



# ESRD Quality Incentive Program: CY 2020 ESRD PPS Proposed Rule Call


**Moderated by: Charlie Eleftheriou**  
**August 20, 2019 2:00 pm ET**

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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Charlie Eleftheriou. Thank you. You may begin.

## Announcements & Introduction

Charlie Eleftheriou: Good afternoon. I'm Charlie Eleftheriou from the Provider Communications Group here at CMS, and I'm your moderator today. I'd like to welcome you to this Medicare Learning Network call on the End-Stage Renal Disease Quality Incentive Program or ESRD QIP. During today's call, you'll learn about proposals for the ESRD QIP in the calendar year 2020 ESRD Prospective Payment System, or PPS proposed rule. Before we get started, you received a link to the presentation in your confirmation email. The presentation is also available at the following URL, [go.cms.gov/npc](https://go.cms.gov/npc) as in National Provider Call; again, that URL is [go.cms.gov/npc](https://go.cms.gov/npc).

Today's event is not intended for the press and the remarks are not considered on the record. If you're a member of the press, you're welcome to listen in. If you have inquiries, contact [press@cms.hhs.gov](mailto:press@cms.hhs.gov). Please note, this call will not include a question and answer session.

At this time, I'd like to turn the call over to Dr. Delia Houseal, the ESRD QIP Program Lead in the Division of Value, Incentives, and Quality Reporting here at CMS. Delia?


## Presentation

Dr. Delia Houseal: Thank you Charlie, and good afternoon to you all. As Charlie stated, my name is Dr. Delia Houseal and I'm the Program Lead for the End-Stage Renal Disease Quality Incentive Program, also known as ESRD QIP for short. Thanks again to all of you for joining us this afternoon and welcome to this proposed Medicare Learning Network event. As Charlie mentioned, today, I'll be providing an overview of the ESRD QIP proposals contained in the calendar year 2020 ESRD Prospective Payment System notice of proposed rulemaking.

This includes proposed policies and measures for payment years 2022 and 2023 of the ESRD QIP. By the conclusion of today's presentation, attendees should be familiar with the statutory foundations and legislative drivers that guide QIP, the CMS Meaningful Measures Initiative and its alignment to ESRD QIP, policies proposed in the calendar year 2020 ESRD PPS proposed rule, the rationale for proposed modifications and estimated impacts, how and where to view the proposed rule, and to submit comments.

And lastly, where to access additional resources about ESRD QIP. And now, let's move on to page number 4. And so, before we begin, I'd like to make certain that it's clear that the content of today's call should not be considered official CMS guidance. This webinar is only intended to provide information regarding requirements for the ESRD QIP. Please refer to the proposed rules located in the Federal Register to clarify and provide a more complete understanding of the proposals we will be discussing.

Next page, so here on slide 5, you'll see a few notes about the Administrative Procedures Act. I'd like to remind you to please note that Federal Regulations prevent us from answering any specific questions or addressing



your opinions about the proposed rule during this call. Instead, we encourage you to share your ideas and questions on the proposed rule itself by participating in the formal comment period that is now ongoing. I'll be providing a summary of the formal public comment process later in the presentation. And after the conclusion of this session, I invite you to review and visit the online resources identified at the end of the presentation.

## Introduction and ESRD QIP Overview

Okay, so let's move to some history about the ESRD QIP. So now you should be on page 7 of the presentation. Here, you'll see references to the foundational legislative drivers of the ESRD QIP which was enacted by the Medicare Improvements for Patients and Providers Act of 2018, otherwise known as MIPPA. The ESRD QIP was supplemented by language included in the Protecting Access to Medicare Act of 2014, also known as PAMA.

So, as you can see, the intent of the ESRD QIP is to promote patient health by providing a financial incentive for Renal Dialysis Facilities to deliver high-quality patient care. And to do this, CMS is authorized to apply payment reductions of up to two percent if a facility does not meet or exceed the minimum total performance score as set forth by CMS. And please move now to page 8.

On this page, we've included a summary of our statutory requirements. You'll see that ESRD QIP is responsible for selecting measures that address a variety of high-priority areas, including anemia management, dialysis adequacy, and to the extent possible patient satisfaction, management, bone mineral metabolism, and vascular access. CMS is required to establish performance standards and specify the performance period for any given payment year. We're also required to develop a methodology for assessing the total performance of each facility and apply the appropriate payment reduction for those facilities that do not meet or exceed the established minimum total performance score.

Lastly, we are required to publicly report the results through websites such as DFC or Dialysis Facility Compare and [cms.gov](https://www.cms.gov). Facilities are required to publicly post Performance Score Certificates, which we call PSCs, within 15 days of their availability. Please forward to the next slide.

So, this image on slide 9 shows a high-level overview of a rule development process for ESRD QIP. Prior to issuing the proposed rule each year, CMS uses a process to draft proposals for ESRD QIP. This drafting process includes a rigorous series of reviews within CMS, HHS, and OMB of all the policy proposals that CMS plans to include in the proposed rule.

When the proposed rule is published, we provide the public with a 60-day opportunity to submit comments on the proposals in that rule. This comment period allows facilities and the general public the opportunity to provide their feedback on the proposals included in the proposed rule. The final rule is drafted after CMS has reviewed and considered all public comments received during the 60-day comment period. This draft is also subject to CMS, HHS, and OMB review, prior to publication. I'd also like to note that the public comments are taken very seriously by CMS.

In the past, comments have led to the postponement of measures implementation, which in some instances has led to those measures being stronger and the point that they are added in future years, -at the point they are added in future years, excuse me. So, it's very important that the public participate in the comment period.



We hope that you will share your thoughts about the ESRD QIP, and also let us know how we can best serve the needs of beneficiaries who have - who receive dialysis services.

## Meaningful Measures & the ESRD QIP

Okay, so the next page here, and so now we want to take a few minutes to discuss how ESRD QIP works with a major CMS quality initiative, the Meaningful Measures Initiative.

Here on page 11, you'll see a quote from the CMS Administrator, Dr. Seema Verma. This page illustrates how CMS uses Meaningful Measures and high-impact areas to put patients first, with the context of CMS strategic goals and with the ultimate effect of high-quality care and better patient outcomes.

So, on slide 12, with the goals of quality care of patient, better patient outcomes, and reduce provider burden in mind, CMS has developed an approach that focuses on streamlining measures around high-impact areas to address the importance of balancing measurement with the administrative burden on providers. Under Meaningful Measures, CMS identifies the highest priorities for quality measurement and improvement to assess core areas that are critical to providing high-quality care and improving individual patient outcomes.


Drawn from the work completed by the National Quality Forum, the National Academy of Medicine, and the Health Care Payment Learning and Action Network, as well as feedback from stakeholders such as yourself, these high-impact areas have been incorporated into the initiative known as Meaningful Measures. The illustration here provides a general overview of the Meaningful Measures areas in each of its six quality categories. The individual areas reflect core issues that are most vital to promoting high-quality care and better patient outcomes.

You can also see that these areas include goals such as promoting effective communication and coordination of care, making care affordable, and so forth and so on. Next, we'll describe what this initiative matters to ESRD patients. So, with that, please move forward to page 13.

And so here, this slide shows two recently introduced measures that were finalized in the calendar year 2019 rule. We decided to use these as an example to illustrate the relationship between new measure proposals and the Meaningful Measures areas.

So, as you can see, the Medication Reconciliation Measure, also known as MedRec, assesses how well a facility has evaluated patients' medications. This measure is aligned with the Meaningful Measures area to make care safer and reduce harm. As we all know, ESRD patients are especially vulnerable to medication-related problems, and medication management is a critical safety area for all patients, but particularly for those patients with End-Stage Renal Disease, many of whom are prescribed 10 or more medications simultaneously.

On average, individuals with ESRD take about 17 to 25 doses of medications each day. These individuals also have a variety of comorbid conditions, generally are seen by multiple health care providers and prescribers, and frequently undergo medication changes. Lastly, we know that medication-related problems contribute significantly to the approximately 40 billion dollars in public and private funds spent annually on ESRD care in the US.



Next, you'll take a look at the percentage of prevalent patients wait listed measure, which assesses the percentage of current patients at each dialysis facilities who are on the kidney or kidney-pancreas transplant wait list. This measure allows for the Meaningful Measure areas to promote effective communication and coordination of care. This intentional alignment of ESRD QIP measures to the Meaningful Measures Initiative helps keep CMS focused on what matters most to promote the delivery of safe quality care that supports individuals who receive dialysis.

More details about each of these measures is available on the ESRD QIP technical specifications page on [cms.gov](https://www.cms.gov). We've also provided a URL at the end of this presentation to help you find those documents. Now, let's move on to the next slide.

## CY 2020 Rulemaking

So now that I provided some background on the ESRD QIP and its alignment to the Meaningful Measures Initiative, the next topics I'll be reviewing are the policies proposed in the calendar year 2020 ESRD PPS proposed rule and the rationale for proposing these modifications, and their estimated impact. Just to make certain, everyone is following along, you should now be at page 15.

Okay, so here on page 15, you should see an image that shows the measure sets, domains, and weights to be used for payment years 2022 and payment years 2023. This slide is based on the payment year --- the calendar year 2019 final rule, and you'll notice that those two new measures that we just discussed are pointed out here. Payment year 2020 is the first year for each of these measures and that means that performance period for them will begin in January of 2020.

As a reminder, a facility must be eligible to receive a score on at least 1 measure in 2 of the 4 domains to receive a total performance score in any given payment year. Each measure is assigned to 1 of the 4 domains. The 4 domain scores are weighted, combined, and the sum will provide the TP, the total performance score. The payment year 2022 and payment year 2023 measure sets are identical. This includes the measure domains and their assigned measure and weights, and so here you'll see that the Clinical Care Domain accounts for about 40% of the total performance scores, and contains the following measures: Kt/V Dialysis Adequacy-the comprehensive version, a Vascular Access, Measure Topics which includes the Standardized Fistula Rate and the Long-Term Catheter Rate. It also includes Hypercalcemia, the Standardized Transfusion Ratio measure, and the Ultrafiltration Rate reporting measure.

Next, we'll move on to the Care Coordination Domain, which accounts for 30% of the total performance score. This domain includes four measures: the Standardized Readmission Ratio, the Standardized Hospitalization Ratio, the Clinical Depression Screening and Follow-Up measures. And lastly, the Percentage of Prevalent Patients Waitlisted, and this measure is being used for the first time, as it was introduced in the calendar year 2019 ESRD PPS final rules.

The Safety Domain provides 15% of a total performance scores and it consists of 2 measures. Here, we have the CDC Bloodstream Infection measure and it also includes the CDC BSI Reporting measure, and lastly the new Medication Reconciliation measure. And again, this measure is being used for the first time, as it was introduced in the calendar year 2019 ESRD PPS final rule. Okay. And the 4th and final domain is the Patient



and Family Engagement Domain, which accounts for 15% of the TPS, and currently it includes only one measure, which is the ICH CAHPS.

So, moving on to our proposed ESRD QIP modifications, here is an overview of the proposal that we will be discussing today. We will review each one in detail to give you more information about the proposed changes, our reasons for making them, and what that means to you as stakeholders. As a brief preview, CMS is proposing to update the score methodology for the NHSN Dialysis Event reporting measure, convert the transfusion ratio clinical measure into a reporting measure, and revise the score equations for the MedRec reporting measure. We also are proposing to codify regulatory program requirements and continue data validation and payment years 2022 and beyond.

Okay. Next slide here. So, for the first proposal we'll be discussing today is an update to the score methodology for the National Healthcare Safety Network Dialysis Event reporting measure. Please note that this proposal will not affect most facilities and that it will only affect a few facilities—excuse me—that it will only affect new facilities and facilities with an improved ECE or Extraordinary Circumstance Exception. Beginning with the payment year 2022 ESRD QIP, we proposed to assess facilities based on the number of months that they were eligible to report the measure.

Under this proposal, facilities can receive credit for scoring purposes, based on the number of months they successfully report data out of the number of months they are eligible to report. If a facility is ineligible to report for all 12 months in a performance period, this proposal would now allow those facilities to receive a score based on the months they are eligible to report. Also, under this proposal, new facilities would not be required to have a CCN open day before October 1st prior to the performance year.

So, as you can see in the proposed scoring distribution on this page, a facility that reports a 100% of eligible months would be awarded 10 points and a facility reporting less than a 100% but 50% or more of eligible months would get 2 points and a facility reporting less than 50% would receive 0 points. For example, let's say a facility had 10 eligible reporting months because it was granted an ECE or an Extraordinary Circumstance Exception for 2 months of the performance period.

Under the proposal, if the facility reports data for all of the 10 eligible months, they would receive a score of 2 points, where it's under the current policy the facility would not receive a score. And I think, just to go back on that --- let me go back on that example actually, because I believe in this case, if a facility had 10 eligible reporting months because of that ECE for 2 months and they reported 10 out of those 10 eligible, they would actually receive 10 points and not 2 points, I did want to clarify that. I think I said 2 and that response should have been 10. And so just to be clear, eligible months include the months in which dialysis facilities are required to report data to NHSN, and includes facilities offering in-center hemodialysis, as well as facilities that treat at least 11 eligible patients during the performance year. Now, let's move on to page 18.

Okay, under the existing requirements, new facilities, or a facility with an ECE, are not eligible to receive a score if they are not eligible to report before 12 months reporting period. This approach is not fair to new facilities and those facilities who were closed for reasons outside of their control. So, in an effort to give facilities credit, we wanted to update our policy. The existing requirements also do not provide an incentive for these facilities to report data.



This is a very important critical topic, and we believe it's important to encourage these facilities to accurately report all of their data. We continue to believe that complete and accurate reporting of NHSN's data is critical to maintaining the integrity of the NHSN surveillance system, enables facilities to implement their own quality improvement initiatives, and enables the Centers for Disease Control and Prevention, or CDC, to design and disseminate prevention strategies. So, let's move on to our next proposal.

Proposal 2 concerns the standardized transfusion ratio, or STrR measure. Under our current final last policy, the STrR is a clinical measure. Our proposal would change STrR into a reporting measure that is based on the NQF-endorsed measure. Facility scores would be based on whether the required data was reported, rather than based on the reported values. Under this proposal, to receive the full 10 points on the STrR measure, a facility must report the data required to determine the number of eligible patient-years at risk and have a minimum of 10 patient-years at risk.

Multiple patients can be included within 1 patient year. So, if you look at the graphic in the lower right corner, you'll see patient A is a patient for 4 months and patient B is a patient for 8 months and the experience for the two of them can be combined to report 1 full patient year. Now, we will move on to discuss the rationale for proposal 2. So, as you'll see here, CMS is currently examining concerns raised by commenters to the calendar year 2019 ESRD PPS proposed rule about the measure's validity.

Commenters stated that many hospitals are no longer accurately coding blood transfusions due to the new levels of coding specifically required under ICD-10. Commenters said that because the STrR measure is calculated using hospital data, the rise of inaccurate blood transfusion coding by hospitals have negatively affected the STrR's measure validity. And so, we want to ensure that the ESRD QIP scoring methodology provides fair and reliable measure scores, because those scores are linked to total performance scores and possible payment reductions.

We believe that converting the transfusion ratio measure into a reporting measure is the most appropriate way to achieve that goal, while fulfilling the statutory requirement to include a measure of anemia management in the program.

Okay. Now, we'll take a look at proposal 3, and so, our next proposal would revise the Medication Reconciliation, or MedRec, reporting measures scoring equation to correct an error that was made in the MedRec scoring equation.

When we finalized the adoption of this measure in the calendar year 2019 ESR DPPS final rule, we finalized that MedRec reporting measures scoring equation using the term "Patient-Months". The use of this terminology was an error and instead we should have used the term "Facility-Months". So, under this proposal, the MedRec scoring equation would be calculated by taking the number of months the facility successfully reports data, divided by the number of eligible months, multiplied by 12. That figure would then subtract 2 to get a MedRec score. And next slide.

So, here we're going to talk a little bit about the rationale for this update, and so, the term "Facility-Months" assesses the proportion of months in a year that a facility reported the data necessary to calculate the measure. Facility-months are generally used when calculating scores for reporting measures that require monthly reporting and are therefore more appropriate for the use in MedRec score and equation. We note that



this proposal would correct the MedRec score and equation beginning in payment year 2022, and that year is also MedRec's first year in the ESRD QIP measure set. Next slide.

Our next proposal would codify certain program requirements. Codifying program requirements and regulation techs will make it easier for the public to locate and understand those requirements. First, we are proposing to adopt the baseline periods and performance period for each payment year automatically, by advancing each period by one year from the baseline and the performance period that were adopted during the previous payment year. We are also proposing to codify data submission requirements for calculating measure scores.

We would also codify the Extraordinary Circumstances Exception process, including a new option for facilities to reject an ECE that's granted by CMS under certain circumstances. For example, any hurricane or event that would affect a large scale or many facilities. We believe this new option will provide facilities with more flexibility under the ECE process. Okay. Next Slide.

As we said, we think that codifying these existing program requirements would make previously finalized policies more accessible to the public and would make our requirements easier to understand. We believe that these help CMS meet its goal of providing clear guidance on policies and requirements that affect its stakeholders. Okay, next slide here.

Our next proposal concerns the NHSN data validation study. As finalized in the calendar year 2019 ESRD PPS final rule, the payment year 2022 study will include a sample of 300 facilities, and each facility will be required to submit 20 patient records per quarter for the first 2 quarters of the year for a total of 40 records. We are proposing to continue using the payment year 2022 methodology for payment years 2023 and beyond. We are also proposing to adopt the NHSN validation study as a permanent feature of the End-Stage Renal Disease Quality Incentive Program. Next slide please.

Now, we'll take a look at the rationale for continuing data validation -- the NHSN data validation. The purpose of our validation program is to ensure the accuracy and completeness of data that are scored under the ESRD QIP. CMS believes that validating NHSN data using this methodology achieves that goal. A recent statistical analysis conducted by the CDC concluded that to achieve the most reliable roles for a payment year, CMS would need to review approximately 6,072 charts submitted by 303 facilities.

This sample would produce results with a 95% confidence level and a one percent margin of error. We propose to continue using the payment year 2022 study methodology and payment year 2023 and beyond, because we believe that this methodology ensures enough precision within the study and signals CMS's commitment to ensure the accuracy of data reported to NHSN. Next slide please.

In order to give you some clear guidance on policies for payment year 2023 and future payment years, let's do a quick overview for payment year 2023. To be clear, we are not proposing changes that would affect measures, which measures are used in payment year 2023. And as you saw earlier on page 8, the statute dictates that ESRD QIP must specify the performance period for each payment year. We continue to believe that 12-month performance and baseline periods provides us with sufficiently reliable quality measure data for the ESRD QIP.





We therefore propose to establish calendar year 2021 as the performance period for the payment year 2023 ESRD QIP for all measures. Additionally, we proposed to establish calendar year 2019 as the baseline period for the payment year 2023 ESRD QIP for all measures for the purposes of calculating the achievement threshold benchmark and the minimum total performance score, and calendar year 2020 as a baseline period for the payment year 2023 ESRD QIP for purposes of calculating the improvement threshold.

And what we have done is to propose that beginning in payment year 2024, we will automatically adopt the performance period and baseline period for each year by advancing the previous year's performance and baseline periods by 1 year. Now, what does that look like? So, for example, to determine the performance period and baseline periods for payment year 2024, we would add a year to the payment 2023 performance period and baseline period.

So, for payment year 2024, the performance period is calendar year 2022; the baseline period for purposes of calculating the achievement threshold, benchmark, and minimum TPS would be calendar 2020; and the baseline period for the purposes of calculating the improvement threshold would be calendar year 2021. Although this is a pretty simple formula, there are lots of numbers and dates that were shared, and so what I'd like to do is just to restate it for clarity.


As an example, under this policy, we would automatically adopt calendar year 2022 as a performance period for the payment year 2024. We would also automatically adopt calendar year 2020 as the baseline period for purposes of calculating the achievement threshold, benchmark, and minimum total performance score, and we would automatically adopt calendar year 2021 as the baseline period for purposes of calculating the improvement threshold for the payment year 2024 ESRD QIP.

Okay. So, here is just to make sure you follow. We should be on slide 28. So here on slide 28, you can see the estimated minimum TPS and payment reduction scale based on the most recently available data. Note that we will include the final minimum TPS and payment reduction scale with more recent data in the calendar year 2020 ESRD PPS final rule. That means that at the present time, we estimate that a facility will need a TPS of 53 or higher to avoid a payment reduction. However, as I mentioned, this could change in the final rule as new data becomes available.

Okay, so now we're going to move ahead. Okay, so on page 29, you will see a series of tables and graphs. These are our projected payment reductions based on current facility performance on the measures. The actual payment reduction distribution will depend on facility performance during the performance period and baseline period of the prospective payment year. Let's begin by reviewing the projected payment reductions and history shown in the upper right corner of the page. Here you will see that we are estimating a significant decrease in payment reductions from payment years 2021 to payment year 2022.

Several factors are driving this decrease. One, the 1st factor is we have newly available data for two measures, the ultra-filtration and the PPPW.

The 2nd factor is that our proposal to convert STrR from a clinical measure to a report measure. The 3rd factor is that there was a calculation error in prior rule making related to the reallocation of measure weights when a measure is missing, which was a policy finalized in the calendar year 2019 ESRD PPS final rule. And the 4th and final factor is that we've updated data for FHR and the VAT measures along with the PPS eligibility list.



Moving to the lower right corner, we have a table showing the number of facilities we estimate will be affected by the payment reductions in each of the payment years 2022 and 2023. The last two tables break down the estimated impact by freestanding versus hospital base for each of these payment years. Okay. So, I know that's a lot. I'll give you a few minutes to review it and then I'll move on to the next slide.

## Participating in the Comment Period: How to Locate the Proposed Rule or Submit a Comment

Okay, so this next section includes important details to inform you of how and where you could read the proposed rule, ask questions, or submit comments. Please turn to page 31, and we'll take a look at some of that information. This slide provides an overview of the process CMS follows in creating and implementing federal regulations. We pointed out the period in which the public may provide input or propose rules. In past years, the comments that CMS received have helped to shape the final rules. In some instances, this leads to differences from the proposed rules, as a result of those comments.

Therefore, again, your participation in the process is essential in creating the best possible program for measurable facility performance and providing quality care to the ESRD population. This page also includes a link to [regulations.gov](https://www.regulations.gov) where you can directly enter a comment. Please remember that the comment period will end on September 27th. So, we encourage all of you to enter your comments as soon as possible. And now, please move to the next page.


On slide 32, you'll see the most convenient way to submit a comment, which is to do so online via [regulations.gov](https://www.regulations.gov). The site has a search box that allows you to navigate directly to the rule and the comment portion. We were able to use several search terms that successfully returned the proposed rule as a result, including the file number, as pictured 1713- P, as well as calendar year 2020 ESRD PPS, which is part of the proposed rule formal title.

If you choose to use [regulations.gov](https://www.regulations.gov), you can use the comment now button to submit your comment, as illustrated here. You can also upload files as part of your formal comments. Of course, you do not have to use the online interface to submit comments. You can deliver your comments in hard copy format if you prefer. The text of the proposed rule includes information on how to do so.

Please be sure, however, to allow time for transit and delivery to prevent any delays. More information can be found at the very beginning of the proposed rules. Whatever comment method you choose, please be sure to include a reference to the file number CMS -1713 - P on all correspondences. And so, again, you'll see here that we were able to use several terms that successfully returned the proposed rule. I think one of the best ones, or the easiest one to use, is if you enter 1713 – P as well as the calendar year.

## Resources

Okay, and so as we near the end of today's call, there are just a few more items to cover, and these are offered to help you gain additional information and be an active participant in the rulemaking process. Let's move on and review these resources. Okay. Here you see a few important dates that we like for you to keep in mind this year. Given the overlap of the rulemaking process and the scoring process, it's easy to see that a lot of activity impacting multiple payment years happened at the same time.



To recap, the payment year 2019 payment reductions are currently being applied. We are also currently in our payment year 2020 -- a preview period with an end date of August the 24th 2019 at 11:59 PM Pacific time. We are currently in our payment year 2021 performance period which spans from January 1st to December 31st of 2019, and as we've been talking about today, we are currently in our calendar year 2020 rulemaking cycle which affects payment years 2022 and payment year 2023.

We displayed our proposed rule in the Federal Register on August 6, 2019. The 60-day comment period for the proposed rule ends September 27th, 2019 and we expect to publish the calendar year final rule at some point in November 2019. And our plan is to make the payment year 2020 PSCs available for download in mid-December. As a reminder, we'd like to highlight that all facilities are required to publicly post their PSCs within 15 business days. And lastly, the payment year 2020, the payment reductions will be effective beginning January 1st, 2020.

On slide 36, we provide a list of hyperlink resources for information that was referenced in our discussion. This includes technical specifications, the proposed rule text, statutes, and methods for providing your comments and feedback, and on behalf of CMS, I'd like to share our appreciation for your cooperation, input, and recommendations during the comment period and at other times.

Again, I'd like to encourage all of you to submit any questions or comments using the methods mentioned earlier, and we appreciate your time today. And with that, I'd like to turn it back over to Charlie to close out today's presentation, and again, thank you all so much for joining us, and we look forward to reading your comments. Charlie?

### Additional Information

Charlie Eleftheriou: Thank you, Delia. Thanks for that very comprehensive and informative presentation. If you have additional questions, please refer to the resources slide number 36 and use the formal comment process on [regulations.gov](https://www.regulations.gov). An audio recording and transcript will be available in about 2 weeks at [go.cms.gov/npc](https://go.cms.gov/npc). Again, this is Charlie Eleftheriou, and I'd like to thank our presenter here at CMS, and also thank you for participating in today's Medicare Learning Network event on ESRD QIP. Have a great day everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect.