosage for the requisite percentage of patients on Medicare claims for every eligible month: 10 points.
- Facility reports hemoglobin and hematocrit values and any ESA dosage for the requisite percentage of patients on Medicare claims for a portion of its eligible months: apply the following ratio - [(# months reported ÷ # of eligible months) x 12] - 2

NHSN Dialysis Event Reporting Measure:

- Facility reports information about dialysis events to the NHSN for every eligible month: 10 points.
- Facility reports information about dialysis events to the NHSN for fewer than six months: 0 points.
- Facility reports information about dialysis events to the NHSN for a portion of its eligible months: apply the following ratio - (# months reported ÷ 12) x 10

Note: Only facilities that provide in-center hemodialysis services are eligible for the NHSN measure. Facilities that do not provide in-center hemodialysis services will be exempt and do not earn points for this measure.

Patient Experience of Care Survey Attestation:

- Facility attests to the successful administration of the ICH CAHPS survey to patients during the performance period: 10 points.
- Facility does not complete the above requirement: 0 points.

Note: Only facilities that provide adult in-center hemodialysis services are eligible for the ICH CAHPS reporting measure. Facilities that do not provide adult in-center hemodialysis services will be exempt and do not earn points for this measure.

Mineral Metabolism Reporting Measure:

- Facility reports serum calcium and phosphorus levels for the requisite percentage of patients for every eligible month: 10 points.
- Facility reports serum calcium and phosphorus levels for the requisite percentage of patients for a portion of its eligible months:
  apply the following ratio - [(# months reported ÷ # of eligible months) x 12] - 2

Calculating Your Total Performance Score and Payment Reduction Percentage (see Tables 15 – 16)

To determine your Total Performance Score, CMS applies the following weights to your scores on the clinical and reporting measures:

- **Clinical measures**: 75%
- **Reporting measures**: 25%

Within each measure category, the scores for each applicable measure are weighted equally, adding up to the total weight for that measure category (i.e., clinical and reporting measures). If a facility has no score for a specific measure, the scores it received for other measures in that category are weighted equally to add up to the total weight for that measure category.

In the case that a facility does not receive any measure scores within a measure category, then the facility will not receive a Total Performance Score, and the facility is not subject to a payment reduction.