

**Guide to the
Payment Year 2012
End-Stage Renal Disease
Quality Incentive Program
Performance Score Report**

July 2011

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I. Background and Purpose

The purpose of the Centers for Medicare & Medicaid Services (CMS) End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) is to improve patient care by setting quality of care performance standards. Facilities failing to meet the quality of care performance 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). The Final Rule (CMS-3206-F) outlining the program was published in the *Federal Register* on January 5, 2011.

Under the 2012 Payment Year (PY) ESRD QIP, CMS applies a formula to award points to facilities based on their performance on three quality of care measures—two related to anemia management and one related to dialysis adequacy. Specifically, CMS will examine facility performance based on the percentage of patients with Hemoglobin (Hg) less than 10 g/dL, the percentage of patients with Hg greater than 12 g/dL, and the percentage of patients with urea reduction ratio (URR) of at least 65%.

CMS will compare each facility's performance in the performance period (calendar year 2010) to a performance standard to calculate scores for each measure. The performance scores are then weighted and combined to derive the facility's Total Performance Score. Facilities with a Total Performance Score below 26 (out of 30) points will have their Medicare payments for dialysis services delivered during the payment year (2012) reduced on a sliding scale, with a maximum two percent reduction applied to any facility.

The purpose of this *Guide to the PY 2012 ESRD QIP Performance Score Report* is to explain in detail the methodology used in the QIP process, with specific references to items provided throughout the Performance Score Report (PSR). The purpose of the PSR is to provide each facility with information regarding:

- Performance on the three quality measures during the performance period
- Total ESRD QIP performance score and how the score was calculated
- Information regarding how Medicare payments to this facility will be affected as a result of the total performance score

The information presented in this guide applies to the Preview PSR which will be released on July 15, 2011, and the Final PSR which will be released in the fall of 2011. In December 2011, a Performance Score Certificate (PSC) will be available for each facility based on the data presented in the Final PSR. All facilities are required by law to print and display their PSC in a public area for the duration of calendar year 2012, even if the facility did not receive a total performance score.

II. Preview Period and Inquiry Process

During the Preview Period (*July 15 through August 15, 2011*) facilities may ask clarification questions and make inquiries about how scores were calculated. If you believe an error has been made in the calculations or data used in calculating this facility's score, you may submit a formal inquiry outlining your concern(s) for CMS' consideration. All formal inquiries will be addressed prior to finalizing facility

performance score and payment reduction percentage before publishing Performance Score Certificates. Use the www.DialysisReports.org website to submit clarification questions or formal inquiries.

For any general questions about the QIP process or the use of the website please first review the frequently asked questions (FAQ) page of the website and this Guide.

Using the www.DialysisReports.org website, each facility can designate one person to ask clarification questions and submit formal inquiries. This is controlled by your facility's "Master Account Holder" as reported to CMS by your ESRD Network. If you wish to submit a clarification question or formal inquiry but do not have the permission to do so, please contact your facility's "Master Account Holder."

What is the difference between a Clarification Question and a Formal Inquiry?

Throughout the Preview Period, facilities will be able to submit clarification questions and comments—for example, questions related to scoring methodology or what data were included in the calculation of their scores. CMS strongly encourages facilities to review their scores early and submit any clarification questions no later than August 1, 2011 to ensure that a response from CMS is received prior to the close of the Preview Period.

If a facility believes it has identified an error in its score, it may submit a single Formal Inquiry requesting CMS review. Facilities must indicate approval of the Medical Director/Facility Administrator at the time of submission of their Formal Inquiry. CMS will respond to all Formal Inquiries submitted during the Preview Period (though the response may be transmitted after the Preview Period ends). Please note that CMS will respond to clarification questions and formal inquiries via Arbor Research and the www.DialysisReports.org website.

While each facility is permitted to submit only one Formal Inquiry, facilities are not limited in the number of clarification questions and comments they submit. However, if clarification questions are submitted after August 1, 2011, CMS cannot guarantee that facility will have all questions resolved with sufficient time to submit a Formal Inquiry if desired.

Formal Inquiries and questions will not be accepted after 5:00 p.m. August 15.

Clarification Questions: "Question/Comment about my QIP Score"

If your question is not fully covered by the FAQ and this Guide, you can submit a question using the www.DialysisReports.org website. To submit a question/comment choose "Quality Incentive Program (QIP) Question / Comment about my QIP Score" and continue as instructed.

This can be used to address a wide range of concerns, including:

- General questions and comments on QIP methodology;
- Reporting potential errors in the facility information including the facility name, address, or CMS Certification Numbers (CCNs) included; or

- Asking for details or reporting potential errors in facility-specific calculations including patient counts and facility performance.

Facilities may not receive changes to the PSR in response to clarification questions. These requests must be submitted as formal inquiries for CMS review.

Formal Inquiries: “Submit a Formal QIP Inquiry to CMS”

Before submitting a formal inquiry, it is often useful to submit concerns as a clarification question. While facilities can submit multiple clarification questions, each facility can only submit one formal inquiry for CMS review. Submitting concerns as a clarification question first allows a facility to ensure proper use of the one formal inquiry.

If your facility believes the results of the calculation of the QIP measures are incorrect, or that the data used for the calculations was inappropriate for your facility, you may submit a formal inquiry to challenge the results and request a change to the data being used in the calculations. To submit a formal inquiry, go to the www.DialysisReports.org website and choose “Quality Incentive Program (QIP) Submit a Formal QIP Inquiry to CMS” and continue as instructed.

CMS requires each facility to have their Medical Director approve the content of the formal inquiry before submission. Please note only one formal inquiry can be made by a facility during the Preview Period. All inquiries submitted during the Preview Period will be investigated, and the final determination will be approved by CMS. Please note that the final determination may be that no change is warranted.

After the Preview Period

The Final PSR showing the final results of the PY 2012 ESRD QIP will be provided in fall of 2011 and will reflect the results shown in the Preview PSR unless the inquiry process leads to any CMS-approved changes. In December of 2011 the Performance Score Certificate (PSC) will be made available for download on the website (<http://www.DialysisReports.org>). Each facility must download their PSC which they will be required to print and post in a public area for the duration of calendar year 2012.

III. Inclusion Criteria

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

Which Medicare Claims are Included?

All Medicare outpatient dialysis facility claims (bill type 72x) from this facility were reviewed for inclusion in the calculations of the QIP measures. A facility is defined by CMS Certification Number (CCN) listed on Dialysis Facility Compare as of April 21, 2011. Facilities with multiple CCNs are identified and linked using CMS data sources.

Each patient’s date of first ESRD service may be a kidney transplant, a Medicare dialysis claim, or other indication of ESRD in CMS data sources (such as a 2728 Form or an entry on the SIMS database). It is determined by linking several data sources.

Each claim must have met the inclusion criteria detailed below in order to be included the corresponding measure calculation. There is a different set of inclusion criteria for the anemia management measures (Hemoglobin less than 10 g/dL and Hemoglobin greater than 12 g/dL) and the dialysis adequacy measure (URR greater than or equal to 65%). Please note that it is possible for a claim to have met the inclusion criteria for one type of measure but not the other.

Anemia Management (Hg Less than 10 g/dL, Hg Greater than 12 g/dL)

In order for a claim to have been included in the calculation of the anemia management measures it must have a reported hemoglobin value or a reported hematocrit value and must also have met the following criteria:

- The patient must be 18 years of age or older at the beginning date of the claim.
- The beginning date of the claim must have been at least 90 days since the date of first ESRD service for the patient.
- The reported hemoglobin value (or the reported hematocrit value divided by 3) must have been between 5 and 20 g/dL.
- The claim must indicate that an erythropoiesis stimulating agent (ESA) was used.

If during a month, multiple claims meet these criteria for the same patient at the same facility, the last claim of the month is used.

Dialysis Adequacy (URR of at Least 65%)

In order for a claim to be included in the calculation of the dialysis adequacy measure it must have a URR category (<60%, 60-64.9%, etc) and must also have met the following criteria:

- The patient must be 18 years of age or older at the beginning date of the claim.
- The beginning date of the claim must have been at least 183 days since the date of first ESRD service for the patient.
- The primary modality of the claim must have been in-center hemodialysis.
- The claim must not indicate the occurrence of frequent hemodialysis. Frequent hemodialysis claims are identified for exclusion in three ways:
 - If the claim covers 7 or fewer days, the claim must have had fewer than 4 sessions documented.
 - If the claim covers more than 7 days, the claim must have had a rate of fewer than 4 sessions per week.
 - The beginning date of the claim must not have occurred in a month during which the SIMS database recorded the patient's modality as frequent in-center hemodialysis (defined as 5 or more dialysis sessions per week).

If during a month, multiple claims meet these criteria for the same patient at the same facility, the last claim of the month is used.

Which Patients are Included?

In order for a patient's Medicare claims to be used in a facility's annual measure calculation, the patient must have had at least four months of claims that met the inclusion criteria above from the facility during the year.

Please note that it is possible for a patient's claims to be used in one measure calculation, but not another. For example, a patient may have had five months of claims meeting the

inclusion criteria for anemia management, but only three months of claims meeting the inclusion criteria for dialysis adequacy. (For example, two months of claims may be for frequent hemodialysis, while the other three months may be for standard thrice weekly hemodialysis.)

Each facility's annual calculations include only Medicare claims from that facility; Medicare claims from other facilities are not included. However, some patients receive treatment at multiple facilities during a year. Thus, these patients have Medicare claims at more than one facility. These patients were included in any facility for which they had four months of Medicare claims meeting inclusion criteria. For example, a patient with six months of claims at Facility A and six months of claims at Facility B would be included in both facilities. However, that patient's claims from Facility A would only be used in Facility A's PSR, not in Facility B's PSR, and vice-versa.

Which Facilities are Included?

All facilities that were listed on Dialysis Facility Compare (DFC) as of April 21, 2011 are included in the QIP.

To be used for QIP, a facility's annual quality measure must have at least 11 patients that met the patient criteria specified above. It is possible for a facility to have had sufficient patients to calculate one measure, but not another. For example, a facility may have had 15 patients meeting the inclusion criteria for the anemia management measures, but only 10 patients meeting the inclusion criteria for the dialysis adequacy measure.

Facilities with fewer than 11 patients for any of the three measures do not receive a QIP score, but will still receive a PSR.

IV. Calculation Process

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

Claims Processing

First, Medicare outpatient dialysis claims data are linked to other patient and facility data. This is done primarily to determine date of first ESRD service to determine claim eligibility and attribute claims to the appropriate facility in the case of a facility using multiple CCNs.

After the claims, patient, and facility data were combined, the validity of each claim was checked by applying the claim level inclusion criteria described in the inclusion criteria section. The inclusion criteria are different for the anemia management measures and the dialysis adequacy measure. It is possible that a claim may have met the inclusion criteria for one type of measure but not the other. Only claims that have met all of the claim level inclusion criteria for a measure are used in the calculation process of that measure going forward.

Patient Level Processing

After the set of valid claims were determined for each measure, the claims were summarized for each patient at each facility during each year. Patients with four months

of eligible claims were included in the measure calculation. Patients with valid claims at two facilities were essentially treated as different patients going forward. Separate summaries were produced for 2007 and 2010. The patient information going into each of the QIP measures was calculated as follows.

Anemia Management (Hg Less than 10 g/dL, Hg Greater than 12 g/dL)

For each patient, the mean (or average) hemoglobin value was calculated from included claims at the facility during the year. The patient's mean hemoglobin value was then categorized as being either less than 10 g/dL, between 10 and 12 g/dL (not used for QIP), or greater than 12 g/dL.

Dialysis Adequacy (URR of at Least 65%)

For each patient, the median (or mid-point) URR category was selected from included claims at the facility during the year. URR is reported as one of the following categories: less than 60%, 60-64.9%, 65-69.9%, 70-74.9%, or 75% or greater. If there was a tie between two categories in the calculation of the median, the higher of the two was selected as the median URR category. The median URR category was then categorized as being less than 65% or greater than or equal to 65%.

Facility Level Processing

Next, calculation of annual facility performance uses the patient summaries at this facility: patient mean Hg less than 10 g/dL, patient mean Hg greater than 12 g/dL, and patient median URR at least 65%. Annual performance was calculated separately for 2007 and for 2010. Several calculations are made for each facility, as described below.

Facility Performance for 2007 and 2010

We counted the number of patients at each facility who met the measure in each year. For example, we counted the number of patients at each facility during 2007 with a mean Hg < 10 g/dL, and divided by the total number of patients eligible for inclusion in the measure to calculate 2007 Facility Performance.

This process was repeated for each QIP measure, first in 2007, and then 2010.

Facility Performance Standard

A Performance Standard is then selected for each measure. Each measure has two possible performance standards: facility's performance in 2007 or the national performance in 2008. The performance standard is selected as the lesser of the two possible performance standards, where "lesser" indicates the weaker standard, which results in a higher score for the facility.

The 2008 national performance for QIP measures was as follows:

- 2% of patients had mean Hg < 10 g/dL,
- 26% of patients had mean Hg > 12 g/dL, and
- 96% of patients had median URR at least 65%.

Facilities with insufficient data for a measure in 2007, defined as fewer than 11 eligible patients in 2007, are assigned a 2007 facility performance of 100% for the anemia management measures or 0% for the dialysis adequacy measure. Because these represent

theoretical “least” performance and are a weaker performance standard than the 2008 national performance, these values will be used as the performance standard.

Performance Measure Score

Performance Measure Scores range from 0 to 10 and are calculated by comparing the facility’s Performance Standard to Facility Performance for 2010. If Facility Performance in 2010 was at least as good as the Performance Standard the Performance Measure Score was set to 10 points. If Facility Performance in 2010 was worse than the facility’s Performance Standard, then 2 points were subtracted from 10 for each percentage point difference (until the full 10 points were subtracted).

Note that for the anemia management measures, a lower Facility Performance percentage indicates a better performance rate. However, for the dialysis adequacy measure, a higher Facility Performance percentage reflects a better performance rate.

Facilities that do not have sufficient data for a measure in 2010, defined as fewer than 11 eligible patients in 2010, will not receive a performance measure score.

Remember that facilities with fewer than 11 eligible patients in 2007 are assigned a Performance Standard of 100% for the anemia management measures or 0% for the dialysis adequacy measure. Thus, if the facility has at least 11 patients in 2010, the facility will receive 10 points as it is impossible to do worse than this standard. If the facility does NOT have sufficient data to calculate a performance rate in 2010, the performance score cannot be calculated and the facility would not receive a score for that measure.

Total Performance Score

After each of the facility’s three Performance Measure Scores are calculated, they are combined to create a Total Performance Score. The Total Performance Score is a whole number between 0 and 30.

The Performance Measure Scores are combined as a weighted average. Thus:

- the Performance Measure Score for Hg<10 g/dL was multiplied by 0.5,
- the Performance Measure Score for Hg>12 g/dL was multiplied by 0.25, and
- the Performance Measure Score for URR at least 65% was multiplied by 0.25.

These three numbers are added together, and the resulting sum was multiplied by three and rounded to the nearest whole number. This is the facility’s Total Performance Score.

If one or more of the Performance Measure Scores cannot be calculated due to insufficient data (that is, fewer than 11 eligible patients in 2010), then the Total Performance Score is not calculated. However, all facilities still receive a PSR and PSC.

Payment Reduction Percentage

The Total Performance Score was used to assign the appropriate Payment Reduction to the facility. The Payment Reduction indicates the percent reduction that will be applied to

the facility's reimbursement for all Medicare dialysis claims for services delivered during all of calendar year 2012.

The facility's Payment Reduction is defined as follows:

- no reduction for a Total Performance Score of 26 to 30,
- a 0.5% reduction for a Total Performance Score of 21 to 25,
- a 1.0% reduction for a Total Performance Score of 16 to 20,
- a 1.5% reduction for a Total Performance Score of 11 to 15, or
- a 2.0% reduction for a Total Performance Score of 0 to 10.

If a Total Performance Score cannot be calculated, then the facility does not receive a payment reduction. However, all facilities still receive a PSR and PSC.

V. 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 (July 15 through August 15) and any formal inquiry. Information in the Final PSR will incorporate any changes from the preview and inquiry process.

Table 1. Performance Score Overview

Table 1 provides an overview of the facility's PY 2012 ESRD QIP results. The projected payment reduction percentage is listed first. This will be the percent reduction applied to the reimbursement of Medicare dialysis claims submitted by this facility throughout calendar year 2012.

This facility's Total Performance Score is given next in Table 1. As described in the Calculation Process section, this is a number between 0 and 30 calculated as a weighted sum of the three Performance Measure Scores. The facility's individual Performance Measure Scores are also given in Table 1. Each Performance Measure Score is a number between 0 and 10. Further detail about the calculation of these values is given in the Calculation Process section.

Table 2. Projected Payment Reduction Percentage

Table 2 reports the range of total performance scores that correspond with each payment reduction. In addition, an arrow to the right of the table indicates which payment reduction applies to this facility.

Facility Information

Facility information on record with CMS is provided for review. The information includes this facility's name, address, and CMS Certification Number (CCN). Also listed are other CCNs associated with this facility in various CMS data sources that were linked during the QIP calculation process.

If any of the facility identification information is incorrect, please inform us during the Preview Period by submitting a correction. You can do this by submitting a clarification question using the www.DialysisReports.org website. Choose "Quality Incentive Program (QIP) Question / Comment about my QIP Score" from the drop down menu,

and continue as instructed. This information must be corrected for display on the final PSR and the PSC. More details about contacting us with corrections or questions can be found in the Preview Period and Inquiry Process section.

Table 3. Points Facilities Earn Based on Performance Relative to the Performance Standard

Table 3 shows how differences between Facility Performance in 2010 and the Performance Standard translate into Performance Measure Scores between 0 and 10. No facility-specific data is shown in this informational table.

Table 4. Scoring Example Using National Average Performance Rates in 2008 as the Performance Standard

Table 4 illustrates how a facility's scores would be calculated using the national average in 2008 as the performance standard. No facility-specific data is shown in this informational table.

Table 5. Performance Measure Score Calculation: Patients with Hemoglobin Less than 10 g/dL

This table shows the Performance Measure Score calculation for the Hg<10 g/dL measure. Lines 5a through 5c show the Facility Performance Rate Calculation for 2007. Lines 5d through 5f show the Performance Standard Determination. Lines 5g through 5i show the Facility Rate Calculation for the Performance Period (2010). Finally, lines 5j through 5n show the Performance Measure Score Calculation. Each line in this table is discussed below.

5a. Number of patients with hemoglobin less than 10 g/dL

The number of patients with at least four claims that meet the anemia management inclusion criteria (see the Inclusion Criteria section) at this facility in 2007 whose mean hemoglobin value was less than 10 g/dL.

5b. Total number of patients included in calculation

The number of patients with at least four months of claims that meet the anemia management inclusion criteria (see the Inclusion Criteria section) at this facility in 2007.

5c. Percent of patients with hemoglobin less than 10 g/dL

The percent of patients with a mean hemoglobin value that is less than 10 g/dL (5a) out of all patients with at least four months of claims that meet the anemia management inclusion criteria in 2007 (5b).

5d. Facility comparison rate in 2007 (from 5c)

The percent of patients that have a mean hemoglobin value that is less than 10 g/dL (5a) out of all patients with at least four months of claims that meet the anemia management inclusion criteria in 2007 (5b). This is the same value as in 5c.

5e. National average in 2008

The national percent of patients with mean hemoglobin less than 10 g/dL in 2008. This was calculated as 2% and is not a facility-specific value.

5f. Performance standard applied

Indicates which of the 2007 facility performance (5d) or the 2008 national average (5e) gives a larger (worse) percent and is therefore assigned as this facility's performance standard.

5g. Number of patients with hemoglobin less than 10 g/dL

The number of patients with at least four months of claims that meet the anemia management inclusion criteria (see the Inclusion Criteria section) at this facility in 2010 whose mean hemoglobin value was less than 10 g/dL.

5h. Total number of patients included in calculation

The number of patients with at least four months of claims that meet the anemia management inclusion criteria (see the Inclusion Criteria section) at this facility in 2010.

5i. Percent of patients with hemoglobin less than 10 g/dL

The percent of patients with a mean hemoglobin value that is less than 10 g/dL (5g) out of all patients with at least four months of claims that meet the anemia management inclusion criteria in 2010 (5h).

5j. Facility performance rate in 2010 (from 5i)

The percent of patients with a mean hemoglobin value that is less than 10 g/dL (5g) out of all patients with at least four months of claims that meet the anemia management inclusion criteria in 2010 (5h). This is the same value as in 5i.

5k. Performance standard (from 5f)

The value of the metric in 5f: either the 2007 facility performance (5d) or the 2008 national average (5e).

5l. Does the facility meet or exceed the standard?

- Yes if the 2010 facility performance (5j) is less than or equal to (better or as good as) the performance standard (5k).
- No if the 2010 facility performance (5j) is greater than (worse than) the performance standard (5k).

5m. Difference between facility rate and performance standard

- “Meets or exceeds” if the 2010 facility performance (5j) is less than or equal to the performance standard (5k). In other words, if 5l is Yes.
- If the 2010 facility performance (5j) is greater than the performance standard (5k) (that is, if 5l is No), this is equal to the value of the 2010 facility performance (5j) minus the performance standard (5k).

5n. Performance Measure Score

The score is 10 if the facility rate (5j) is the same or better than the performance standard (5k). If the facility rate is worse than the performance standard, this is calculated as 10 minus 2 times the difference given in 5m.

Table 6. Performance Measure Score Calculation: Patients with Hemoglobin Greater than 12 g/dL

This table shows the Performance Measure Score calculation for the Hg>12 g/dL measure. Lines 6a through 6c show the Facility Performance Rate Calculation for 2007. Lines 6d through 6f show the Performance Standard Determination. Lines 6g through 6i show the Facility Rate Calculation for the Performance Period (2010). Finally, lines 6j through 6n show the Performance Measure Score Calculation. Each line in this table is discussed below.

6a. Number of patients with hemoglobin greater than 12 g/dL

The number of patients with at least four months of claims that meet the anemia management inclusion criteria (see the Inclusion Criteria section) at this facility in 2007 whose mean hemoglobin value was greater than 12 g/dL.

6b. Total number of patients included in calculation

The number of patients with at least four months of claims that meet the anemia management inclusion criteria (see the Inclusion Criteria section) at this facility in 2007.

6c. Percent of patients with hemoglobin greater than 12 g/dL

The percent of patients with a mean hemoglobin value that is greater than 12 g/dL (6a) out of all patients with at least four months of claims that meet the anemia management inclusion criteria in 2007 (6b).

6d. Facility comparison rate in 2007 (from 6c)

The percent of patients that have a mean hemoglobin value that is greater than 12 g/dL (6a) out of all patients with at least four months of claims that meet the anemia management inclusion criteria in 2007 (6b). This is the same value as in 6c.

6e. National average in 2008

The national percent of patients with mean hemoglobin greater than 12 g/dL in 2008. This was calculated as 26% and is not a facility-specific value.

6f. Performance standard applied

Indicates which of the 2007 facility performance (6d) or the 2008 national average (6e) gives a larger (worse) percent and is therefore assigned as this facility's performance standard.

6g. Number of patients with hemoglobin greater than 12 g/dL

The number of patients with at least four months of claims that meet the anemia management inclusion criteria (see the Inclusion Criteria section) at this facility in 2010 whose mean hemoglobin value was greater than 12 g/dL.

6h. Total number of patients included in calculation

The number of patients with at least four months of claims that meet the anemia management inclusion criteria (see the Inclusion Criteria section) at this facility in 2010.

6i. Percent of patients with hemoglobin greater than 12 g/dL

The percent of patients with a mean hemoglobin value that is greater than 12 g/dL (6g) out of all patients with at least four months of claims that meet the anemia management inclusion criteria in 2010 (6h).

6j. Facility performance rate in 2010 (from 6i)

The percent of patients with a mean hemoglobin value that is greater than 12 g/dL (6g) out of all patients with at least four months of claims that meet the anemia management inclusion criteria in 2010 (6h). This is the same value as in 6i.

6k. Performance standard (from 6f)

The value of the metric in 6f: either the 2007 facility performance (6d) or the 2008 national average (6e).

6l. Does the facility meet or exceed the standard?

- Yes if the 2010 facility performance (6j) is less than or equal to (better or as good as) the performance standard (6k).

- No if the 2010 facility performance (6j) is greater than (worse than) the performance standard (6k).

6m. Difference between facility rate and performance standard

- “Meets or exceeds” if the 2010 facility performance (6j) is less than or equal to the performance standard (6k). In other words, if 6l is Yes.
- If the 2010 facility performance (6j) is greater than the performance standard (6k) (that is, if 6l is No), this is equal to the value of the 2010 facility performance (6j) minus the performance standard (6k).

6n. Performance Measure Score

The score is 10 if the facility rate (6j) is the same or better than the performance standard (6k). If the facility rate is worse than the performance standard, this is calculated as 10 minus 2 times the difference given in 6m.

Table 7. Performance Measures Score Calculation: Patients with URR of at Least 65%

This table shows the Performance Measure Score calculation for the URR at least 65% measure. Lines 7a through 7c show the Facility Performance Rate Calculation for 2007. Lines 7d through 7f show the Performance Standard Determination. Lines 7g through 7i show the Facility Rate Calculation for the Performance Period (2010). Finally, lines 7j through 7n show the Performance Measure Score Calculation. Each line in this table is discussed below.

7a. Number of patients with URR of at least 65%

The number of patients with at least four months of claims that meet the dialysis adequacy inclusion criteria (see the Inclusion Criteria section) at this facility in 2007 whose median URR category was at least 65%.

7b. Total number of patients included in calculation

The number of patients with at least four months of claims that meet the dialysis adequacy inclusion criteria (see the Inclusion Criteria section) at this facility in 2007.

7c. Percent of patients with URR of at least 65%

The percent of patients with a median URR category that is at least 65% (7a) out of all patients with at least four months of claims that meet the dialysis adequacy inclusion criteria in 2007 (7b).

7d. Facility comparison rate in 2007 (from 7c)

The percent of patients with a median URR category that is at least 65% (7a) out of all patients with at least four months of claims that meet the dialysis adequacy inclusion criteria in 2007 (7b). This is the same value as in 7c.

7e. National average in 2008

The national percent of patients with a median URR category of at least 65% in 2008. This was calculated as 96% and is not a facility-specific value.

7f. Performance standard applied

Indicates which of the 2007 facility performance (7d) or the 2008 national average (7e) gives a smaller (worse) percent and is therefore assigned as this facility’s performance standard.

7g. Number of patients with URR of at least 65%

The number of patients with at least four months of claims that meet the dialysis adequacy inclusion criteria (see the Inclusion Criteria section) at this facility in 2010 whose median URR category was at least 65%.

7h. Total number of patients included in calculation

The number of patients with at least four months of claims that meet the dialysis adequacy inclusion criteria (see the Inclusion Criteria section) at this facility in 2010.

7i. Percent of patients with URR of at least 65%

The percent of patients with a median URR category that is at least 65% (7g) out of all patients with at least four months of claims that meet the dialysis adequacy inclusion criteria in 2010 (7h).

7j. Facility performance rate in 2010 (from 7i)

The percent of patients with a median URR category that is at least 65% (7g) out of all patients with at least four months of claims that meet the dialysis adequacy inclusion criteria in 2010 (7h). This is the same value as in 7i.

7k. Performance standard (from 7f)

The value of the metric in 7f: either the 2007 facility performance (7d) or the 2008 national average (7e).

7l. Does the facility meet or exceed the standard?

- Yes if the 2010 facility performance (7j) is greater than or equal to (better or as good as) the performance standard (7k).
- No if the 2010 facility performance (7j) is less than (worse than) the performance standard (7k).

7m. Difference between facility rate and performance standard

- “Meets or exceeds”, if the 2010 facility performance (7j) is greater than or equal to the performance standard (7k). In other words, if 7l is Yes.
- If the 2010 facility performance (7j) is less than the performance standard (7k) (that is, if 7l is No), this is equal to the value of the performance standard (7k) minus the 2010 facility performance (7j).

7n. Performance Measure Score

The score is 10 if the facility rate (7j) is the same or better than the performance standard (7k). If the facility rate is worse than the performance standard, this is calculated as 10 minus 2 times the difference given in 7m.

Table 8. Total Performance Score Calculation

This table shows the Total Performance Score calculation. Lines 8a through 8f show the three Performance Measure Scores before and after weighting. Lines 8g through 8i show how the three Performance Measure Scores are combined to create the Total Performance Score and the relevant Payment Reduction Percentage for this facility.

8a. Performance measure score (from 5n)

The score is 10 if the difference between the facility rate and performance standard (5m) is “Meets or exceeds”. Otherwise, this is calculated as 10 minus 2 times the difference found in 5m.

8b. Weighted measure score (multiply by 0.5)

The performance measure score for hemoglobin less than 10 g/dL (8a) multiplied by 0.5. This step provides the hemoglobin less than 10 g/dL measure with the 50% weight described in the Calculation Process section.

8c. Performance measure score (from 6n)

The score is 10 if the difference between the facility rate and performance standard (6m) is “Meets or exceeds”. Otherwise, this is calculated as 10 minus 2 times the difference found in 6m.

8d. Weighted measure score (multiply by 0.25)

The performance measure score for hemoglobin greater than 12 g/dL (8a) multiplied by 0.25. This step provides the hemoglobin greater than 12 g/dL measure with the 25% weight described in the Calculation Process section.

8e. Performance measure score (from 7n)

The score is 10 if the difference between the facility rate and performance standard (7m) is “Meets or exceeds”. Otherwise, this is calculated as 10 minus 2 times the difference found in 7m.

8f. Weighted measure score (multiply by 0.25)

The performance measure score for URR of at least 65% (8a) multiplied by 0.25. This step provides the URR of at least 65% measure with the 25% weight described in the Calculation Process section.

8g. Sum of weighted measure scores (8b + 8d + 8f)

Gives the sum of the three weighted performance measure scores (8b + 8d + 8f).

8h. Total Performance Score (8g multiplied by 3, rounded)

Gives the result of the calculation of the sum of the three weighted performance measure scores (8g) multiplied by 3, rounded to the nearest whole number.

8i. Payment reduction at this facility (from Table 2)

Gives the payment reduction that corresponds to the Total Performance Score (8h) which will be assigned to this facility. The full set of payment reduction categories is given in Table 2 of the PSR.