MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
ESRD QIP: Payment Year 2020 Final Rule Call
MLN Connects National Provider Call
Moderator: Aryeh Langer
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call.

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 Aryeh Langer. Thank you. You may begin.

Announcements and Introduction

Aryeh Langer: Thank you very much.

And as you just heard, my name is Aryeh Langer from the Provider Communications Group here at CMS, and I am your moderator for today's call. I would like to welcome all of you to this MLN Connects National Provider Call on the End-Stage Renal Disease Quality Incentive Program, also known as ESRD QIP. MLN Connects Calls are part of the Medicare Learning Network®.

Today's MLN Connects National Provider Call topic is the ESRD QIP Payment Year 2020 Final Rule. A question-and-answer session follows today's presentation.

Two quick announcements.

You should have received a link to today's slide presentation in an email earlier this afternoon. If you have not already done so, you may view or download the presentation from the following URL: www.cms.gov/npc. Again, that URL is www.cms.gov/npc, as in National Provider Call. At the left side of the webpage, click on the National Provider Calls and Events link. Then on the following page, select the date of today's call from the list below, and you'll see the presentation can be found under the Call Materials section.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. Registrants will receive an email when these materials become available.

At this time, I'd like to turn the call over to our first presenter. Tamyra Garcia is the Deputy Director of the Division of Value, Incentives, and Quality Reporting here at CMS. Tamyra?

Presentation

Tamyra Garcia: Thank you so much for the introduction, Aryeh.

And thank you to all who've joined us this afternoon to meet and discuss the ESRD QIP's most recent final rule. Joining me today in presenting are Celeste Bostic, the ESRD QIP Nurse Consultant and subject matter expert, and Joel Andress, the Measures Development Lead for ESRD measures here at CMS.

Today, please take a look at slide 4 to provide an overview of what will be discussed on the call, including the final rule for payment year 2020. The ESRD QIP team will be presenting a great deal of detail over the next 90 minutes, and we are hopeful that we will be able to provide a good understanding of what the rule contains and associated facility responsibilities. First, we will go over prepared presentation with you on the rule. And, then we will open up at the end of the call for some questions – some discussion questions.

Now, many of you will want additional information that we won't be able to cover today. So, we invite you to review some online resources identified on slide 43 of this presentation. Questions that remain even after taking a look at these resources can always be sent to the ESRD Quality Incentive Program mailbox at esrdqip@cms.hhs.gov.

With that being said, let's go ahead and get started with today's presentation.

Introduction

Payment year 2020 represents the 9th payment year for the End-Stage Renal Disease Quality Incentive Program. And these recently finalized regulations build upon earlier measures and approaches in a wide variety of ways, as will be discussed in the presentation today.

But, how does the End-Stage Renal Disease Quality Incentive Program fit into CMS's overall goal for improving quality? Well, to answer this question, we're going to give you a quick overview before going into the specific elements of the rule. We always think it's

a good idea to reinforce the foundation of our programmatic policy goals in our presentations before delving into the specific policies that support CMS overall goals.

Now, to do this we are going to take a look at slide 6. And on slide 6, we summarize how CMS uses value-based purchasing programs to incentivize better care across many health care settings. Beneficiaries expect cost-effective quality care, and VBP is an avenue that CMS uses to assist us in achieving this goal. And it promotes the three-part aim of better health care for individuals, better care for populations and communities, and smarter spending to improvement.

The End-Stage Renal Disease Quality Incentive Program was CMS's first pay-for-performance program, as opposed to traditional fee for service reimbursement, which means that rather than paying dialysis facilities based on how many services they provide for patients, Medicare now pays dialysis facilities based on how well those services help keep patients safe and healthy. The End-Stage Renal Disease Quality Incentive Program uses the Government's purchasing power through Medicare to incentivize improvements in the treatment of patients with end-stage renal disease. These incentives really seek to drive care throughout the entire health care sector, not just to Medicare patients.

And with that, I am happy to turn the presentation over to Celeste Bostic to provide an overview of the ESRD QIP's most recently finalized policy.

Celeste?

ESRD QIP Overview

Celeste Bostic: Thank you so much, Tamyra.

Again, my name is Celeste Bostic, as Tamyra mentioned, and I am the Nurse Consultant for the ESRD QIP. We will now move on to an overview of the legislative aspects of the program.

On slide 9, the ESRD QIP is grounded in the Medicare Improvements for Patients and Providers Act, or MIPPA, which amended the Social Security Act to mandate the creation of the program. The ESRD QIP is intended to promote patient health by creating a financial incentive for renal dialysis facilities to deliver high-quality

patient care. MIPPA provides the mechanism for establishing standards of care, and it authorizes payment reductions for facilities failing to meet these standards.

MIPPA gives CMS the authority to establish standards by which ESRD facilities will be evaluated. 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 ESRD QIP also establishes the way individual measurements are used to create an overall score.

CMS will impose a payment reduction of up to 2 percent if the facility's score does not meet a minimum total performance score, which is calculated using national performance standards. Information about the facility's performance and the ESRD QIP is contained the Performance Score Report, or PSR. Public reporting of the results is a key component because it allows beneficiaries to select facilities based on the quality of care provided, and it provides a mechanism by which facilities may judge their performance compared to the performance of others.

Dialysis Facility Compare is a great example of the public reporting of ESRD quality metrics and results. The Performance Score Certificate, or PSC, is a prime vehicle for communicating a facility's performance to patients under the ESRD QIP. Facilities are required to display this document in a public place each year. In addition, CMS releases detailed facility performance information in a large spreadsheet and posts it on the web.

With the structure of the program in mind, we will now turn to how it evolved from year to year through the rulemaking process.

On slide 11, 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 communicate – to comment on the proposal and suggest approaches it would like to see in the program. In this way, facilities and the general public have an opportunity to influence the shape of the rule governing each payment year. Those comments are taken very seriously by CMS. Comments have led to the postponement of implementing measures, and those measures are stronger when they are implemented in future years due to the input received. So, it's very important

that stakeholders participate in the comment period and share their thoughts on how the ESRD QIP can best serve the needs of patients with ESRD.

On slide 12, it's also important to understand how CMS gathers and uses facility information to calculate performance rates and scores for 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 come from, and the impact on payment. The main reason for this is the reliance on Medicare reimbursement claims for a lot of the data we use.

As we move to other data sources, we will not be as dependent on claims data and we hope to reduce this interim between performance and the resulting payment impact. That said, the preview period is a statutory requirement so facilities will always have an opportunity to review and formally inquire about their scores before they are finalized.

On slide 13, earlier we touched on the importance of the comment period as an element in the rulemaking process and that the public input on proposed rules modifies the program, often strengthening the program as a result. The comment period last summer certainly resulted in several changes reflected in the final rule for the payment year 2020 program. As an example, CMS revised the implementation of the Hypercalcemia clinical measure update and changed the weighting of domains in payment year 2020. The text of the final rule addresses the subject of each of the public comments and provides a response to everyone.

Finalized Revisions to PY 2019

So, with that introduction, we will now turn our attention to finalized revisions to payment year 2019. With this rule, CMS altered the structure of 2019 from what it looked like in previous years. Let's take a look at this restructure payment year starting with a general overview.

On slide 15, although the payment year 2019 measures and scoring methodology were previously finalized in November of 2015, CMS modified that program in the payment year 2020 final rule. Instead of the NHSN Bloodstream Infection clinical measure being a part of the Clinical Measure Domain, we created a new Safety Measure Domain combining the NHSN Bloodstream Infection clinical measure already in effect with a reintroduced reporting measure on the same topic. We'll discuss that addition in a

moment. But, in this graphic, we wanted to point out the impact that change has on the makeup of the measure domains overall.

By removing the NHSN Bloodstream Infection clinical measure from the Clinical Measure Domain, we reduced the number of subdomains to two, altering the weighting among those subdomains to come up with a Clinical Measure Domain score and assign a 75-percent TPS weight to the revised Clinical Measure Domain. The new Safety Measure Domain provides 15 percent of the TPS, and the Reporting Measure Domain provides the remaining 10 percent of the score.

So let's delve into the measures that we reintroduced in the new Safety Domain.

On slide 16, ESRD QIP reporting measures enable CMS to gather data that later can 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 the clinical measure it supported. For payment year 2019, CMS reintroduced the NHSN Dialysis Event reporting measure as established for payment year 2015 while retaining the clinical measure. Our goal is two-fold: to reward high performance and accurate reporting. Infections are a leading cause of preventable mortality and morbidity across several settings in the health care sector, including dialysis facilities. Reducing infections among patients with ESRD will support national goals for patient safety.

At the same time, complete and accurate reporting is critical to maintaining the integrity of the NHSN surveillance system, enable facilities to implement their own quality improvement initiatives, and enables the CDC to design and disseminate prevention strategies. Feedback from our stakeholders, as well as independent analysis, have shown that facilities do not always report 12 months of data and they do not report all events. CMS believes that the reintroduction of the reporting measure, along with the enhanced validation that we will 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 for high performance.

On slide 17, the new NHSN BSI measure topic provides a way to align the incentives for reporting and the incentives for high performance. 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 topics in the Safety Measure Domain, as we will demonstrate in a couple of minutes when illustrating the scoring calculation.

We continue to use a 100-point scale for the TPS. We apply a 15-percent weighting to the new Safety Domain that reduces the weight of the Clinical Measure Domain to 75 percent. We kept the Reporting Measure Domain constant at 10 percent.

Requirements for TPS eligibility have been modified slightly. A facility is only eligible to receive a TPS 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. If a facility is not eligible for a score in the Safety Measure Domain, then the 15-percent weighting is evenly distributed across all remaining measures. CMS also clarified that a facility is not eligible for TPS or a payment reduction if it is only eligible for a Safety Measure Domain score.

And with that, I will turn it over to Joel to illustrate the scoring methodology. Joel?

Joel Andress: Thank you, Celeste. Good afternoon everyone. My name is Joel Andress. I'm the ESRD Quality Measure Development Lead here at CMS.

As Celeste was just mentioning, the payment year 2020 final rule has altered the weighting structure for clinical measures in the QIP. And, so, I want to take the next few slides to illustrate what that looks like.

With the shift of the Bloodstream Infection clinical measure to the Safety Measure Domain, we've reduced the number of clinical measures in the Clinical Measure Domain. And as a consequence, the weight of the remaining measures has been redistributed accordingly. Over the next two slides, we'll be using a hypothetical facility and its scores on the payment year 2019 measures to illustrate how these scores are used to create the three domain scores and the total performance score.

On the left-hand side of the slide is a list of each measure or measure topic score along with the hypothetical facility's performance on each score. On the right-hand side, we provide you with the formula for the remaining clinical measures with the weight for

each score represented as its portion of the overall domain score. In the example provided on slide 19, the facility qualifies for a score in each of the clinical measures.

The arrows illustrate where each clinical measure score will be used in the formulas. And the weight of the individual measure were selected according to the number of measures in each subdomain, the facility experience with the measures, and how closely the measures are aligned with CMS priorities for quality improvement as we discussed them earlier in the presentation. As you can see from the performance score here, 93.9, Facility A has performed quite well.

Shifting over to slide 20, we'll take a look at the Safety Measure Domain score. The format for the slide is similar to the last. And we can see that the calculation of the Safety Measure Domain uses the clinical measure to inform 60 percent of the measure topic score, whereas the reporting measure makes up the remaining 40 percent of that score. Again, our fictitious Facility A has scored quite well on both measures and their domain score of 94.

On slide 21, we look at the calculation of the Reporting Measure Domain score. CMS will apply equal weight to each of the five reporting measure scores. And, again, Facility A has performed fairly well and earned a domain score of 92. This domain makeup and weighting remains unchanged from the methodology described in the payment year 2019 final rule, which we issued last year.

And, then on slide 22, we provide you with an illustration of the calculation of this facility's Total Performance Score. As we noted previously, the facility's performance on each individual domain is high. And, so, it should come as no surprise that the facility's Total Performance Score is also very strong.

And now, I'll turn it over to Celeste, who will discuss the performance values for payment year 2019.

Celeste Bostic: Thank you, Joel.

On slides 23 and 24, we present a table listing the finalized achievement thresholds, benchmarks, and performance standards for calculating clinical measure scores via the achievement method for payment year 2019. Data used to calculate these values may

be found on the ESRD QIP payment year 2020 final rule data file, which has been posted on the Public Reporting and Certificates page of the ESRD QIP section of the cms.gov website. These values have been updated following the publication of the final rules and reflect the values and the technical corrections published last month. And now that we've finalized these values, we have also established the minimum TPS for payment year 2019 to be 60 points.

On slide 25, this illustration provides a summary graphic depicting how facilities will be scored, how those scores will translate into a TPS, and whether a payment reduction will be applied. It includes the measures – Clinical Measure subdomain, subdomain weight, relevant calculations and the scale for the payment reduction, if any. And as we have done throughout the presentation, new measures are identified with a gold star.

And with that, I will turn the conversation over to Aryeh for an important announcement. Aryeh?

Keypad Polling

Aryeh Langer: Thank you, Celeste.

At this time, we will pause for a few moments to complete keypad polling. Holley, can you begin that process, please?

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine. Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling.

Again, please hold while we complete the polling. Once again, please hold while we complete the polling. Please continue to hold while we complete the polling.

Thank you for your participation. I'd now like to turn the call back over to Aryeh.

Aryeh Langer: Thank you very much. And I'm going to turn the call back over to Celeste for the next portion of our presentation.

Presentation (Continued)

Celeste Bostic: All right. Thank you. In the next portion of our discussion, we will review the finalized measures from the payment year 2020 rule based on public comments.

Just as we did for payment year 2019, on slide 27, this illustration is an overview of the measure domains for payment year 2020. As you can see, we added a new outcome-based clinical measure, as well as two new reporting measures notated with gold stars.

I will now turn it over to Joel to discuss the new Standardized Hospitalization Ratio measure. Joel?

Joel Andress: Thank you, Celeste.

If you'll look at slide 28, please, you can see a brief description of the Standardized Hospitalization Ratio, or the SHR, which is an outcome measure of hospitalization in ESRD dialysis patients. We had previously proposed the SHR in an earlier rule but have withdrawn that due to concerns raised by public comments around the issue of its risk adjustment and the degree to which it robustly reflected the condition of patients being treated by the dialysis facilities or hospitalized.

Recently, we have submitted – we had revised the measure's risk adjustment to incorporate claims-based comorbidities and had submitted this to the National Quality Forum for consideration of endorsement. At the time we finalized this measure, the SHR was still under consideration but, as of now, has been confirmed as endorsed by the NQF. The results of the SHR are reported to you in much the same fashion as they are for the Standardized Readmission Ratio, which you'll be familiar with from last year, with a lower ratio reflecting higher quality of care provided by the dialysis facility.

And I'll – with that, I'll turn this back over to Celeste.

Celeste Bostic: Thanks, Joel.

Here on slide 29, we have a list of key terms with definitions that will be used on the following slides to explain the scoring of clinical measures. Note that the performance standard is not used in scoring measures but, instead, it is used to calculate the minimum TPS for that payment year. This determines whether a facility will be subject to a payment reduction.

The next slide presents the general approach for scoring clinical measures. CMS uses the better of the achievement and improvement method result as the facility score on each measure. If a facility's rate is better than or equal to the benchmark, the 90th percentile of national performance during 2016, as described on the previous slide, then the facility will receive the full 10 points for the 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. That 2017 performance rate is the facility's improvement threshold, the rate at which a facility can begin to earn points on the measure using this method.

As you can see, a facility can increase its score if it shows an improvement over its previous performance while it strives to reach a national average of performance on a measure. CMS favors achievement over improvement, which is why a facility can score a maximum of 10 points using that first method, but the maximum number of points is limited to nine using the improvement method.

On slide 31, when talking about clinical measures, it's important to understand that bigger isn't always better. This is what we mean by the directionality of a measure. And it varies according to what element of care is measured. For the measures listed at the top of the slide, a higher rate indicates better care. A higher rate of dialysis adequacy is great outcome for patients. Likewise, the use of fistulas tend to reduce infection, so a large patient population having that method of vascular access is also positive.

For the measures at the bottom of the slide, a lower rate indicates better care. For example, catheters are not an ideal method of vascular access for most patients. So, this number should be as small as possible. CMS wants to prevent hypercalcemia and reduce incidents of infection, hospitalization, and transfusion. So those rates also should be as

small as possible. Different directionalities may exist even within a measure topic. With regard to vascular access types, 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 the next slide, starting in payment year 2020, CMS will replace the existing Mineral Metabolism reporting measure with the Serum Phosphorus measure, which uses the specification for NQF number 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/V draw submitted to CROWNWeb for that clinical month.

On slide 33, CMS will continue to use the calculation for the minimum TPS as well as the method for determining each facility's TPS, as we've done for several years, with some modifications over time. Because the comparison period for determining the national performance standard is under way, we cannot estimate the minimum TPS at this time. As we've done in the past, we expect to estimate the payment year 2020 minimum TPS during this year's rulemaking process and finalize that value in this November's final rule. We will continue to use the payment reduction methodology CMS has employed for several years. This scale is segmented into 10-point increments capped at a 2-percent maximum reduction.

On slide 35, this illustration again provides a graphic summary of how facilities will be scored, how those scores will translate into a TPS, and whether a payment reduction will be applied. It includes the measures, clinical measure subdomains, subdomain weight, relevant calculations, and the scale for the payment reduction, if any. The calculations for scoring the measure domains and TPS are similar to what Joel described for payment year 2019. And, again, new measures are identified with a gold star.

The final rule also covers a great deal of programmatic ground. We want to review these issues at a high level to determine some of the aspects of the ESRD QIP that we wish to refine as we go along. At this time, I will turn it over to Joel.

Finalized Revisions to PY 2019

Joel Andress: Thank you, again, Celeste.

On slide 37, you will see a description of how we've modified the Hypercalcemia clinical measure. These changes were made in response not only to public comments and requirements for the Protecting Access to Medicare Act of 2014 but also to changes in the NQF-endorsed measure specifications in 2014 or – I'm sorry, in 2015. Excuse me.

The first of those changes is that we have modified the measure to allow the reporting of plasma and serum calcium values whereas, previously, specifications had limited reporting only to serum calcium. Additionally, commenters expressed concerns that facilities might underreport data if null values were excluded from the measure calculations. And, so, the second change has been – so, the second change effectively penalizes facilities for non-reporting because null values apply to the measure specifications. Finally, CMS chose to implement these changes in payment year 2019 rather than payment year 2018 as was initially proposed.

Celeste, I'll turn it back over to you.

Celeste Bostic: Thanks, Joel.

The first validation study on slide 38 that we will discuss involves CROWNWeb. CMS remains committed to making sure that the data entered into CROWNWeb by facilities that CMS then uses to score performance is as accurate as possible. The final rule furthers this effort by continuing in payment year 2019 the studies performed in previous years. CMS will apply a significant TPS deduction for facilities failing to respond to requests for information used to support that validation effort.

On slide 39, the second validation study involved the accuracy of data that facilities enter into NHSN. CMS's commitment to encouraging a reduction in patient infections is reflected in measures of vascular access type and the Safety Measure Domain as well as the NHSN data validation activities described here. The methodology used for this validation study will sample candidate events as in the previous years. But it will also involve a random sampling of facility records. This change to the methodology will provide additional insights into facility underreporting of dialysis events. Additionally, CMS increased the sample size for the study from 9 to 35 facilities.

On slide 40, to recap today's presentation, the final rule for payment year 2020 shares a lot of structure with prior years but includes a new outcomes measure and important

programmatic changes. In addition, the final rule altered payment year 2019 by establishing a safety-oriented domain and reintroducing a related reporting measure.

Next Steps and Resources

Now, I'd like to bring the presentation portion of our call today to a close with a brief overview of what's coming next in the program. Let's start with an overview of the next couple of years.

On slide 41, 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 happens at the same time. This graphic illustrates what's going on with the program as we speak. So, right now we're in the midst of payment implications from the payment year 2017 program, the 30-day preview period, and opportunity for facilities to review their ESRD QIP scores for payment year 2018 will take place this summer. Additionally, we have the performance period under way for payment year 2019. And later this year, we will propose and then finalize the rules for payment year 2021. That final rule will include the achievement method values for payment year – for measuring payment year 2020 clinical measures. In this way, the ESRD QIP can be seen as a series of multi-year programs.

Finally, on slide 42, here are a few action items that we recommend you take this year. First, make sure your facility has posted its payment year 2017 performance score certificate in English and Spanish. Second, read and comment on the payment year 2021 proposed rule when it's posted in early July. Review payment year 2018 preview PSRs when available in mid-July and submit any clarification questions or formal inquiries. Join us again for National Provider Calls discussing the payment year 2021 proposed rule and payment year 2018 preview period when scheduled. Review payment year 2018 final PSRs when available in mid-December. CMS appreciates your cooperation, input, and recommendation.

On slide 43, here we list some useful content about the program that is available online, which includes MIPPA, the ESRD QIP section of cms.gov, the ESRD Network Coordinating Center, QualityNet, Dialysis Facility Compare, and the final payment year 2020 rule itself.

Thank you for joining us today. And I will now hand the presentation over to Aryeh to proceed with the Q&A portion of the presentation. Aryeh?

Question and Answer Session

Aryeh Langer: Thank you, Celeste.

Excuse me. Our subject matter experts will now take your questions. But, before we begin, I would like to remind everyone that this call is being recorded and transcribed. Please state your name and the name of your organization once your line is open. In an effort to get to as many participants as possible, we ask that you limit your question to just one.

All right, Holley. We are ready to take our first question, please.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Please hold while we compile the Q&A roster. Again, if you would like to ask a question, please star then one on your telephone keypad.

And stand by for your first question. Again, please continue to hold while we compile the roster.

Okay. Our first question comes from Ludd Ladic.

Ludd Ladic: Hi. This is Ludd Ladic, TCI. I noticed that for several measures, we used to have exclusion criteria for hemodialysis patients based on the seven treatments per month. So if a patient has less than seven treatments per month, the patient will be excluded from the measure. And it looks like it has changed in 2019 and 2020 payment years, and now the criteria is patients who were not assigned to the facility for the entire month. How do you plan to calculate or how do you plan to figure out who was or who was not assigned to the facility for the entire month? And how do you plan to

address situations where a patient is assigned to a facility but spends the majority of the month in the hospital?

Joel Andress: Thank you, Ludd. This is Joel. Give me a brief moment and we'll be right back with you.

Okay. All right, Casey, I believe you're on the line? Can you please respond to Ludd's question about the calculation for Kt/V and the identification of the individual – of the patient placement?

Casey Parotte: So, we can quickly respond in just – I mean, that's a pretty technical answer. We'll just have to say they're assigned to the facility – I don't know the details of how or -- whoever wants to define that. And for the answer for the hospitalization, the answer is yes, they are covered for the facility if they are at the hospital for most of the month.

Joel Andress: Okay. I apologize.

Ludd Ladic: So, what I'm trying to say is the patient may have one treatment in the beginning of the month and then be in the hospital the remaining of the month. And if you – such a patient likely will not have Kt/V done during the month because the patient is in the hospital, but the patient is assigned to the facility for the entire month.

Joel Andress: Okay. Ludd, I apologize, let me see if I can touch base on that. So, we use it for the admit data that comes to us through CROWNWeb as the primary source of information for identifying patients who are present in a facility for a given month. For hospitalizations, we do not take the patient out of the facility unless their stay is long enough within the hospital to trigger a discharge from the facility, in which case they are not included within the measure. So, yes, it is possible for a patient to be hospitalized for a portion of the month and then still be included within the facility's denominator for that patient.

Operator: And our next question will come from the line of Susan Senich.

Aryeh Langer: And just before you go ahead, Susan, I just want to remind our speakers that are on their lines, if we prompt you to answer one of the questions for us, you are in the speaker line and everybody can hear you. So, just take into account. Thank you.

Susan, do you want to go ahead?

Susan Senich: Sure. Okay. Thank you. Susan Senich, North Central PA Dialysis. I have a question about the Standardized Hospitalization Ratio. Is that only counting unplanned – do we count only unplanned? We don't – or do we count planned hospitalizations or both?

Joel Andress: Thank you. This is Joel Andress again. The answer to that is that we do not distinguish between planned and unplanned hospitalizations with the Standardized Hospitalization Ratio. We do incorporate that into returning hospitalizations following the Standardized Readmission Ratio, but it is not part of the SHR.

Susan Senich: Okay, and where do the data come from to figure the Standardized Hospitalization Ratio?

Joel Andress: I'm sorry. So, the data for Standardized Hospitalization Ratios are a combination of Medicare Fee-for-Service claims data and the 2728 form. We incorporate the 2728 form data as well as claims data to establish the comorbidities list for each patient. And we use Medicare claims data to identify hospitalizations.

Susan Senich: Okay. Thank you.

Operator: Our next question will come from the line of Dolly Baker.

Diane Holinsky: Hi. This is Diane Holinsky. I'm new to the hemodialysis arena. So, my question is, for the phosphorus for 2020, the term "phosphorus" is replacing the term "mineral metabolism." What exactly was mineral metabolism?

Joel Andress: Just a moment, please.

Aryeh Langer: We'll be with you in one moment, please.

Joel Andress: Okay. Thank you for your patience. This is Joel Andress again. So, there have been a couple of changes to the measure. Now, the primary changes here include – involves that this measure now also allows both the serum and plasma readings, as we described in the Hypercalcemia measure. We also altered the inclusion criteria so that the same criteria used for – I'm sorry – the same criteria used to identify whether or not a patient should be included within the denominator for a Kt/V is now also applied to the Phosphorus reporting measure. We also now have a measure in place for phosphorus reporting that is NQF-endorsed. And those specifications are maintained at the National Quality Forum.

Diane Holinsky: So, mineral management or mineral metabolism includes calcium – hypercalcemia and hyperphosphatemia?

Joel Andress: To clarify, no. We have a measure of hypercalcemia, which is in place and it address mineral management. We also have a reporting measure for phosphorus. It simply requires that you report phosphorus data for your patients. We have investigated the possibility of a hyperphosphatemia measure in the past and we have been unable to establish sufficient evidence to present one for implementation in the QIP up until now.

Diane Holinsky: Will that include the peritoneal dialysis patients or is this just strictly for in-center hemo?

Joel Andress: Just a second, please.

Thank you again for your patience. The phosphorus reporting measure includes hemodialysis patients but not peritoneal dialysis patients.

Diane Holinsky: Okay.

Operator: And our next question will come from the line of Rebeca Sauceda-Garcia.

Rebeca Sauceda-Garcia: Hi. I am from the university. I do have a question about the Kt/V adequacy. Could you differentiate the previous Kt/V adequacy from the new measure comprehensive adequacy? What is the difference from that?

Joel Andress: Thank you for your question. This is Joel Andress. So, the Comprehensive Dialysis Adequacy measure essentially incorporates an assessment of dialysis adequacy for patient who fall within all four of the populations of the original Dialysis Adequacy measures. So, it essentially asks the question for any of the patients that fall within these pre-existing measures or for the total of all of those patients, for what percentage do you achieve adequate dialysis as appropriately defined for that population. So, the – so it provides us with a single measure assessing dialysis adequacy for as much of the population as we can as opposed to having individual measures that apply only to the specific subpopulations within the facility.

And the reasoning for that is that it increases the number of patients who can be included in the assessment, particularly among peritoneal dialysis patients and pediatric patients who, because of relatively small numbers within facilities, would frequently see facilities excluded from the performance of those measures because they would have relatively few patients who qualified for the denominator.

Rebeca Sauceda-Garcia: All right. I do have a followup question on that. We do have a number of people, usually the small ones, no matter what we do, we repeat their Kt/V and they get a high Kt/V greater than 2.5. And I understand that they're excluded from the denominator. Will the facility still get penalized for these patients having Kt/V greater than 2.5?

Joel Andress: Yes. This is Joel again. So, they are not excluded from the measures for the ESRD QIP. They are – but, we do exclude high-range values from measures for Dialysis Facility Compare. And, I think, that may be what you were thinking of here. What I would suggest is sending a question to the help desk, and we can start talking with you about what your particular experience with that is. I can speak as the measure developer. We'd be interested in getting any feedback on to the specifications we have for those measures.

Rebeca Sauceda-Garcia: Okay. Thank you.

Joel Andress: Thank you very much.

Operator: Our next question will come from the line of Lindsey Clemente.

Aryeh Langer: Go ahead, Lindsey.

Operator: And that question has been withdrawn. Stand by for your next question.

Our next question will come from Nancy Pelfrey.

Nancy Pelfrey: Thank you. This is Nancy Pelfrey with Reliant Renal Care. My question has to do with the comprehensive clinical measure for the dialysis adequacy, which now combines hemodialysis and peritoneal. And the combined value is lower – the percentage is lower than what the previous years – the – just the in-center or the hemodialysis percentage was. So, how does that work when you have just a center that has hemodialysis with a center that has both hemo and PD? Because it seems like the center that only has hemo now does not have to strive for a higher percentage of Kt/V greater than 1.2. I just wondered the thought behind that and how that works.

Joel Andress: Sure. Thank you. So – this is Joel again. Thank you for the question. The answer is that your performance for the Comprehensive Dialysis Adequacy measure is essentially weighted based upon the number of patients you have in a given subpopulation. So, if you have only hemodialysis – in-center hemodialysis patients who are adults, then that will be the entirety of your dialysis adequacy score. If you were to evenly split between the two, then your score will be evenly split between your performance on hemodialysis and on peritoneal dialysis.

I think, if you have a particular question about how your performance has changed, then I would take that to the help desk so that we can look at your particular scores and we can describe how that – how it shifted. But, the one possible answer to your concern is that if you have – if you had a relatively small number of PD patients or pediatric patients, they may have been excluded from your performance assessment previously. And, so, their overall performance rate may have been lower. But, that wouldn't have previously been capture in the QIP because the measure – your performance was not included in the TPS calculation due to low numbers. And, so, that's one possible explanation. But, to delve more deeply into your particular experience, I think it would be useful to contact the help desk and we can discuss it with you directly.

Aryeh Langer: Thank you very much.

Operator: Our next question comes from Karen.

Aryeh Langer: Karen, your line is open.

Operator: And that question has been withdrawn. Our next question comes from Jane Wallace.

Aryeh Langer: Jane, are you there?

Operator: Jane, go ahead.

Aryeh Langer: We should go ahead and….

Operator: That question has been withdrawn. Our next question will come from Felicia Lambert.

Felicia Lambert: Hi. I just wanted to get little clarification again. The young lady asked about the denominator to be – in Adequacy – the 2.5 excluded. So, my question that the gentleman had said it wasn't – it was in Dialysis Compare and in – that it is included in the ESRD QIP. On the CMS fact sheet, it lists in the denominator number 7 for the exclusion criteria patients who have not met – well, patients 0.5 or 2.5 greater are excluded from the denominator. So, is that fact sheet not current or is there something that has changed, because it is on the fact sheet for CMS?

Joel Andress: Just a moment, please.

Celeste Bostic: Hi, Felicia. This is Celeste. So, the place to look for the updated fact sheet is on cms.gov on the QIP section, where you will find the updated exclusions for payment year 2020.

Felicia Lambert: Okay. Thank you.

Aryeh Langer: Thank you.

Operator: Once again, if you would like to ask a question, press star one on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

And our next question will come from the line of Lindsey Clemente.

Lindsey Clemente: Hi. This is Lindsey again. Can you hear me?

Aryeh Langer: Are you able to speak up a little bit, please?

Lindsey Clemente: Yes. Is this any better?

Aryeh Langer: Yes. Thank you.

Lindsey Clemente: Thank you. Just a question about QIP in general and its relation to AKI patients now that you're probably aware that Medicare pays for them effective January 1st, 2017. From my understanding, they're not included in QIP at all in any of the measures and in any of the scoring. And I know that they are not included in CROWNWeb and you're able to distinguish AKI patients from ESRD patients on Medicare claims. But, my concern is for the NHSN BSI measure. They have no way to distinguish between an ESRD patient and an AKI patient, and they do require AKI patients to be entered in. So, my concern is how are they being filtered out from that QIP measure, because if an AKI patient has a positive blood culture, that really will significantly affect our positive blood culture rate because one event really throws it off. So, I just wanted to bring that up with you in case you weren't aware of it.

Celeste Bostic: Hi. Thank you. This is Celeste. Thank you, Lindsey. We did receive your question before the call, and we are actually in the process of getting a response back to you. So, we will be replying to you via the QIP mailbox shortly. Thank you.

Lindsey Clemente: Thanks.

Operator: And our next question will come from the line of Joseph Rich.

Joseph Rich: Hello. Can you hear me?

Aryeh Langer: Yes. Go ahead, Joseph.

Joseph Rich: Okay. I did have a question that had to do with the hospitalization – I mean, the Kt/V and the – being in the clinic for the entire month. But, I think, I'm going to reserve that follow up for just the question I had, which had to be with NHSN and the reporting on that. Because we give antibiotics in dialysis clinics for other reasons other than dialysis-related or even access-related. Maybe they're in – they have a foot ulcer or they have some other – prophylactically, you are making for dental extraction and so forth.

And we get – we are going to go ahead and put those into NHSN because it is an antibiotic. So, how does that affect the SRR?

Celeste Bostic: Thank you, Joseph. This is Celeste. Give us one second.

Aryeh Langer: Be with you in one moment, please.

Celeste Bostic: This is Celeste. Thank you again, Joseph, for your question. Please forward your question to the ESRD QIP mailbox and we will follow up with the CDC to provide you with a response.

Joseph Rich: Okay. Well, thank you. Would I be able to ask a question about the hospitalization readmission?

Aryeh Langer: Yes. Go ahead. Are you able to speak up? We're having a hard time hearing you. Thank you.

Joseph Rich: I'm trying to speak up as loud as I can. I apologize.

Aryeh Langer: Go ahead.

Joseph Rich: Hospital readmission – we sometimes have patient who go into the hospital and, let's say for a foot ulcer and then come out of the hospital and then go back in for a GI bleed and neither one of those may be dialysis-related. How does that affect the Standardized Readmission Ratio?

Joel Andress: Thank you. This is Joel Andress. I just wanted to confirm. You're referring to the readmission ratio and not the hospitalization ratio?

Joseph Rich: Well, both, the hospitalization ratio and the readmission, whichever you can speak to.

Joel Andress: Okay. I can speak to both because the answer's the same for both, and that is at present we don't distinguish the cause of a hospitalization or a readmission, that is, we don't try to identify whether or not it is related to dialysis care. What we do do with the readmission measure only is apply a set algorithm of planned readmissions. And so these are diagnosis and procedure codes that are attached to the readmission event which we identify as being likely to be a consequence of a planned readmission. And, so, we consider that to – that, you know, that return to the hospital to not be a failure in care but to be a continuation of care. And, so, facilities are not penalized for any readmissions that contain those procedure and diagnostic codes within that algorithm. The hospitalization ratio doesn't have that algorithm applied to it because is it not capturing return events but just overall hospitalization.

Joseph Rich: Okay. Thank you.

Operator: And our next question will come from the line of Noah Espinoza.

Noah Espinoza: Hello. This is Noah Espinoza from the Northwest Kidney Centers. Can you hear me?

Aryeh Langer: Yes. Perfectly.

Noah Espinoza: Okay. Great. Awesome. My question is in regard to the ICH CAHPS measure. And I just wanted to see how CMS is taking into account the relatively low response rates for the questionnaire. In most of our facilities, they are under 50 percent of the patients responding to the questionnaires given out. Thank you.

Celeste Bostic: Hi. This is Celeste. Thank you, Noah, for your question. Give us one second.

Hi, Noah. Thank you. So, you are required to have 30 completed surveys returned in order to be eligible for the measure for ICH CAHPS. If you do not have 30 completed returned surveys, you will be excluded from the measure.

Noah Espinoza: Okay. Great. Thank you for your answer.

Celeste Bostic: You're welcome.

Operator: Our next question comes from the line of B.J. Liamniso.

B.J. Liamniso: Hi. This is B.J. with QMS. I just had a question about the ultrafiltration rate value. Where are those values being pulled from?

Joel Andress: Thank you. This is Joel Andress. And I'm interpreting your question to mean where are we getting the values for the ultrafiltration rates. And the answer is that we are not receiving an actual ultrafiltration rate value. We are receiving data elements through CROWNWeb that can be used to calculate an ultrafiltration rate. The measure that was finalized for payment year 2020 is not a clinical performance measure. And, so, no one is being assessed based on their patients' ultrafiltration rates, only submission of the relevant clinical data to CROWNWeb. Thank you.

Operator: Once again, if you would like to ask a question, please star, then one on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key. And our next question will come from Ludd Ladic.

Ludd Ladic: Hi. This is Ludd Ladic, TCI. Slide 23 of the presentation that we had today has the finalized PY 2019 performance values. And I have two questions. Question number one, were those values generated using old rules or using new rules? For example, old seven treatments per week – per month rule for adequacy or new rule of entire month for adequacy? And the second question, I see only one set of parameters for Kt/V dialysis adequacy. We have several clinics that provide only peritoneal dialysis treatments. And for those clinics, their Kt/V outcome is much lower than what you would see in clinics that provide only hemodialysis treatments or mixed treatments. And how do you plan to assess clinics that have only peritoneal dialysis population?

Joel Andress: Thank you, Ludd. This is Joel. I'm going to answer your second question first and then, I think, we'll take a second to discuss your first question and then come back to it.

For the second question, the answer is that these facilities are assessed based on the percentage of the patients they treat for whom they achieve the listed level of clearance. So, we've defined within the specifications for adult and pediatric peritoneal dialysis patients the appropriate – the adequate level of dialysis that should be received, and your score is based upon the percentage of your patients who achieve that. If the facility has a relatively low number – low percentage of patients who achieve that level, then their performance will also be relatively low. There's no adjustment in place based upon the kind of dialysis that they are receiving. And we'll be back in a second with your – with a response to your first question.

Ludd Ladic: And it says – actually, for the second question, if you look at 2017, adult peritoneal dialysis achievement threshold was 70 percent, whereas for hemodialysis, it was almost 87 percent – so, meaning that facilities that had only peritoneal dialysis patients and had 87.5 percent of patients with Kt/V greater than 1.7 would have scored 5. Now, there's a new combined measure that a facility would be judged not against 87.5 percent but against 93.6 percent or whatever – 93.08 percent, which is indicative for hemodialysis more than for peritoneal dialysis.

Joel Andress: So, Ludd, I think, the answer to your comment or, actually, this question – the answer to your comment is yes, that is how it's applied. If you have – I mean, if you have comments with regard to the appropriateness for the quality measure, then I – then we have our help desk at dialysisdata.org, which addresses – can readdress specifically to the measure development specifications. And we would be happy to respond to your comments there.

Also, for the ESRD QIP, you have, as always, the opportunity to submit comments to the proposed rule with regard not only to the measures that we propose but to existing measures as well. And, so, that would be another venue to submit comments. And, as always, we have an inbox for the ESRD QIP ongoing and receiving comments.

I'll be back in just a second with a response to your first question.

And, Ludd, with response to your – with regard to your first question, the measure specifications are updated before we calculate the performance standards. And, so, any performance standards that you're seeing are calculated are using the new criteria. So they're not using the seven-touch – the old seven-touch rule that had been in place for the individual dialysis adequacy measures.

Operator: And our next question comes from the line of Karen.

Karen: Hello. Can you hear me? Hello.

Aryeh Langer: Yes, Karen. Go ahead.

Karen: Okay, good. Sorry. So, I just had a question as far as pediatric facilities. We often don't have a very good fistula graft rate because of our population. So, I know that we want to have limited catheters. But, we can't always do so. That also applies to us – can't always have pain assessment and depression scores and different things like that. Are those things taken into consideration for pediatric facilities or is there something we should be doing so that it is taken into consideration?

Joel Andress: Okay. Thank you. This is Joel Andress again.

So, we don't take into account a facility's type. Any exclusions or adjustments that are incorporated within the measure specifications will be specific to the patient characteristics of the – for the measure that we've developed. We don't, I believe – and I'm going off of what I've heard just from your comment – I don't believe we have any particular adjustments or exclusions that would be applied direct specifically for pediatric patients at this time.

We do have a new pair of measures that were just recently NQF-endorsed. And I'd encourage you to look at the specifications at the National Quality Forum to review whether or not those – you think those address any of your concerns and if you have remaining concerns.

And, then, I would suggest to you the same course that I discussed with Ludd, which is that we have a help desk at dialysisdata.org where you can submit question specific to measure specifications. And you can also contact the ESRD QIP inbox or submit

comments during the proposed rule – for the proposed rule where you can address concerns specific to individual measures to us. And we certainly encourage you to do so.

Operator: And our next question will come from the line of Pamela Patterson. Pam, your line is open.

Pamela Patterson: Hi. Can you hear me?

Aryeh Langer: Yes. Go ahead.

Pamela Patterson: Hi. I think it was Celeste who was speaking about the 2020 measures, and she was talking about the ultrafiltration rate. And she went on to say that it would be – the information would be taken from, I guess, the week that we report the last Kt/V in CROWNWeb. But, I missed the majority of what she said. Could she clarify that for me?

Aryeh Langer: Give us one moment, please.

Pamela Patterson: Thank you.

Celeste Bostic: Hi. This is Celeste. Thank you for your question, Pamela. On slide 32, facilities are required to report data for all chemo sessions during the week of the monthly Kt/V draw that is submitted to CROWNWeb for that clinical month.

Operator: And our next question will come from the line of Shelly Guyer.

Shelly Guyer: Can you hear me?

Aryeh Langer: Yes, Shelly. Go ahead.

Shelly Guyer: I have a question about the payment year 2020 scoring methodology. Under the clinical measures, there's a subdomain of patient family engagement and the clinical care, which is 60 percent. We are a small pediatric facility, and we don't have enough patients to do the ICH CAHPS survey. So, that's 40 percent of our score there for that subdomain. How do they adjust for that?

Aryeh Langer: Give us one moment, please.

Shelly Guyer: Okay.

Joel Andress: Thank you for your patience. This is Joel Andress again.

Shelly Guyer: Yes.

Joel Andress: So, the answer to your question is that if you are not eligible for the ICH CAHPS, then the percentage of the clinical domain score that would have been applied for the ICH CAHPS measure is then distributed equally across the remaining measures in the clinical domain for which you are qualified – for which you are eligible.

Shelly Guyer: Okay. All right. Thank you.

Operator: And our next question will come from the line of Deborah Werner.

Aryeh Langer: Deborah, your line is open.

Deborah Werner: Hi. This is Deb Werner. Can you hear me?

Aryeh Langer: Yes. Go ahead.

Deborah Werner: Hi. Yes. I was interested in the two questions that were asked about the acute renal failure patients and then patients receiving IV antibiotics. And you said you were going to have to get back to them.

Will that be shared like a question-and-answer document that we'll be able to look at?

Celeste Bostic: Hi, Deborah. This is Celeste. Thank you for your question. Please also submit to the ESRD QIP mailbox, and we will also provide you that response. Thank you.

Deborah Warner: Okay. Perfect. Thank you.

Operator: Our next question comes from the line of Richard Dominguez.

Richard Dominguez: Are you able to hear me okay?

Aryeh Langer: Yes, sir.

Richard Dominguez: Okay. I had a followup question on the one that was asked about the ICH CAHPS as far as the minimum response. You indicated 30. And I wanted to know if that was 30 per semi-annual survey or was that 30 for the entire year?

Celeste Bostic: Hi. This is Celeste. Thank you for your question, Richard. That would be 30 for the entire year.

Richard Dominguez: Okay. That's perfect. And I had a followup question as well. When is the latest performance score going to be released, do you know? On the QIP?

Celeste Bostic: The payment year 2017 Performance Score Report?

Richard Dominguez: Correct.

Celeste Bostic: They're actually available for download today.

Richard Dominguez: Okay. I went online and I didn't see them available yet. So, I was questioning. Okay. Perfect. That's great. Thank you so much.

Celeste Bostic: You're welcome.

Operator: And our final question will come from the line of Jane Wallace.

Jane Wallace: Hello. Can you hear me?

Aryeh Langer: Yes. Go ahead.

Jane Wallace: Hello?

Aryeh Langer: Hello, Jane.

Jane Wallace: Hi. I apologize for before. I think I hit the wrong button. My question – and I don't know if I got disconnected and I didn't hear if you answered it for someone else – it was related to the Standardized Hospitalization Ratio. I know it was mentioned that the data would come from the 2728 plus the Medicare Fee-for-Service claims data form. Since we cannot add any extra comorbids on the 2728, will we – I guess, will the other comorbids come from that same form? Because in our population, we deal with a lot of home patients, and we have a lot of sick patients in our clinic, and we're just trying to figure out how we can get the extra comorbids in.

Joel Andress: Thank you very much. So, to clarify, we do incorporate data from the 2728 to capture patient comorbidities at the start of dialysis. We also incorporate recent comorbidity data from Medicare Fee-for-Service claims data for those patients. So, more recent comorbidity information has now been incorporated in the SHR. And that's the version of the measure that was just endorsed by NQF—so, its maintenance cycle—and ones finalized for this measure. So, those additional comorbidities will be included in the measure calculation for payment year 2020 and moving forward.

Jane Wallace: Okay. Would the facilities have any input in that or we would just have to get whatever's sent from the hospital?

Joel Andress: So, the data we currently capture for that is captured through the hospital inpatient claims for the measure.

Jane Wallace: Okay.

Joel Andress: There is –I guess, the answer to that is that there's not a separate period where you can add additional comorbidities upon review. But, we do capture a full spread of, I believe, 200 comorbidity categories from the Medicare Fee-for-Service data available to us. And I should also mention that we do include outpatient claims as well for the Clinical Rating capture.

Jane Wallace: Okay.

Joel Andress: So, I just want to make sure that's clarified. Does that answer your question?

Jane Wallace: It helps. Thank you so very much.

Joel Andress: All right. Thank you.

And I believe that was the last question. So, now's the final round where I get to wear egg on my face. There are two clarifications I would like to make with regard to previous questions.

The first has to do with the pediatric patients and the vascular access measures. So, to clarify, the vascular access measures do not include pediatric patients. They are adult only. So, I just want to make sure that we touch that.

And then, finally, for the Phosphorus reporting measure, I stated very resolutely that PD patients were not included in that measure. And I was incorrect on that point. Both peritoneal dialysis and hemodialysis patients are included in the patient population for the Phosphorus reporting measure. I just want to make sure that that is clear before we sign off.

Thank you.

Additional Information

Aryeh Langer: And thank you, Joel, for your clarification.

So, that's – we plowed through all those questions. We did a really good job here. If we did not get to your question, we encourage you to send an email to the esrdqip@cms.hhs.gov email address.

As a reminder, an audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these materials become available.

On slide 46 of today's presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are voluntary, anonymous, and are kept confidential. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Aryeh Langer. I'd like to thank our presenters here at CMS and also thank you to everybody on the lines for participating in today's MLN Connects Call. Have a great day, everyone.

Operator: That concludes today's conference call. Presenters, please hold.

-END-


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