Outpatient Quality Program Systems and Stakeholder Support Team

CY 2024 ESRD PPS Proposed Rule
Presentation Transcript

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Danielle Leffler: Hello everyone and thank you for joining us today. My name is Danielle Leffler, and I will be your host. Today, we are fortunate to have the ESRD QIP Program Lead, Dr. Delia Houseal, with us to go over the ESRD PPS proposed rule as it relates to the ESRD QIP. Before I hand things over to Delia, I will cover some general information. First, you can access the slides and other materials in this presentation by clicking the paper icon on your control panel. You can also access the chat by clicking the bubble with three periods and the question-and-answer box by clicking the bubble with the question mark.

During this presentation, I will discuss some of the statutory and legislative components related to the rulemaking cycle. Delia will discuss the proposals put forth in the proposed rule and the rationale behind these decisions. At the end of this presentation, I will discuss how and where to comment on the proposed rule, as well as where to access resources.

Before I hand things over to Delia, let's briefly go over some statutory foundations and legislative drivers surrounding the rulemaking process.

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 2008, otherwise known as MIPPA. 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 2 percent if a facility does not meet or exceed the minimum Total Performance Score as set forth by CMS. The ESRD QIP was supplemented by language included in the Protecting Access to Medicare Act of 2014, also known as PAMA, which stipulates that ESRD QIP must include measures specific to the conditions treated with oral-only drugs, these measures are required to be outcome-based, to the extent feasible.

This slide provides an overview of the statutory requirements for ESRD QIP. Under MIPPA, ESRD QIP is responsible for selecting measures that will address anemia management, dialysis adequacy, patient satisfaction, iron management, bone mineral metabolism, and vascular access; all as specified by the Health and Human Services Secretary. CMS is required to establish performance standards that apply to individual measures, specify the performance period for a given payment year and develop a methodology for assessing total performance of each facility based on performance standards for measures during a performance period. In addition, CMS is required to apply an appropriate payment percentage reduction to facilities that do not meet or exceed established total performance scores. Finally, CMS is required to publicly report results through various websites. Facilities are also required to publicly post their performance score certificates in their facility within 15 days of their availability.

The content covered on today's call should not be considered official guidance. This webinar is only intended to provide information. Please refer to the proposed rule, located in the *Federal Register* to clarify and provide a more complete understanding of the modifications and proposals for the program which Delia will be discussing. We have placed a direct link to this document here on this slide.

Without further delay, let me hand things over to Dr. Delia Houseal to discuss the calendar year 2024 ESRD QIP proposed rule. Delia?

Delia Houseal: Thank you, Danielle, and welcome everyone. As Danielle mentioned, my name is Delia Houseal and I am the ESRD QIP program and policy lead.

Before we discuss this years' proposals, I would like to first share the policy goals and drivers that serve as the premise for the calendar year 2024 proposed rule. CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes. CMS works to improving people's lives through advancing public policy to ensure the U.S. health care system works better

for everyone. Last year, CMS announced the CMS strategic vision and six strategic pillars – advance equity, expand access, engage partners, drive innovation, protect programs, and foster excellence. CMS teams remain committed to collaborate across its Centers and Offices to establish shared strategic objectives, define success measures, and holistically look across the agency to identify policy levers and opportunities to advance these priorities.

In today's presentation, we will be discussing the calendar year 2024 ESRD PPS proposals as they relate to the ESRD QIP. We will discuss two measure removals, three measure adoptions, and two measure updates impacting calendar years 2026 and 2027. I highly encourage you to read the proposed rule for a more complete understanding of our policies and to capture the details of what we have put forth. Now, let's take a look at our first proposal.

The first proposal we will discuss is the proposal to adopt the Facility Commitment to Health Equity Reporting Measure beginning with payment year 2026. Significant and persistent disparities in healthcare outcomes exist in the U.S. Data indicate that, even after accounting for factors such as socioeconomic conditions, members of racial and ethnic minority groups reported experiencing lower quality healthcare. Additionally, inequities in the drivers of health affecting these groups, such as poverty and healthcare access, are interrelated and influence a wide range of health and quality-of-life outcomes and risks. CMS is working toward the goal of all patients receiving high-quality healthcare, regardless of individual characteristics. This includes patients receiving the right to care, at the right time, in the right setting for their condition, regardless of those characteristics. We believe that strong and committed leadership from dialysis facility executives, board members, and facility leadership is essential and that the commitment of all stakeholders to health equity would result in a reduction of health disparities in the ESRD population. The Facility Commitment to Health Equity reporting measure was developed to align with the first pillar of our strategic priorities and to assess facility commitment to health equity across five domains using a suite of organizational competencies aimed at achieving health equity for all patients. We believe these elements are

actionable focus areas, and assessment of dialysis facility leadership commitment to them is foundational. Let's look at the Facility Commitment to Health Equity reporting measure, its five domains and the elements within each domain.

The proposed Facility Commitment to Health Equity reporting measure would assess dialysis facility commitment to health equity using a suite of equity-focused organizational competencies all aimed at achieving health equity for all populations, including those that have been disadvantaged, marginalized, and underserved by the healthcare system. This includes but is not limited to racial and ethnic minority groups, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, rural populations, religious minorities, and people facing socioeconomic challenges. This proposed measure includes five attestation domains that you see here on this slide and elements within each of those domains to which a facility would report an affirmative attestation for the facility to receive points for that domain. Now, let's take a closer look at each domain and the elements within each of those domains.

The first domain in the Facility Commitment to Health Equity reporting measure is Equity is a Strategic Priority. This domain assesses a facility's strategic plan for advancing health equity by ensuring it identifies priority populations who currently experience health disparities, it identifies health equity goals and discrete actions steps for achieving those goals, outlines resources that are dedicated to achieving equity goals, and describes the facility's approach for engaging key stakeholders.

The second domain of the Facility Commitment to Health Equity reporting measure is Data Collection. Facilities should collect valid and reliable demographic and social determinant of health data on patients to identify and eliminate health disparities. Specifically, to earn all possible points in this domain, facilities must attest that they collect demographic information and/or social determinant of health information on the majority of their patients, provide training to staff on how to collect such data in a culturally sensitive way, and inputs collected data using Electronic Health Record (EHR) technology.

The third domain in the Facility Commitment to Health Equity reporting measure is Data Analysis and encourages facilities to analyze data to identify equity gaps on facility performance.

The fourth domain of the Facility Commitment to Health Equity reporting measure is Quality Improvement and encourages facilities to engage in quality improvement through local, regional, or national quality activities focused on reducing health disparities.

Finally, the fifth domain of the Facility Commitment to Health Equity reporting measure is Leadership Engagement. This domain includes activities that encourage leaders and staff to annually review their strategic plan and key performance indicators stratified by demographic and/or social risk factors to ensure its action steps that support health equity are included.

The measure consists of five attestation-based questions, each representing a separate domain of commitment. For a facility to affirmatively attest "yes" to a domain, and receive points for that domain, the facility would need to determine that it engages in all of the activities that are included as elements under the domain. A facility that engages in all of the activities for a domain would report an affirmative attestation by answering "yes" to the attestation-based question for that domain. There is no option for a facility to answer "yes" in response to an attestation-based question for a domain if the facility engages in some, but not all, of the activities included as domain elements, and there is also no option for a facility to answer "no" in response to any attestation-based question for a domain. The measure would be expressed as a fraction, and a facility can score either 0, 2, 4, 6, 8, or 10 for the performance period, depending on the number of domains to which a facility positively attests. We are proposing that the measure denominator would be "10," with each domain being represented as two points out of that total 10 points, and that the numerator would be calculated as two points for each "yes" answer the facility reports which are then summed together.

We are proposing that facilities would be required to submit data needed to calculate the Facility Commitment to Health Equity measure, once on an annual basis, using EQRS beginning with the calendar year 2024

performance period for payment year 2026. We are proposing that the deadline for submission would be the end of the EQRS December data reporting month for the applicable performance period, which is consistent with current reporting deadlines for other ESRD QIP measures. We are also proposing to publicly display the facility-specific results for the Facility Commitment to Health Equity reporting measure on an annual basis through our *Care Compare* website. We anticipate making the first public report available in January 2026. We invite public comment on this proposal. And just as a friendly reminder, Danielle will provide directions for how to provide comment on the proposals we discuss at the end of this presentation.

Our next proposal is a modification to the COVID-19 Vaccination Among Healthcare Personnel measure. The COVID-19 Public Health Emergency expired on May 11, 2023; however, the public health response to COVID-19 remains a public health priority with a whole government approach to combatting the virus, including through vaccination efforts. We continue to believe it is important to incentivize and track Healthcare Personnel vaccination through quality measurement across care settings, including dialysis facilities, in order to protect health care workers, patients, and caregivers, and to help sustain the ability of Healthcare Personnel in each of these care settings to continue serving their communities through the Public Health Emergency and beyond. In the calendar year 2023 ESRD PPS final rule, we stated that Healthcare Personnel should be counted as vaccinated if they received COVID-19 vaccination any time from when it first became available in December 2020. We also stated that, as vaccination protocols continue to evolve, we will continue to work with the CDC to update relevant measure specifications, as necessary. Since we finalized the calendar year 2023 ESRD PPS final rule, new variants have emerged around the world and vaccine manufacturers have responded by developing bivalent COVID-19 vaccines. We believe that vaccination remains the most effective means to prevent the worst consequences of COVID-19, including severe illness, hospitalization, and death. Given the availability of vaccine efficacy data, the continued presence of COVID-19 in the United States, and variance rates among rates of booster dose vaccination, it is important to modify the COVID-19 Vaccination Coverage Among Healthcare

Personnel measure to reflect recent updates that explicitly specify for Healthcare Personnel to receive primary series and booster vaccine doses in a timely manner.

We propose to modify the COVID–19 Vaccination Coverage Among Healthcare Personnel measure to replace the term "complete vaccination course" with the term "up to date" in the Healthcare Personnel vaccination definition. We also propose to update the numerator to specify the time frames within which a Healthcare Personnel is considered up to date with recommended COVID–19 vaccines, including booster doses, beginning with payment year 2026. The definition of up to date on this slide applies to the Quarter 3 2023 reporting period. Individuals are only considered up to date with their COVID-19 vaccines during this surveillance period if they have received an updated bivalent vaccine.

Facilities should refer to the definition of up to date as of the first day of the applicable reporting quarter, which can be found at the first link on this slide. We also refer facilities to the second link on this slide for more details on measure specifications. We note that the proposed updated COVID-19 Vaccination Coverage Among Healthcare Personnel measure will remain a reporting measure and that the proposed updates to measure weighting for payment year 2026 and 2027 will be discussed later in this presentation. Finally, we refer readers to the calendar year 2023 ESRD PPS final rule for information on data submission and reporting for the measure. We are not proposing any changes to the existing data submission requirements. As always, we invite public comment on this proposal.

Next, we are proposing to convert the Clinical Depression Screening and Follow-Up reporting measure to a clinical measure. Depression is a highly prevalent condition in patients with ESRD, which impacts many aspects of a patient's life and is associated with higher rates of mortality in the ESRD population. Adoption of a measure that assesses whether facilities screen patients for depression, and develop follow-up plans when appropriate, was and still is an opportunity to improve the health of patients with ESRD. Clinical guidelines indicate that providers should both screen for depression and develop a follow-up plan for patients who test positive for depression.

Screening for depression is an important aspect of ESRD patient care, especially because ESRD and depression may present with similar symptoms, including but not limited to fatigue, poor appetite, headaches, and lack of focus. Developing a follow-up plan for patients who screen positive for depression is equally important because ESRD patients may not be aware that they can seek treatment or that such treatment could be beneficial.

We are proposing to convert the Clinical Depression Screening and Follow-Up reporting measure to a clinical measure and to move the measure to the Care Coordination Measure Domain. We are also proposing to adopt a new methodology for scoring that measure as a clinical measure.

We believe this proposal would help to ensure that the measure is scored in a manner that more closely aligns with current clinical guidelines for depression screening and follow-up because it narrows the number of conditions on which a facility can earn points. A facility would not be awarded points if they report no action was taken or no screening was performed. If a facility selects one of the other two conditions, that is, "Screening for clinical depression is documented as positive, the facility possesses no documentation of a follow-up plan, and no reason is given" and "Screening for clinical depression is not documented, and no reason is given", the facility would not receive any points on the measure. We believe this proposed update is important because it would assess facility performance on both the clinical depression screening and the follow-up plan, to the extent that one is needed, and would also incentivize facilities to report the reason for either not documenting whether they screened for clinical depression, or why they do not possess documentation of a follow-up plan. We believe that the performance score calculation methodology changes we are proposing to the Clinical Depression Screening and Follow-Up reporting measure would have a greater impact on fostering care coordination among providers and improving patient outcomes by incentivizing the documentation of depression screenings and follow-up plans, or alternatively requiring facilities to provide a reason why no screening or follow-up plan was documented. We welcome public comment

on our proposal to update the Clinical Depression Screening and Follow-Up measure and our proposal to convert it to a clinical measure beginning with payment year 2026.

The next proposal we will discuss is the proposal to remove the Ultrafiltration Rate reporting measure from the ESRD QIP measure set beginning with payment year 2026. The Ultrafiltration Rate reporting measure is intended to guard against risks associated with high ultrafiltration rates for adult dialysis patients undergoing hemodialysis, because of indications that high ultrafiltration is an independent predictor of mortality. Faster ultrafiltration may lead to a number of health risks resulting from large volumes of fluid removed rapidly during each dialysis session, with consequences for the patient both in the short and longer term. When we added this measure to the ESRD QIP, we believed the documentation of the ultrafiltration measurements would ultimately contribute to the quality of the patient's ESRD treatment. More recent studies have indicated that the Ultrafiltration Rate reporting measure may not result in the intended patient outcomes. For example, a patient's body size may be a confounding, possibly explanatory factor for the relationship between higher UFR and increased mortality. Additionally, although the Ultrafiltration Rate reporting measure captures a patient's UFR measurements reported monthly, the mortality risks associated with high UFR may be due to the frequency or number of hemodialysis sessions with high UFR. We believe these findings show that the documentation of a patient's ultrafiltration measurements through the current Ultrafiltration Rate reporting measure may not necessarily indicate the quality of a patient's ESRD treatment and tracking the ultrafiltration rate as a quality indicator may influence decision-making regarding treatment. Therefore, a facility's performance on the measure may not accurately reflect the quality of care provided.

Accordingly, we are proposing to remove this measure from the ESRD QIP measure set under measure removal factor 2, performance or improvement on a measure does not result in better or the intended patient outcomes,

beginning with the payment year 2026 ESRD QIP. We welcome public comment on our proposal.

Next is the proposal to remove the Standardized Fistula Rate clinical measure beginning with payment year 2026. Along with the Long-Term Catheter Rate clinical measure, we previously stated that the two vascular access measures, when used together, consider AV fistula use as a positive outcome and prolonged use of a tunneled catheter as a negative outcome. With the growing recognition that some patients may exhaust their options for an AV fistula or have comorbidities that limit the success of AV fistula creation, pairing the measures accounts for all vascular access options. The Standardized Fistula Rate measure adjusts for patient factors where fistula placement may be either more difficult or not appropriate and acknowledges that in certain circumstances an AV graft may be the best access option by accounting for that possibility in the current measure specifications. In the calendar year 2018 ESRD PPS final rule, we stated that this paired incentive structure that relies on both measures reflects consensus best practice and supports maintenance of the gains in vascular access success achieved via the Fistula First/Catheter Last Project over the last few decades. Since the calendar year 2018 ESRD PPS final rule, there have been several changes to what many experts consider to be best practices with respect to vascular access in ESRD patients due to improvements in the care of ESRD patients overall, changes in patient demographics, and increasing patient longevity. Instead, a patient-centered approach to hemodialysis vascular access that is based on a consideration of the patient's needs and dialysis access eligibility is preferred. Providers should consider what would be most appropriate for the individual patient, including that AV fistula may not always be most appropriate based on the individual patient's needs.

After considering these evolving best practices, we have determined that the Standardized Fistula Rate Clinical Measure does not provide patients and their healthcare providers the necessary level of flexibility to choose the most suitable AV access. We believe that patients, in consultation with their healthcare providers, should have the flexibility to choose AV access (either AV fistula or AV graft) where appropriate to their specific patient

characteristics and treatment plans. This determination should be based on the healthcare provider's best clinical judgment that considers the vessel characteristics, patient comorbidities, health circumstances, and patient preference. These updated clinical practices no longer align with the prior Fistula First approach which is currently captured through the Standardized Fistula Rate clinical measure. Accordingly, we are proposing to remove the Standardized Fistula Rate clinical measure from the ESRD QIP measure set beginning with payment year 2026 under measure removal factor 3 - a measure no longer aligns with clinical guidelines or practice. We are also proposing to remove the reference to the Vascular Access Type Measure Topic and to assign the total weight of that topic (12 percent) solely to the Long-Term Catheter Rate clinical measure. We are proposing to assign the total weight to the Long-Term Catheter Rate clinical measure because we believe this continues to be an important measure of facility performance tied to improved patient outcomes. We believe that our proposal to assign the total 12 percent weight to the Long-Term Catheter Rate clinical measure will reflect our view that long-term catheter use is the least-favored vascular access treatment option and should be avoided where more clinically preferable vascular access treatment options would be appropriate. We welcome public comment on our proposal.

Now that we have discussed the proposed adoptions, removals, and modifications to the ESRD QIP measure set for payment year 2026, let's take a look at the proposed impact to measure domains and to measure weights used to calculate a facility's Total Performance Score.

The previously finalized and newly proposed measures that would be included in each domain, along with the proposed new measure weights, for payment year 2026 are depicted in this table. We are proposing that beginning with payment year 2026, the Clinical Depression Screening and Follow-Up reporting measure would be converted to a clinical measure and included in the Care Coordination Domain, the Standardized Fistula Rate clinical measure would be removed from the Clinical Care Domain, the Ultrafiltration Rate reporting measure would be removed from the Reporting Domain, and the Facility Commitment to Health Equity reporting

measure would be added to the Reporting Domain. To accommodate the new numbers of measures in the Care Coordination Domain, Clinical Care Domain, and Reporting Domain, we are proposing to update the individual measure weights in each of these domains. We believe that these proposed updates to the individual measure weights would help to ensure that a facility's individual measure performance has an appropriately proportionate impact on a facility's Total Performance Score, while also further incentivizing improvement on clinical measures. We note that although we are proposing to change the number of measures in three of the domains and the weights of certain individual measures in those domains, we are not proposing to change the weights of the five domains themselves because we believe the proposed updates to individual measures and measure weights do not significantly impact the measure domains themselves such that updating the weights of the measure domains would be required to accommodate the updated individual measure weights. We welcome public input on our proposal.

Under our current policy, a facility does not receive a payment reduction for a payment year in connection with its performance under the ESRD QIP if it achieves a Total Performance Score that is at or above the minimum Total Performance Score for that payment year. Payment reductions are implemented on a sliding scale using ranges that reflect payment reduction differentials of 0.5 percent for each 10 points that the facility's Total Performance Score falls below the minimum Total Performance Score. Let's take a look at the estimated payment reduction scale for payment year 2026.

For payment year 2026, we estimate using available data that a facility must meet or exceed a minimum Total Performance Score, or mTPS, of 52 to avoid a payment reduction. We note that the mTPS estimated in this proposed rule is based on data from calendar year 2021 and calendar year 2019 instead of the payment year 2026 baseline period of calendar year 2022 because calendar year 2022 data is not yet available. We will update and finalize the mTPS and associated payment reduction ranges using calendar year 2022 data in the calendar year 2024 ESRD PPS final rule.

The next proposal we will discuss is the proposal to adopt the Screening for Social Drivers of Health reporting measure beginning with payment year 2027. First, research has shown that certain health-related social needs disproportionately impact populations that have historically been underserved by the healthcare system and screening helps identify individuals who may have healthcare-related social needs. Due to the association between chronic risk factors and these needs, screening for these needs could serve as evidence-based building blocks for supporting ESRD facilities in addressing persistent disparities and tracking progress towards closing the health equity gap in the ESRD population. Additionally, we believe health-related social needs screening by facilities could enable them to engage in meaningful collaboration with other healthcare providers and community-based organizations as part of a more holistic approach to addressing health equity gaps that negatively impact their ESRD patients, which may also eventually result in implementing and evaluating related innovations in health and social care delivery among these facilities, healthcare providers, and community-based organizations. Let's take a look at this proposed measure.

The Screening for Social Drivers of Health measure would assess the percentage of patients aged 18 and older that a dialysis facility screens for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. To report on this measure, facilities would provide: (1) the number of patients admitted to the facility who are 18 years or older during the applicable performance period who are screened for all of the following five health-related social needs, and (2) the total number of patients at the facility who are 18 years or older during the applicable performance period and who are not excluded from the measure. We are proposing to add this measure to the Reporting Measure Domain beginning with payment year 2027. We refer you to the proposed rule for more details regarding each domain.

We are proposing that facilities would be required to report annually using a 12-month period of performance for the measure. The measure would be scored according to the equation on this slide. The Screening for Social

Drivers of Health measure would be calculated as the number of patients at a dialysis facility who are 18 years or older who are treated at the facility during the applicable performance period and are not eligible to be excluded from the measure, and are screened by the facility for all five health-related social needs (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) divided by the total number of patients 18 years or older on the first day of the performance period, which is January 1st, at that dialysis facility. We believe that this scoring policy would encourage facilities to report the measure data appropriately without penalizing facilities for the results of such data, which may be based on circumstances beyond a facility's control.

We are proposing that facilities would report this measure on an annual basis beginning with the calendar year 2025 performance period for payment year 2027. We are also proposing that facilities would be able to select their own screening tool or method to screen patients for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. Multiple screening tools exist and are publicly available for facilities to use. The deadline for submission would be the end of the EQRS December data reporting month for the applicable performance period, which is consistent with current reporting deadlines for other ESRD QIP measures. Finally, facility-specific results for the Screening for Social Drivers of Health measure would be publicly displayed on an annual basis through our *Care Compare* website. We anticipate making the first public report available in January 2027. We invite public comment on this proposal.

The final measure adoption proposal for this proposed rule is the Screen Positive Rate for Social Drivers of Health reporting measure beginning with payment year 2027. The Screen Positive Rate for Social Drivers of Health measure would allow facilities to capture the magnitude of these needs by reporting the rate of those patients who screen positive for health-related social needs and even potentially estimate the impact of individual-level health-related social needs on healthcare utilization when evaluating quality of care. This measure compliments the Screening for Social Drivers of

Health reporting measure because they would require facilities to report both the percentage of patients they screened under the proposed Screening for Social Drivers of Health measure and the results of that screening under the proposed Screen Positive Rate for Social Drivers of Health measure in order to potentially identify gaps and develop sustainable solutions at a facility level and a community level.

The Screen Positive Rate for Social Drivers of Health measure would identify the proportion of patients at the facility who screened positive for each of the following five health-related social needs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. We would require facilities to report these data as five separate rates. The facility's measure rate for this measure would be calculated for a payment year as the number of eligible patients for whom the facility reports the screening results for all five health-related social needs during the performance period over the total number of eligible patients who the facility screened for all five health-related social needs during that performance period. To calculate the facility's score on the measure, we would multiply the results of that fraction by 10

We are proposing that facilities would be required to submit data necessary to calculate the numerator and the denominator for this measure once annually within the ESRD Quality Reporting System (EQRS), beginning with the calendar year 2025 performance period for payment year 2027. The deadline for submission would be the end of the EQRS December data reporting month for the applicable performance period, which is consistent with current reporting deadlines for other ESRD QIP measures. We are proposing to publicly display the ESRD QIP score and facility-specific rates for the Screen Positive Rate for Social Drivers of Health measure on an annual basis beginning in payment year 2027 through our *Care Compare* website. For purposes of public reporting, we are proposing to display the facility's screen positive rate for each health-related social need separately, for a total of five separate rates. Although we will not score facilities on the results of those rates, we believe that making such data public may help to better inform patients and their caregivers about a facility. We believe that

these policies would encourage facilities to report the measure data appropriately without scoring facilities based on the results of such data, which may be based on circumstances beyond a facility's control. Although we believe that it is important to encourage facilities to screen their patients for health-related social needs and to report data for screen positive rates, we want to avoid potential unintended consequences that may result from scoring facilities on the outcomes of the screen positive rates themselves. That is, we do not want to score a facility based on its patients' given socioeconomic factors, which may be based on circumstances beyond a facility's control. We invite public comment on this proposal.

Beginning with payment year 2027, we are proposing to add the Screening for Social Drivers of Health reporting measure and the Screen Positive for Social Drivers of Health reporting measure to the Reporting Measure Domain. To accommodate the new number of measures in the Reporting Measure Domain, we are proposing to update the individual measure weights in this domain. We believe that these proposed updates would help to ensure that a facility's individual measure performance has an appropriately proportionate impact on a facility's TPS, while also continuing to further incentivize improvement on clinical measures through those individual measure weights. Let's take a look at the proposed updates to the measure domains and weights beginning with payment year 2027.

So, you will see here, the previously finalized and newly proposed measures that would be included in each domain, along with the proposed new measures weights, for payment year 2027 are depicted in this table. Consistent with our approach in the calendar year 2023 ESRD PPS final rule, we are proposing to assign individual measure weights to reflect the proposed updated number of measures in the Reporting Measure Domain so that each measure is weighted equally. We note that although we are proposing to change the number of measures in three of the domains and the weights of certain individual measures in those domains, we are not proposing to change the weights of the five domains themselves because we believe the proposed updates to individual measures and measure weights do not significantly impact the measure domains themselves such that

updating the weights of the measure domains would be required to accommodate the updated individual measure weights. We invite public comment on this proposal.

As I have said throughout this presentation, CMS does want your feedback and we appreciate your comments. Now I will turn it over to my colleague, Danielle, to provide you with information on how to submit comments on the proposed rule. Danielle?

Danielle Leffler: Thank you, Delia. As Delia stated, CMS is asking for your comments and feedback on the topics in the calendar year 2024 ESRD PPS proposed rule. This is your opportunity to be involved in the decision-making process for this program and CMS looks forward to hearing from you. In this section of the presentation, I will review the public role in the rulemaking process and give directions for how to submit comments on the proposed rule.

This is a brief overview of the public's role in the rulemaking cycle. CMS writes proposals and brings them forward in the proposed rule which is posted publicly in the *Federal Register.* The comment period then opens for all stakeholders to provide CMS with comment and feedback on the proposed rule. CMS reviews all comments. The comments and the final decision on the proposals is then put forth publicly in the final rule which is also posted in the *Federal Register.*

To be assured consideration, comments must be submitted no later than August 25, 2023. CMS cannot accept comments by fax transmission. They do encourage submission of comment by electronic means. However, you may also submit comment via regular mail, express or overnight mail. There are separate addresses which you can find in the proposed rule. Please allow sufficient time for mailed comments to be received before the close of the comment period.

You can find the proposed rule published in the *Federal Register*. If you want to view a PDF version of the proposed rule, the ESRD QIP-specific information begins on page 57 of that document.

To locate the proposed rule, click the *Federal Register* link on this slide and select the PDF option under Document Details on the right. This will open the PDF version of the proposed rule.

To begin the commenting process, instead of selecting the PDF link, you will select the green Submit a Formal Comment button.

This will redirect you to the *regulations.gov* website where you will be able to submit a comment. Here you see the top part of that page. You can enter your comment and add a file if you wish to do so. You will scroll down that page and enter your information. Fill in the necessary information and make sure you click on the "I read and understand the statement above" box, the Submit Comment button will not turn green unless that box is selected. Once complete, you will simply click the Summit Comment button. Again, please comment. CMS does look forward to hearing from you about the proposals discussed here today.

Here are a list of resources for information, some of which we discussed here today. We have also provided a direct link to the proposed rule in the *Federal Register* at the bottom of this slide. Delia, thank you so much for spending time with us today to go over the proposed rule. It is always nice to have CMS keep us all up to date on these important program updates. This concludes our presentation on the 2024 ESRD QIP proposed rule. Thank you to all of you for joining us and we hope you have a great day.