ESRD QIP 2020 Proposed Rule

[music playing]

Aryeh Langer
Welcome to this MLN Connects video on the End-Stage Renal Disease Quality Incentive, Payment Year 2020 Proposed Rule.

Tamyra Garcia:
Welcome to this MLN Connects video on the End-Stage Renal Disease Quality Incentive, payment year 2020 proposed rule. My name is Tamyra Garcia, and I am the program and policy lead for the End-Stage Renal Disease Quality Incentive Program, also known as the ESRD QIP. Thank you for joining me this afternoon and taking the time to watch this video, the first that the ESRD QIP has offered to the public.

Today, we are going to provide an overview of the rules that CMS has proposed for Payment Year 2020 and for other years of the ESRD QIP. We'll be presenting a great deal of detail in this video, and we think that we will be able to provide a great understanding of what the rule contains and the associated facility responsibilities. The video will discuss the ESRD QIP legislative framework and the statutory authority that authorizes CMS to implement the program; proposed revisions to the Payment Year 2019 rule; proposed measures, standard scoring, and payment reduction scales for Payment Year 2020; as well as proposed programmatic changes, how to review and comment on the proposed rule, and available resources.

Many of you will want additional information, so we invite you to review the online resources identified at the end of the video and to attend one of the two call-in sessions to be held on -- in August 2016 if at all possible. Questions that remain can always be sent to the ESRD QIP mailbox at esrdqip@cms.hhs.gov.

So now, let's get to the meat of the presentation. Payment Year 2020 represents the ninth year for the ESRD QIP. The regulations proposed in Payment Year 2020 build on earlier measures and approaches in a wide variety of ways as we'll discuss. But how does the ESRD QIP fit into CMS' overall goal of improving quality via value-based purchasing? To answer this question, we are going to give you a quick overview before going into the payment year 2020 proposals as we always think it a good idea to reinforce the foundation of the program in our presentations.

On slide four, we summarize how CMS uses the value-based purchasing program to incentivize better care across health-care settings. Beneficiaries expect cost-effective, quality care, and value-based purchasing is a mechanism that CMS uses to assist us in achieving this goal. VBP promotes CMS' three-part aim for better health, better care, and smarter spending. We like to note that the ESRD QIP was CMS' first pay-for-performance program as opposed to the traditional fee-for-service reimbursement, where rather than paying facility -- dialysis facilities based on how many services were provided, Medicare now pays dialysis facilities based on how well those services help to keep patients safe and healthy.

The ESRD QIP uses the government's purchasing power through Medicare to incentivize improvements of treatments in patients with ESRD with a potential payment reduction of up to

two percent for facilities that do not meet certain standards. These incentives drive care throughout the health-care sector, not just for Medicare patients.

Slide five summarizes the six domains of quality measurement based on the National Quality Strategy. The End-Stage Renal Disease Quality Incentive Program for payment proposals for payment year 2020 adjusts five of the six national quality strategy domains. That includes safety, patient and family engagement, treatment and prevention of chronic disease, population and community health, as well as care coordination.

Now that we've touched on how the ESRD QIP fits into CMS' goals to improve quality, we're going to move onto an overview of the legislative aspects of the program. Slide seven describes the Legislative Drivers for the End-Stage Renal Disease Quality Incentive Program. The Medicare Improvements for Patients and Providers Act, or MIPPA, which is an amendment to the Social Security Act to mandate the creation of the ESRD, is what provides CMS with the authorization to implement the ESRD QIP program. The program's intent is to promote patient health by encouraging renal dialysis facilities to deliver high-quality patient care.

MIPPA does two important things. First, it provides the mechanism for establishing standards of care, and it also authorizes payment reductions for facilities failing to meet these standards. Slide eight lists the actions that MIPPA authorizes. MIPPA gives CMS the authority to establish standards by which ESRD facilities will be evaluated.

The first action is selecting measures. The ESRD QIP is required to include measures of anemia management and dialysis adequacy. The secretary may specify that the program measures also cover other important aspects of ESRD care, including patient satisfaction, iron management, bone mineral metabolism, and vascular access.

The second action is establishing performance standards that apply to individual measures. In addition, specifying the performance period for a given payment year is something that MIPPA authorizes CMS to do, developing a methodology for assessing total performance of each facility based on performance standards for measures during a performance period as well as applying an appropriate payment percentage reduction to facilities that do not meet or exceed established total performance scores. This payment reduction can range from a half of a percent up to a full two percent payment reduction. Information about the facility's performance in the ESRD QIP is contained in the performance score report or PSR, which is produced annually.

MIPPA also authorizes that CMS publicly report results through websites and facility postings on performance score certificates. Dialysis Facility Compare or DFC is another CMS program that also provides information about facility performance to the public. With the structure of the program in mind, we will now turn to how it evolves from year to year through the rule-making process.

Slide nine summarizes the rule-making process in a series of steps. By issuing a proposed rule, CMS sets out the clinical and reporting measures as well as the scoring mechanisms it wants to include in a payment year. Then, the public has a 60-day opportunity to comment on the proposal and suggest approaches it would like to see in the program. This is identified as the 60-

day comment period. In this way, facilities and the general public have an opportunity to influence and shape the rule governing each payment year. These comments are taken very seriously by CMS and have led to the postponement of implementing measures until commenters' requests were addressed, and those measures have been stronger when implemented in future years due to the input received. In this way, it is very important that stakeholders participate in the comment period and share their thoughts on how the End-Stage Renal Disease Quality Incentive Program can best serve the needs of patients with end-stage renal disease.

After the 60-day comment period is completed, CMS drafts a final rule, which, again, addresses the public's comments, and publishes a final rule in the federal register. Slide 10 summarizes the scoring of facility performance, which speaks to the CMS preview period. We think it's also important to understand how CMS gathers and uses facility information to calculate performance rate and scores for the ESRD QIP measures. Many facilities and other stakeholders often wonder what the reason is for the delay between the performance period, where the facility data comes from, and the impact on payment, which is associated with the payment year. The main reason for this delay is the reliance on Medicare reimbursement claims for a lot of the data that are needed to calculate ESRD total performance scores.

As we move to other data sources, this delay will not be as long, and will not be as dependent on claims data. That said, the preview period is truly a statutory requirement, and facilities will always have an opportunity to review and formally inquire about their scores before they are finalized. After the 30-day preview period, CMS adjusts scores where required for the purposes of developing a final file for the Center for Medicare. After final scores are calculated, they are released, and a final performance score report for facilities and in the performance score certificate to be posted in facilities for patients to see.

Next, we will move onto discussing proposed revisions, specifically for payment year 2019 associated with the proposed rule for payment year 2020. This portion of our discussion will review the details of the proposed rule itself. We'd like to call your attention to the disclaimer at the bottom of this screen on slide 11, which also appears at the beginning of each section that delves into the proposal. It's important to note that these elements are not finalized, and so this material is subject to change—a significant amount of change if previous comment periods serve as indication. Let me also mention that CMS is interested, again, in obtaining your comments and feedback on any element of the proposed rule and on the ESRD QIP generally, so we encourage to use the comment period and the methods we'll outline later in this presentation to share your opinions and concerns.

Now, we will take a look at the measures, old and new, that we propose to use in Payment Year 2019, and we'll begin with the significant change proposed for the Payment 2019 program and the Payment Year 2020 proposed rule. Slide 12 provides us with an overview of the Payment 2019 proposed revisions. Although the Payment Year 2019 measures and scoring methodology were finalized last year, CMS is looking to propose a significant modification. Instead of the National Healthcare Safety Network, bloodstream infection clinical measure being a part of the clinical measure domain, CMS intends to create a new safety measure domain combining the NHS/NBSI clinical measure already in effect with the reintroduced reporting measure on the

same topic.

We'll discuss this a bit more further along in the presentation, but in this graphic, we wanted to point out the impact that that change would have on the makeup of the measure as well as the measure domains overall. By removing the NHS/NBSI clinical measure from the clinical measure domain, we reduced the number of subdomains to two. We altered the weighting among those subdomains to come up with the clinical measure domain score and reassign a total performance score weight to the revised clinical measure domain. That clinical score weight is currently 75 percent, decreased 15 percent from the previous 90 percent finalized in past rules.

Under this proposal, the new safety measure domain would provide 15 percent of the TPS, and the reporting measure domain would remain the same, providing the remaining 10 percent of the score. So, now that we've summarized the change in weighting that resulted from this new safety measure domain, we're going to delve into the reporting measure that we've proposed to reintroduce.

In taking a look at slide 13, we'd like to discuss, in a general sense, the NHSN Dialysis Event Reporting Measure. ESRD QIP reporting measures enable CMS to gather important data that can later be used to score future clinical measures. CMS established the NHSN dialysis event reporting measure for Payment Year 2014 to gather such data about infections occurring during dialysis treatment. CMS discontinued the reporting measure in Payment Year 2016 in favor of implementing a clinical measure that assesses facility performance as opposed to a facility's ability to report on the measure.

For Payment Year 2019, we propose to reintroduce the NHSN dialysis event reporting measure as established for Payment Year 2015 while retaining also the clinical measure to continue to assess facility performance. Our goal is twofold: to reward high performance and to also reward accurate reporting. It's important to do both of these because infections are a leading cause of preventable mortality and morbidity across different settings in the health-care sector, especially in the dialysis sector. Reducing infections among patients with ESRD will support national goals for patient safety that we all agree are necessary and needed in order to optimize the patient experience and health outcomes amongst end-stage renal disease patients.

At the same time, complete and accurate reporting is critical to maintaining the integrity of the NHSN surveillance system. It enables facilities to implement their own quality improvement initiatives, and it also enables the Centers for Disease Control and Prevention to design and disseminate prevention strategies. Feedback from stakeholders as well as independent analyses have shown that facilities do not always report the full 12 months of data. In addition, facilities may not always report on all events. CMS believes that the reintroduction of the reporting measure along with the proposed enhancement to our validation process for the NHSN that we'll discuss later in the presentation will address both types of underreporting. This approach is better than replacing the clinical measure with the reporting measure because it retains the incentives of high performance.

In moving along to slide 14, we'll discuss in further detail the establishment of the NHSN BSI Measure Topic and Safety Measure Domain. Introducing this measure topic provides a way to

align the incentives for reporting and the incentives for high performance, as stated previously. Facilities will receive more credit in the reporting measure for reporting more months of data and more credit in the clinical measure for higher performance. The two measures are weighted individually to comprise 100 percent of the measure topic and the safety measure domain, as we will demonstrate in a couple of minutes when illustrating the scoring calculations.

Slide 15 provides information on calculating the total performance score. CMS continues to use a 100-point scale for the total performance score as well as the requirement that a facility needs a score on at least one measure in each category in order to receive a total performance score. With the addition of the safety measure domain, we propose adjusting the calculation to apply, again, a 15 percent weighting to the new domain. That reduces the weight of the clinical measure domain to 75 percent from previously 90 percent. We propose keeping the reporting measure domain constant at 10 percent. Likewise, this proposal alters the subdomain-based weighting structure for clinical measures, which is a little more involved. So, we want to take a couple of minutes to illustrate how the proposed overall composition of measures would be calculated.

But while we're on this topic, CMS would like to note that the requirements for the total performance score eligibility have been modified slightly. A facility that is only eligible to receive a total performance score if it receives a score on at least one measure in the reporting measure domain and at least one measure in the clinical measure domain -- with this proposal, CMS would like to clarify that a facility that is only eligible for one or both of the safety domain measures will not be eligible to receive a total performance score or a payment reduction.

Over the next few slides, we will use hypothetical facility A's scores on payment year 2019 measures to illustrate how these scores are used to create the three domain scores for the total performance score. Please reference the left-hand side of slide 16 to see a list of each measure or measure topic score along with hypothetical facility A's scores. On the right-hand side, we have the formulas for the two remaining clinical subdomains with the weight for each score represented as its portion of the subdomain score. In this example, the facility qualifies for a score on each of the measures.

With the proposed move of the NHSN BSI clinical measure to its own safety measure domain, the number of measures in the clinical measure domain has decreased and the weight of the remaining measures are increased accordingly. The arrow illustrates where each clinical measure score will be used in the formulas. The weight of the subdomains and the weight of the individual measures within those subdomains were selected according to 1) the number of measures in the subdomain and 2) facility experience with the measures.

Lastly, how closely the measures align with CMS' priorities for quality improvement -- as you can see, Facility A has performed quite well on the clinical measures. On slide 17, we discuss specifically how to calculate the safety measure domain score. Here, we demonstrate where the clinical measure makes up 60 percent of the measure score and the reporting measure makes up the remaining 40 percent. Our fictitious Facility A has also scored quite well on both of the measures, reporting and clinical, for the safety measure domain score as well and earned a domain score of 94.

Now that we've taken a look at the clinical and safety measure domain scores, we're going to reference slide 18 to look at the reporting measure domain score. CMS proposes to apply equal weight to each of the five reporting measure scores. Again, facility A has performed quite well here, as well, and earned a domain score of 92. This domain makeup and weighting remains unchanged from methodology described and finalized in the Payment Year 2019 rule issued last November.

To conclude our illustration on slide 19, we see how the proposed clinical reporting and safety domain scores translate into a total performance score. Facility A's strong performance results in a very high total performance score of 94. The next two tables found on slides 20 and 21 list the projected achievement thresholds, benchmarks, and performance standards for calculating clinical measure scores via the achievement method for Payment Year 2019. These performance standards are based on currently available data and are subject to change.

Data used to calculate these estimated values may be found in the ESRD QIP payment year 2020 proposed rule data file, which has been posted on the public reporting and certificates page of the ESRD QIP section of CMS.gov. We're still compiling the complete years' worth of data from claims, CROWNWeb, and elsewhere. These values will be finalized after all data for 2015 national performance has been calculated, and those finalized values will be published in the Payment Year 2020 final rule this November.

Slide 22 summarizes the proposed scoring and payment reduction methodology discussed in previous slides for Payment Year 2019. Now that we've learned a bit about the estimated values, we can also estimate the minimum total performance score for Payment Year 2019 to be 59 points. As with the estimated clinical measure values, the minimum total performance score is yet to be finalized and is subject to change. This illustration provides a summary graphical interpretation of how facilities will be scored, how those scores will translate into a total performance score, and whether a payment reduction will be applied.

It includes information on the measures as seen in the colored boxes, the clinical measure subdomains, the subdomain weights, relevant calculations, and the scale for the payment reduction where applicable, which ranges from a half-percent reduction up to a two percent reduction, and as we've done throughout the presentation, we've indicated new measures with a gold star. Here, we see that the KT over B dialysis adequacy measure is a new measure for Payment Year 2019.

Next, we are going to move on to proposed measures for the Payment Year 2020 ESRD QIP year. This portion of our discussion will review details associated with Payment Year 2020 itself. Again, please recall that these elements are not finalized, and so this material is subject to change via the note included on slide 23.

Slide 24 provides an overview of the Payment Year 2020 proposed measures. Just as we did for Payment Year 2019, we present this illustration truly as an overview with respect to the proposed structure for this payment year. Instead of the NHSN BSI clinical measure being a part of the clinical measure domain, we intend to create a new safety measure domain combining the NHSI

and BSI clinical measure already in effect with the reintroduced reporting measure, as we discussed in Payment Year 2019. As you can see, we're also looking to propose a new outcome-based clinical measure, the standardized hospitalization ratio measure. We propose to add this along with two new reporting measures, as well -- serum phosphorus and ultrafiltration rate.

Slide 25 provides details on the proposed standardized hospitalization ratio clinical measure, which was previously proposed for adoption in Payment Year 2014. We subsequently decided not finalize the measure due to comments raised about the risk adjustment methodology during the comment period and the potential detrimental effects on access for patients with significant comorbidities. The version of the standardized hospitalization ratio measure that CMS proposes for Payment Year 2020 addresses commenters concerns because the risk adjustment methodology uses comorbidity data from claims instead of relying solely on data from CMS' medical evidence form 2728.

Now that we've discussed the proposed measures for Payment Year 2020, let's take a look at slide 26 for a few terms with specific definitions in the scoring context. Here, we see definitions for the achievement threshold, benchmark, improvement threshold, performance standards, and performance rate. Note the performance standard is not used in scoring any individual measure but is critical in determining whether or not a facility will be subject to a payment reduction because it is used to calculate the minimum TPS that we discussed previously.

Please note also that the performance period for the NHSN health-care personnel influence of vaccination reporting measure is not a calendar year measure but rather associated with the flu season, spanning from October 2016 through March 2017.

Slide 27 provides information on the general approach that CMS uses to score clinical measures, which has been in place since 2014. CMS uses the better of two results associated with an achievement score or an improvement score as a facility score for a given measure. The achievement method compares the facility's 2018 performance to the performance of all facilities during 2016. The improvement method compares the facility's 2018 performance to its own performance during 2017 or the previous year. That previous year performance rate is the facilities improvement threshold -- the rate at which a facility can begin to earn points on the measure using that method. And this way, a facility can increase its score if it shows an improvement over its previous performance while it strives to reach the national average associated with the achievement method.

CMS favors achievement over improvement, which is why a facility can achieve up to 10 points using the achievement method, but the maximum amount of points a facility can use via the improvement method is nine points.

Now that we've learned a bit more about the methods that CMS uses for scoring, we'd also like to talk about clinical methods with respect to directionality. It's important to understand that in the context of the ESRD QIP, bigger isn't always better. In slide 28, we take a look at this in the context of the measures listed at the top of the slide and measures listed at the bottom of the slide. The measures listed at the top of the slide -- a higher rate indicates better care. A higher rate of dialysis adequacy is a great outcome for patients. Likewise, the use of fistulas tend to

reduce infections, so our larger patient population having that method of vascular access is similarly positive.

For measures listed at the bottom of the slide, including vascular access, NHSN bloodstream infection, hypercalcemia, a lower rate indicates better care. For example, catheters are not always an ideal method of vascular access for most patients. So, this number should be smaller in many cases, and CMS wants to prevent hypercalcemia and reduce incidence of infection, hospitalization, and transfusion, so we expect those rates to be small as well.

Different directionalities may exist even within a measure topic with regard to vascular access type. An 80 percent rate on the fistula measure would be a favorable outcome, but an 80 percent rate on the catheter measure would be quite unfavorable.

On slide 29, CMS proposes to replace the existing mineral metabolism reporting measure with the serum phosphorus measure, which uses the specifications for NQF 0255 entitled "Measurement of Serum Phosphorus." For the ultrafiltration measure, please note that facilities are required to report data for all hemodialysis sessions during the week of the monthly KT over B draw submitted to CROWNWeb for that clinical month.

We've discussed in totality the clinical and reporting measures for Payment Year 2020. Now that you all have that information, we'd like to provide additional information on the proposed scoring methodology for the payment year. Slide 31 provides information on how we're looking to calculate the total performance score. The proposed total performance score calculation for Payment Year 2020 is very similar to what we discussed earlier for Payment Year 2019. We propose applying an 80 percent weighting to the clinical measure domain for Payment Year 2020, up from 75 percent in Payment Year 2019 with the remaining split evenly between the other two domains, reporting, and safety. Also, the requirements for the total performance score eligibility proposed for Payment Year 2019 continues for Payment Year 2020. With that in mind, we'd like to illustrate how the proposed overall composition of measures will be calculated.

In slide 32, we'll use a similar approach, just as we did for payment year 2019 using a hypothetical facility to illustrate how scores are used to create the three domain scores and the total performance score for Payment Year 2020. As before, we see a list of hypothetical scores as well as the clinical measures and measure domains on the left side of the slide. We have the formulas for the two subdomains along with the weight for each score represented as its portion of the subdomain score.

In this example, the facility, again, qualifies for a score on each of the measures. The arrows illustrate where each clinical measure score will be used in the formulas, and once again, Facility A has performed quite well.

Slide 33 provides information on how the safety domain score is calculated, and that is essentially unchanged from Payment Year 2019 with the clinical measure that assesses performance making up 60 percent of the measure topic and the reporting measure, which assesses the facility's ability to report, providing the remaining 40 percent. In calculating the

reporting measure domain school, on slide 34 we see that CMS again proposes to apply an equal weight to each of the six reporting measures. Again, facility A has performed quite well here, as well, and earned a reporting domain score of 90.

In calculating the total performance score, we can take a look at slide 35 and see how the proposed domain scores—reporting, clinical, and safety—translate into a total performance score of 92. Facility A performed very well on the ESRD QIP.

Now that we've taken a look at how the scores are calculated for the hypothetical total performance score, we're going to take a look at calculating the minimum total performance score for Payment Year 2020. The method CMS proposes to use to calculate the minimum total performance score can be seen on slide 36 and is similar to that of earlier payment years. Because the comparison period for determining the national performance standard is currently underway, CMS cannot estimate the minimum total performance score at this time. As we've done in previous years, we expect to estimate the Payment Year 2020 minimum total performance score during next years' rule-making process and finalize that value in next year's final rule.

Slide 37 provides information on the payment reduction scale that CMS will use to evaluate a facility's total performance score in comparison to the minimum total performance score. The proposed rule continues the overall payment reduction scale CMS has employed for several years now, and the scale is segmented into 10-point increments capped at a two percent maximum reduction.

Now that we've discussed the minimum total performance score for Payment Year 2020 as well as the payment reduction scale that CMS proposes to implement, we're going to take a look at slide 38 for an illustration that provides a summary graphical interpretation of how facilities will be scored, how those scores will translate into a TPS for Payment Year 2020 as well as whether or not a payment reduction will be applied. We saw a similar illustration for payment year 2019, and this illustration has been updated to reflect the proposals for Payment Year 2020. It includes measures, clinical measure domains, subdomain weights, relevant calculations, and the scale for the payment reductions where applicable, and as we've done throughout this presentation, we've indicated new measures with a gold star. Here, we see that the standardized hospitalization ratio and the clinical measure domain is highlighted, and we see the two reporting measures, serum phosphorus and ultrafiltration rate, that are proposed have been highlighted, as well.

Now that we've discussed the proposed measure changes and proposed policy changes for Payment Years 2019 and Payment Year 2020, we're looking to move on to proposed programmatic changes to demonstrate some of the aspects of the ESRD QIP that we wish to refine and improve as we go along.

Slide 40 summarizes our proposal to modify the hypercalcemia clinical measure in response to public comments. Commenters expressed their desire to report plasma as opposed to serum calcium values for this measure, and this change makes that possible. Additionally, commenters expressed concerns that facilities may underreport data if no values were excluded from the measure calculations. The second change that we're proposing to this measure effectively

penalizes facilities for non-reporting because no values apply to the numerator and the denominator alike for the hypercalcemia clinical measure.

The second proposal that we'd like to discuss with you all is really an improvement upon the validation work for CROWNWeb data. CMS remains committed to making sure that the data it uses to score facility performance is as accurate as possible. Slide 41 describes how the proposed rule furthers this effort by continuing in Payment Year 2019, the studies performed in previous years. CMS proposed applying a significant total performance score deduction for facilities failing to respond to requests for information used to support these validation efforts. That first validation study involves data from facilities that enter data into CROWNWeb.

Finally, CMS would like to discuss our desire to improve the validation work for the NHSN data as discussed previously. In slide 42, CMS discusses how we are committed to encouraging a reduction in payment patient infections. This commitment is reflected in measures of vascular access types and the proposed safety domain that we discussed previously in the presentation.

The NHSN data validation activities described here are really proposing that we use this validation study to sample candidate events as in the previous year, but it will also involve a random sampling of facility records to accompany those candidate events. This methodological enhancement will provide additional insights into facility underreporting of dialysis events for the purposes of quality improvement. Additionally, please note that CMS is proposing to increase the sample size for the study from nine facilities currently in its pilot form to 35 facilities.

Now that CMS has discussed the additional policies that we'd like to implement for the ESRD QIP program, we'd like to discuss how you can participate effectively in the comment period. Slide 44 stresses that your comments matter. The process of creating and implementing federal regulations includes a period in which the public may provide and put on the proposed rules. In past years, the comments that CMS received helped shape the final rules, as demonstrated in some of the changes that we've made to the standardized hospitalization ratio measure among other policies being proposed by CMS for this payment year.

As an example, the Payment Year 2015 proposed rule included hypercalcemia as a clinical measure, but CMS changed course in the final rule due to the feedback it received as a part of the comment process. The hypercalcemia finalized for Payment Year 2016 was written in part to address the issues that commenters raised that year; therefore, your participation in this process is essential in creating the best possible program for measuring facility performance and providing quality care to the ESRD population. Again, please note that the comment period will end 11:59 p.m. Eastern Time on August 23, 2016.

In slide 45, CMS has provided a chart to help you navigate your way around the pretty lengthy proposal and to provide specific details on the proposal more easily. This is offered to assist you in reviewing and commenting on the rule. Please do read the proposed rule in its entirety to ensure you have all the information needed to submit a comment.

Slide 46 provides you with information on how to comment on the proposed rule. We believe

the most convenient way to submit a comment is online via regulations.gov. A screenshot has been provided here so that you can use that search box to navigate to the rule and the comment portion of the rule. We were able to use several search terms to successfully return the proposed rule, including the file number as pictured above, 1651-P, and calendar year 2017 ESRD PPS, which is a part of the proposed rule's formal title.

Slide 47 provides a screenshot of our search results using the file number stated previously. You may use the "comment now" button to submit your comment after thoroughly reading the proposed rule. This slide also identifies some resources for additional help using the system if you run into trouble.

Slide 48 provides additional guidance on submitting a comment. You can upload files as a part of your comment. On this comment form, you will be asked about your state, zip code, country, and your category, which indicates whether you're submitting as an individual, health-care professional, or the like. You must also disclose whether you are submitting the comment on behalf of a third party as well as that organization's name.

CMS would also like to note that if you do not have access to an online interface, you may also submit your comments via hand delivery at D.C. and Baltimore office locations. You may also mail your comments into these locations, as well. More information on how to do this can be found at the very beginning of the proposed rule. Please be sure, however, to allow time for transit and delivery to prevent any delays.

August 16 is an important date that CMS would like you to remember, as indicated on slide 50. In the past, CMS conducted national provider calls to present rule-making content and provide an opportunity for the stakeholder community to ask clarifying questions. This year, on August 16, CMS will conduct a call-in session via webinar along with releasing a fax sheet and publishing a video in lieu of the national provider call. CMS will publish archives of the discussions on the ESRD QIP section of CMS.gov.

Now, we are looking to conclude our presentation with an overview of the program from a timeline perspective. Slide 51 is a very important figure for the ESRD QIP program as it illustrates critical dates and milestones. As you can see, there's quite a bit of overlap in the rule-making and the scoring process. There's also a lot of activity impacting multiple payment years, which happen at the same time.

To start, let's take a look at the overarching timeline of the program. This graphic illustrates what's going on with the program currently. So, right now, we're in the midst of payment implications from the Payment Year 2016 program. The 30-day preview period for Payment Year 2017 will also begin this month on August 15 as well as the performance period, which is underway, for payment year 2018 as of January 1. Finally, we've released the proposed rules for Payment Year 2020 and the 60-day comment period, which has been the topic of our discussion today. Again, the comment period closes on August 23, 2016. In this way, the ESRD QIP can be seen as a series of multiyear programs occurring simultaneously.

Finally, on slide 52, we've provided a list of some useful content about the program that is

available online, including a link on MIPPA, the ESRD QIP section of CMS.gov, the ESRD Network Coordinating Center, QualityNet, Dialysis Facility Compare, and the proposed rule itself. Slide 53 captures what is currently going on with the program as we speak. First, CMS asks that you participate in the August 16 call-in session. We also ask that you comment on the Payment Year 2020 proposed rules by August 23 at 11:59 p.m. Eastern Time. We ask that you review the Payment Year 2017 preview performance score report and submit any clarification questions or formal inquiries by September 16, 2016 at 5:00 p.m. Eastern Time. We also ask that you read the Payment Year 2020 final rule when posted in early November, that you review the final performance score report when available in mid-December of this year, and that you also post your final score performance score certificates in both English and Spanish when available.

CMS appreciates your cooperation and inputs along the way. We all need to work together to make the ESRD QIP a success and are looking forward to collaborating with you all now and in the future.

[music playing]

Aryeh Langer
Thank you for viewing this presentation. The information presented was correct as of the date it was recorded. This presentation is not a legal document. Official Medicare program legal guidance is contained in the relevant statutes, regulations, and rulings.

[music playing]

[end of transcript]