End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

Payment Year (PY) 2026 Preview Period

Guide to the PY 2026 ESRD QIP Performance Score Report (PSR)

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1. Introduction

1.1 Background

The End-Stage Renal Disease Quality Incentive Program (ESRD QIP) promotes high-quality care delivered by outpatient dialysis facilities treating patients with ESRD. The first of its kind in Medicare, this program changes the way the Centers for Medicare & Medicaid Services (CMS) pays for the treatment of ESRD patients by linking a portion of payment directly to facilities' performance on quality care measures.

ESRD QIP was established by Congress under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and is administered by CMS. The final rule outlining the program for calendar year (CY) 2024 / payment year (PY) 2026 was published in the Federal Register on 11/6/2023 (CMS-1782-F).

1.2 Purpose

The purpose of the Performance Score Report (PSR) is to provide each facility with information regarding performance on each of the quality measures. The Guide to the PY 2026 ESRD QIP PSR provides additional details related to the methodology used in the ESRD QIP scoring process, with specific references to elements provided throughout the PSR.

The information presented in this guide applies to the Preview PSR, which will be available for download in summer of CY 2025, and the Final PSR, which will be available for download in late 2025. Additionally, in late CY 2025, a Performance Score Certificate (PSC) based on the data presented in the Final PSR will be available for each facility. All facilities are required by law to print and display their PSC in a prominent area for the duration of CY 2026, even if the facility did not receive a Total Performance Score (TPS). The downloadable file that contains the PSC will include a version of the certificate in English and in Spanish. Facilities are required to display both the English and Spanish versions of the PSC in a prominent area within the facility.

CMS applies a formula to award points to facilities based on their performance on a total of 14 quality of care measures. The performance measures are divided into five domains, including the Clinical Care Measure Domain, Safety Measure Domain, Patient and Family Engagement Measure Domain, Care Coordination Measure Domain, and Reporting Measure Domain.

1.2.1 Clinical Measure Scoring

For the PY 2026 ESRD QIP, the baseline period is CY 2023, or 1/1/2023 – 12/31/2023, and the performance period is CY 2024 (1/1/2024 – 12/31/2024). If your facility does not meet the minimum data requirements for a clinical measure in the performance period, then your facility is not scored on that measure. Facilities with low case numbers are more susceptible to having their ESRD QIP scores significantly impacted by one or two challenging patients. Therefore, for small facilities meeting the minimum data requirements, the ESRD QIP applies a small facility adjuster. This is a favorable adjustment applied to performance rates in the

performance period, effectively giving them the "benefit of the doubt." The minimum data requirement and the small facility adjuster eligibility criteria for each clinical measure are displayed in Table 1.

Table 1. Clinical Measure Minimum Data Requirements and Small Facility Adjuster Eligibility Criteria

Clinical Measure	Minimum Data Requirement	Small Facility Adjuster
Comprehensive Kt/V	11 qualifying patients	11-25 qualifying patients
Long-term Catheter Rate	11 qualifying patients	11-25 qualifying patients
Clinical Depression Screening and Follow Up	11 qualifying patients	11-25 qualifying patients
NHSN Bloodstream Infection (BSI)	11 qualifying patients	11-25 qualifying patients
Standardized Readmission Ratio (SRR)	11 index discharges	11-41 index discharges
Standardized Hospitalization Ratio (SHR)	5 patient-years at risk	5-14 patient-years at risk
Percent Prevalent Patients Waitlisted (PPPW)	11 qualifying patients	11-25 qualifying patients
In-Center Hemodialysis Consumer Assessment of Healthcare Providers (ICH CAHPS)	Facilities with 30 or more survey-eligible patients	N/A
Standardized Transfusion Ratio (STrR)	10 patient-years at risk	10-21 patient-years at risk

1.2.2 Reporting Measure Scoring

CMS calculates ESRD QIP scores for each reporting measure by determining whether your facility reported required data in the ESRD Quality Reporting System (EQRS) and/or the National Healthcare Safety Network (NHSN) system in accordance with the requirements for the measure in question. If your facility does not meet the eligibility requirements (Table 2) for a particular reporting measure, then your facility will not be scored on that measure.

Table 2. Reporting Measure Minimum Data Requirements

Reporting Measure	Minimum Data Requirement
Hypercalcemia Reporting	11 qualifying patients
Medication Reconciliation (MedRec) Reporting	11 qualifying patients
Facility Commitment to Health Equity (FCHE) Reporting	11 qualifying patients
NHSN Dialysis Event Reporting	11 qualifying patients
NHSN COVID-19 Healthcare Personnel (HCP) Vaccination Reporting	N/A

1.2.3 Total Performance Score

In accordance with the CY 2024 Final Rule (CMS-1782-F), the minimum TPS has been set to 53 for PY 2026. For further details on the PY 2026 measures and their scoring methodology, please refer to the CMS ESRD Measures Manual for the 2024 Performance Period.

2. Preview Period and Inquiry Process

During the preview period, facilities may submit an unlimited number of inquiries about how the system calculates measure results. If your facility believes an error has been made regarding the calculations or data used for your facility's results, your facility can also submit inquiries on this topic. Facilities are required to use the ESRD Quality Reporting System (EQRS) at https://eqrs.cms.gov/globalapp/ to submit all inquiries.

Each facility should designate one person as the ESRD QIP facility point of contact (POC) who can submit and respond to inquiries and request patient-level data. If you wish to submit an inquiry or request patient-level data but do not see the options to do so, you may not have the appropriate permission as a facility POC. If you cannot identify your facility's POC, please contact the QualityNet ESRD Help Desk at qnetsupport-esrd@cms.hhs.gov or submit questions through the QualityNet Q&A Tool. Please provide your facility's CMS Certification number (CCN) when contacting the Help Desk.

2.1 Submitting an Inquiry

Throughout the preview period, facilities have the opportunity to submit inquiries regarding their facility results. Inquiries can include specific questions about how a measure is calculated. Facilities can also submit an inquiry if a systemic error regarding the way the system calculates facility results is identified. If your facility believes it has identified an error specific to your facility, your facility's POC may also indicate this in an inquiry. This type of inquiry should include specific evidence or an explanation of why your facility believes a calculation error occurred. CMS will address all inquiries prior to finalizing all PY 2026 reports. Please note that CMS will respond to inquiries via EQRS.

2.2 Patient-Level Data

A review of the list of patients with Medicare claims data or EQRS data included in facility calculations may need to be conducted before submitting an inquiry. Each facility has access to the Preview Patient List Report (PLR). This report provides a listing of patient names and health care IDs, and the patient information for lab values, index discharges, hospital readmissions, numerators, denominators, and other patient-level data pertaining to each measure and associated with your facility.

2.3 After the Preview Period

In late 2025, a Final PSR will be accessible to each facility. The Final PSR will display the results of the PY 2026 ESRD QIP and will reflect the results shown in the Preview PSR. However, if any inquiries during the preview period resulted in approved changes by CMS, these modifications will be reflected in the Final PSR. In late 2025, the PSC will be made available. Each facility must download and print its English and Spanish PSC. Even if a facility did not receive a TPS, each ESRD QIP-eligible facility must post both of its PSCs in a prominent area for the duration of CY 2026.

3. Contents of the Performance Score Report

3.1 Definition of Terms

The following terms and processes are used for scoring purposes. For the PY 2026 ESRD QIP, the Improvement Period is CY 2023 or 1/1/2023 – 12/31/2023, and the Performance Period is CY 2024 or 1/1/2024 – 12/31/2024.

Achievement Threshold: The national Achievement Threshold is the 15th percentile of performance rates nationally during CY 2022

Benchmark: The national Benchmark is the 90th percentile of performance rates nationally during CY 2022

Improvement Score: Compares your facility's performance on a measure during the performance period (CY 2024) to its own performance during the baseline period (CY 2023). An Improvement Score is provided if your facility's Performance Period Rate/Ratio meets the following criteria:

- Your facility's Performance Period Rate/Ratio does not exceed your facility's Improvement Period Rate/Ratio
- Your facility's Performance Period Rate/Ratio does not meet the Benchmark

The Improvement Score is determined by the following equation, and then rounded:

10 x [(Performance Period Rate/Ratio – Improvement Period Rate/Ratio) ÷ (Benchmark – Improvement Period Rate/Ratio)] – 0.5

Achievement Score: Compares your facility's performance on a measure during the performance period (CY 2024) to the performance of all facilities nationally during the comparison period (CY 2022). If your facility's Performance Rate meets or exceeds the Benchmark, then 10 points are awarded for the Achievement Score. If your facility's Performance Rate does not exceed the Achievement Threshold (or falls below the Achievement Threshold where lower rates/ratios are better), then 0 points are awarded for the Achievement Score. An Achievement Score is calculated if your facility's Performance Period Rate/Ratio does not meet or exceed the Benchmark.

The Achievement Score is determined by the following equation, and then rounded:

9 x [(Performance Period Rate/Ratio – Achievement Threshold) ÷ (Benchmark – Achievement Threshold)] + 0.5

Measure Score: Your facility's score for each measure is the higher of either the Improvement or Achievement Score.

For the ICH CAHPS measure, the measure score is determined by averaging the individual scores of the composite items.

Measure Weight (% of Domain): Each measure has an assigned measure weight within each domain, with the total weight of each domain summing to 100% (Table 3). If your facility is not eligible for a measure, the weight of the measure will be equally redistributed to the remaining measures within the domain. In order to receive a TPS, your facility must be eligible for two of the five domains.

Table 3. Measure Weights by Domain

Domain	Measure	Weight (Within Domain)
Clinical Care	Kt/V Comprehensive	31.43%
	Long-term Catheter Rate	34.29%
	STrR	34.29%
Care Coordination	SHR	30.00%
	SRR	30.00%
	PPPW	20.00%
	Clinical Depression Screening and Follow-up	20.00%
Safety	NHSN BSI	100%
Patient and Family Engagement	ICH-CAHPS	100%
Reporting	Hypercalcemia	20.00%
	FCHE	20.00%
	MedRec	20.00%
	NHSN Dialysis Event	20.00%
	COVID-19 HCP Vaccination	20.00%

Eligible Measures/Measure Topics: The number of eligible measures or measure topic for the domain, based on the specified eligibility criteria.

Weighted Domain Score: The weighted domain score for your facility, based on the measure scores and measure weights.

3.2 Clinical Care Domain - Table 1 of PSR

The Clinical Care Domain comprises 35.00% of the TPS. Table 1 of the PSR displays the performance results for your facility on each of the measures and measure topics included in this domain.

The following clinical measures are included in the Clinical Care Domain:

- Standardized Transfusion Ratio (STrR)
- Kt/V Comprehensive
- Long-term Catheter Rate (LTC)

For each measure in the Clinical Care Domain, facilities must meet the minimum case requirements in order to receive a score (see section 1.2.1). When an eligible facility does not meet the minimum eligibility criteria for a measure, no score is calculated for the Improvement or Performance Period rate/ratio fields. If the small facility adjustment is

applied, the adjusted value will be noted in Performance Period Rate/Ratio cell with an indication ([s]). It is possible for your facility to have enough patients to calculate one measure but not others. A dash(-) within the table indicates that your facility was not eligible to receive a score on the measure, while "N/A" indicates that the value is not applicable to the measure or measure topic score calculation.

Specific inclusion criteria for each measure are described in the CMS ESRD Measures Manual for the 2024 Performance Period. The overall calculation process and the details of the content of each cell in the PSR for the Clinical Care Domain measures are described in Table 4.

Table 4. Clinical Care Domain Measure Specifications

Measure	Numerator	Denominator	Rate/Ratio
Kt/V Comprehensive	Number of patient months in the Kt/V Comprehensive denominator for patients whose delivered dose of dialysis met the following specified thresholds: • Hemodialysis (all ages): spKt/V ≥ 1.2 (calculated from the last measurement of the month using UKM or Daugirdas II) • Peritoneal dialysis (pediatric <18 years): Kt/V ≥ 1.8 (dialytic + residual, measured within the past 6 months) Peritoneal dialysis (adult ≥ 18 years): Kt/V ≥ 1.7 (dialytic + residual, measured within the past 4 months)	The number of patient-months that meet the Kt/V Comprehensive inclusion criteria at your facility.	The percentage of all patient-months for patients whose delivered dose of dialysis (either hemodialysis or peritoneal dialysis) met the specified threshold.
Long-term Catheter Rate	The number of adult patient-months that meet the Catheter denominator inclusion criteria where patient is on maintenance hemodialysis using a catheter continuously for three months or longer as of the last hemodialysis session of the reporting month.	The number of patient-months that meet the Catheter inclusion criteria at your facility.	The percentage of adult hemodialysis patient-months where a patient with a catheter continuously for three months or longer for vascular access.
Standardized Transfusion Ratio	The number of eligible observed red blood cell transfusion events.	The number of eligible red blood cell transfusion events that would be expected among patients at a facility during the reporting period, given the patient mix at the facility.	The ratio of the number of observed over the number of expected eligible red blood cell transfusion events.

3.3 Care Coordination Domain - Table 2 of PSR

The Care Coordination Domain comprises 30.00% of the TPS. Table 2 of the PSR displays the performance results for your facility on each of the measures included in this domain.

The following clinical measures are included in the Care Coordination Domain:

- Percentage of Prevalent Patients Waitlisted (PPPW)
- Standardized Hospitalization Ratio (SHR)
- Standardized Readmission Ratio (SRR)
- Clinical Depression Screening and Follow-up

In order to receive a score for the measurement period for the PPPW measure and the Clinical Depression Screening and Follow-up measure, facilities need to have 11 patients who fulfill the patient eligibility criteria. For the SHR measure, facilities must have a minimum of 5 patient-years at risk that meet the eligibility criteria, while the SRR measure requires facilities to have at least 11 eligible index discharges in each measurement period.

When an eligible facility does not meet the minimum eligibility criteria for a measure, no score is calculated for the Improvement or Performance Period rate fields. If the small facility adjustment is applied the adjusted value will be noted in Performance Period Rate cell with an indication ([s]). It is possible for your facility to have enough patients to calculate one measure but not others. If the measure score has the following indication ([c]), it notes that it is a measure topic score that was derived from aggregating the individual measure scores for that topic. A dash (-) within the table indicates that your facility was not eligible to receive a score on the measure, while an "N/A" indicates that the value is not applicable to the measure or measure topic score calculation.

Specific inclusion criteria for the measures are described in the CMS ESRD Measures Manual for the 2024 Performance Period. Beginning with PY 2024, the Standardized Hospitalization Ratio (SHR) and the Standardized Readmission Ratio (SRR) clinical measures are expressed as rates instead of ratios. The overall calculation process and the details of the content of each cell in the PSR for the Care Coordination Domain measures are described in Table 5.

Table 5. Care Coordination Domain Measure Specifications

Measure	Numerator	Denominator	Rate
Percentage of Prevalent Patients Waitlisted	Number of patient-months in which the patient at the dialysis facility is on the kidney or kidney-pancreas waitlist as of the last day of each month during the performance period.	All patient-months for patients who are under the age of 75 on the last day of each month and are assigned to the dialysis facility according to each patient's treatment history as of the last day of each month during the reporting year.	Percentage of patients at each dialysis facility who were on the kidney or kidney-pancreas transplant waitlist averaged across patients prevalent on the last day of each month during the performance period.

Measure	Numerator	Denominator	Rate
Standardized Hospitalization Ratio	The number of inpatient hospital admissions among eligible patients at your facility.	The number of hospital admissions that would be expected among eligible patients at a facility, given the patient mix at your facility.	The ratio of number of observed hospitalizations to the number of eligible hospitalizations that would be expected from a predictive model that accounts for patient characteristics within your facility**.** The ratio is expressed as a risk-standardized rate by multiplying the facility standardized hospitalization ratio by the national average hospitalization rate. For this measure, a lower rate indicates better performance.
Standardized Readmission Ratio	The observed number of unplanned 30-day hospital readmissions at your facility.	The expected number of unplanned 30-day hospital readmissions at your facility, which is derived from a model that accounts for patient characteristics, the dialysis facility to which the patient is discharged and the discharging acute care or critical access hospital involved.	The number of observed unplanned 30-day hospital readmissions divided by the risk-adjusted expected number of hospital 30-day readmissions. The ratio is expressed as a risk-standardized rate by multiplying the facility standardized readmission ratio by the national average readmission rate. For this measure, a lower rate indicates better performance.
Clinical Depression Screening and Follow-up	The number of eligible patients for which your facility successfully reported one of the four conditions in EQRS once before the close of the EQRS clinical month of December in the performance period.	The number of eligible patients at your facility, based on patient age and treatment length.	The percentage of eligible patients for which a facility reports in EQRS one of four conditions related to clinical depression screening and follow-up before the close of the clinical month of December in EQRS.

3.4 Safety Domain - Table 3 of PSR

The Safety Domain comprises 10.00% of the TPS.

The following clinical measure is included in the Safety Domain:

- National Healthcare Safety Network (NHSN) Bloodstream Infection (BSI) Clinical Measure

For the NHSN BSI clinical measure, facilities must have at least 11 patients who meet the denominator inclusion criteria. When 0-10 patients are eligible for the NHSN BSI

clinical measure, the standardized infection ratio (SIR) is not calculated for the Improvement or Performance Period rate/ratio fields. If the small facility adjustment is applied, the adjusted value will be noted in Performance Period Rate/Ratio cell with an indication ([s]). A dash (-) within the table indicates that the facility was not eligible to receive a score on the measure, while "N/A" indicates that the value is not applicable to the measure or measure topic score calculation.

Specific inclusion criteria for the measures in the Safety Domain are described in the CMS ESRD Measures Manual for the 2024 Performance Period. The overall calculation process and the details of the content of each cell in the PSR for the Safety Domain measure is described Table 6.

Table 6. Safety Domain Measure Specifications

Measure	Numerator	Denominator	Ratio
NHSN Bloodstream Infection	The observed number of new positive blood culture events based on blood cultures drawn as an outpatient or within 1 calendar day after a hospital admission.	The expected (risk- adjusted) infections in maintenance in-center hemodialysis patients treated in the outpatient hemodialysis unit on the first 2 working days of the month.	The BSI SIR will be calculated among patients receiving hemodialysis at outpatient hemodialysis centers.

3.5 Patient and Family Engagement Domain - Table 4 of PSR

The Patient and Family Engagement Domain comprises 15.00% of the TPS. The following clinical measure is included in the Patient and Family Engagement Domain:

- In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS)

For the ICH CAHPS measure, facilities that are compliant with the ICH CAHPS reporting requirements must have at least 30 completed surveys during the spring survey period and fall survey period in order receive a score on the measure. Facilities that offer in-center hemodialysis that are not compliant with the ICH CAHPS reporting requirements and do not attest in EQRS that they are ineligible for the measure will receive a score of 0 for the measure, regardless of the number of surveys returned during the performance period. Exceptions include: (1) facilities with a CMS certification date on or after October 1 of the year prior to the performance year; and (2) facilities that do not provide in-center hemodialysis according to EQRS as of December 31 of the performance year.

It is possible for your facility to have enough patients to calculate one measure but not others. If the measure score has the following indication ([c]), it notes that it is a measure topic score that was derived from aggregating the individual measure scores for that topic. A dash (-) within the table indicates that your facility was not eligible to receive a score on the measure, while "N/A" indicates that the value is not applicable to the measure or measure topic score calculation.

The score for the ICH CAHPS measure is determined as a composite score, where the Improvement and Achievement Score is calculated for each sub-measure. The better of the Achievement or Improvement Score is assigned for each sub-measure, then the average is taken to comprise the ICH CAHPS measure score. The ICH CAHPS Topic Score includes three composite measures (Nephrologists' Communication and Caring, Quality of Dialysis Center Care and Operations, and Providing Information to Patients) and three global ratings (Overall Rating of Nephrologists, Overall Rating of Dialysis Staff, and Overall Rating of Dialysis Facility). Accordingly, there is no information for the ICH CAHPS measure presented in the first row of Table 4, except for the Measure Score. For the individual composite items, there is no numerator or denominator information available. All items not available are presented as "N/A" within the PSR.

Specific inclusion criteria for each measure in the Patient and Family Engagement Domain are described in the CMS ESRD Measures Manual for the 2024 Performance Period. The overall calculation process and the details of the content of each cell in the PSR for the Patient and Family Engagement Domain measures are described in Table 7.

Table 7. Care Coordination Domain Measure Specifications

Measure	Numerator	Denominator	Rate/Ratio
Nephrologists' Communications and Caring – ICH CAHPS composite:	*Value is not applicable to the measure/measure topic scoring calculation*	*Value is not applicable to the measure/measure topic scoring calculation*	The percentage of sampled patients who responded that the nephrologist and dialysis center staff "always" communicated well with them.
Quality of Dialysis Care and Operations – ICH CAHPS composite:	*Value is not applicable to the measure/measure topic scoring calculation*	*Value is not applicable to the measure/measure topic scoring calculation*	The percentage of sampled patients who responded that the nephrologist and dialysis center staff "always" operated professionally and according to expectations.
Providing Information to Patients – ICH CAHPS composite:	*Value is not applicable to the measure/measure topic scoring calculation*	*Value is not applicable to the measure/measure topic scoring calculation*	The percentage of sampled patients who responded that the nephrologist and dialysis center staff "always" provided information needed.
Overall Rating of Nephrologists – ICH CAHPS global rating:	*Value is not applicable to the measure/measure topic scoring calculation*	*Value is not applicable to the measure/measure topic scoring calculation*	The percentage of sampled patients who rated the nephrologists a 9 or 10 on the respective questions in the survey.

Measure	Numerator	Denominator	Rate/Ratio
Overall Rating of Dialysis Staff – ICH CAHPS global rating:	*Value is not applicable to the measure/measure topic scoring calculation*	*Value is not applicable to the measure/measure topic scoring calculation*	The percentage of sampled patients who rated the dialysis facility staff a 9 or 10 on the respective questions in the survey.
Overall Rating of Dialysis Facility – ICH CAHPS global rating:	*Value is not applicable to the measure/measure topic scoring calculation*	*Value is not applicable to the measure/measure topic scoring calculation*	The percentage of sampled patients who rated the dialysis facility a 9 or 10 on the respective questions in the survey.

3.6 Reporting Domain – Tables 5, 6 and 7 of PSR

The Reporting Domain comprises 10.00% of the TPS. Table 5 of the PSR displays the performance results for your facility on each of the following measures with patient-months as the unit of analysis.

- Hypercalcemia reporting measure
- Medication Reconciliation (MedRec) reporting measure

Table 6 of the PSR displays the performance results for your facility on each of the following measures with months as the unit of analysis.

- NHSN Dialysis Event reporting measure
- COVID-19 Healthcare Personnel (HCP) Vaccination reporting measure

Table 7 of the PSR displays the performance results for your facility on each of the following measures with attestation domains as the unit of analysis.

- Facility Commitment to Health Equity (FCHE) reporting measure

For the Hypercalcemia reporting measure, MedRec reporting measure, NHSN Dialysis Event reporting measure, and Facility Commitment to Health Equity reporting measure, facilities must have at least 11 patients who meet the patient eligibility criteria. It is possible for your facility to have enough patients to calculate one measure but not others. A dash (-) within the table indicates that your facility was not eligible to receive a score on the measure, while "N/A" indicates that the value is not applicable to the measure or measure topic score calculation.

Specific inclusion criteria are described in the CMS ESRD Measures Manual for the 2024 Performance Period. Table 8 displays the numerator and denominator definitions for each reporting measure.

Table 8. Reporting Measure Domain Measure Specifications

Measure	Numerator	Denominator
Hypercalcemia Reporting	The number of patient-months your facility reported non-missing total uncorrected serum or plasma calcium lab value during the performance period.	Total number of eligible patient-months for all patients assigned to a dialysis facility during the performance period.
Medication Reconciliation Reporting	Number of patient-months in the denominator for which the facility reported the following required data in EQRS: 1. Date of the medication reconciliation. 2. Type of eligible professional who completed the medication reconciliation: • physician, • nurse, • ARNP, • PA, • pharmacist, or • pharmacy technician. 3. Name of eligible professional.	Total number of eligible patient-months for all patients assigned to a dialysis facility during the performance period.
NHSN Dialysis Event Reporting	Number of months for which your facility reported NHSN Dialysis Event data to the Centers for Disease Control and Prevention (CDC).	Total number of eligible months in performance period. Extraordinary Circumstance Exception (ECE) months are not eligible, regardless of whether or not the facility reports dialysis events to NHSN.
COVID-19 HCP Vaccination Reporting	Number of months for which your facility reported the cumulative number of eligible HCP who received a complete vaccination course against SARS-CoV-2 during the performance period.	Total number of eligible months in performance period. ECE months are not eligible, regardless of whether or not the facility reports dialysis events to NHSN.
Facility Commitment to Health Equity Reporting	Number of domains of commitment to advancing health equity of which the facility completes attestations. Attestation of all elements within a domain is required in order to qualify for the measure numerator.	The denominator for each facility is 10, which represents 2 points for each of the following domains of commitment to advancing health equity: 1. Equity is a strategic priority 2. Data Collection 3. Data Analysis 4. Quality Improvement 5. Leadership Engagement

Preview Performance Score Details - Table 8 of PSR

Table 8 in the PSR displays your facility's TPS and your facility's score, state average score, and national average score for each measure and domain. Additionally, it also includes the weights applied to each measure and the score after the weights are applied. Note that if your facility is not eligible for a measure, the weight will be redistributed within the

applicable domain. The content of each cell in Table 8 as well as the other values listed on the Preview Performance Score page of the PSR are described in further detail below.

Facility Score: This column includes your facility's TPS prior to any deductions, domain score, and individual measure or measure topic score.

State Average Score: This column includes the State Average TPS prior to deductions, domain score, and individual measure or measure topic score. Note that the State Average Scores are unweighted.

National Average Score: This column includes the National Average TPS prior to deductions, domain scores, and individual measure or measure topic score. Note that the National Average Scores are unweighted.

Facility Measure Weights: This column includes the weights that are used for each measure within each measure domain.

Facility Weighted Score: This column includes the domain score and individual measure or measure topic score after applying each weight.

Minimum Total Performance Score: The minimum TPS a facility must receive in order to not receive a payment reduction. For PY 2026, the minimum TPS is 53.

Extraordinary Circumstance Exception (ECE): The ECE allows facilities to be exempt from all the requirements of the ESRD QIP clinical and reporting measures during the time that a facility was forced to close temporarily due to a natural disaster or other extraordinary circumstances. If your facility received approval for an ECE, the applicable number of months or years will be listed here.

Total Performance Score Before Applicable Deductions: The TPS that is calculated before any deductions are applied.

Reduction for Noncompliance with CMS EQRS or NHSN Validation Studies: Facilities were randomly selected to participate in the Feasibility and Pilot Validation studies. The selected facilities were required to provide CMS with the requested information within 60 days of receiving a request. Facilities that did not provide CMS with the required information within the specified time period received a 10- point deduction from their TPS. It is possible for your facility to be included in both the Feasibility and the Pilot Validation studies and therefore possible to have a total of 20 points deducted from its TPS. If your facility was selected and did not comply with the requirements, the total points deducted from the TPS will be listed.

Total Performance Score: The TPS after any applicable deductions

Total Payment Reduction: The payment reduction resulting from the TPS. The payment reduction indicates the reduction percentage that will be applied to your facility's reimbursement of all Medicare dialysis claims for services delivered during all of CY 2026.

Acronyms

BSI	Bloodstream Infection
CCN	CMS Certification Number
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
ECE	Extraordinary Circumstance Exception
ESRD QIP	End-Stage Renal Disease Quality Incentive Program
EQRS	End-Stage Renal Disease Quality Reporting System
FCHE	Facility Commitment to Health Equity
HCP	Healthcare Personnel
ICH CAHPS	In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems
MedRec	Medication Reconciliation
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
NHSN	National Healthcare Safety Network
PHE	Public Health Emergency
PLR	Patient List Report
POC	Point of Contact
PPPW	Percent of Prevalent Patients Waitlisted
PSC	Performance Score Certificate
PSR	Performance Score Reports
PY	Payment Year
SHR	Standardized Hospitalization Ratio
SRR	Standardized Readmission Ratio
STrR	Standardized Transfusion Ratio
TPS	Total Performance Score