**Centers for Medicare & Medicaid Services**
**Special Open Door Forum:**
**End Stage Renal Disease Quality Incentive Program**
**Payment Years 2013/2014 Final Rule and Benchmark Data Overview**
**February 2, 2012**
**2:00 – 3:30 PM EDT**
**Conference Call Only**

The Centers for Medicare & Medicaid Services (CMS) will hold a Special Open Door Forum (ODF) to discuss the final rule for the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) for Payment Years (PY) 2013 and 2014 and the related baseline data for PY 2014. The ODF will provide an overview of quality measures, scoring methodologies, and payment reductions.

This Special ODF is designed specifically for dialysis facilities, providers, beneficiaries and their families, and advocates in an effort to increase awareness and understanding of the PY 2013/2014 final rule. Most importantly, this forum provides CMS with the opportunity to engage and listen to the needs and concerns of the clinical, beneficiary and advocate community.

The final rule went on display at the Federal Register on November 10, 2011, and can be read online at: http://www.gpo.gov/fdsys/pkg/FR-2011-11-10/pdf/2011-28606.pdf

During this ODF, CMS will provide a comprehensive overview of the PY 2013/2014 final rule and associated PY 2014 benchmark data including:

- Overall design of the ESRD QIP to improve quality
- Payment Year 2013 program
- Payment Year 2014 program

Discussion of both payment years will include:

1. Performance Measures
2. Applicability of measures to specific patient or facility types
3. Performance Standards
4. Performance Period
5. Scoring Methodology

After CMS' presentation, participants will have an opportunity to ask questions.

Discussion materials for this Special ODF will be available to download at http://www.cms.gov/ESRDQualityImproveInit/ by January 31, 2012.

We look forward to your participation and comments.

Special Open Door Forum Participation Instructions:

Dial: 1-800-837-1935 (toll free)
Reference Conference ID#: 47110132

Note: TTY Communications Relay Services are available for the Hearing Impaired.

For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

An audio recording and transcript of this Special Open Door Forum will be posted to the Special Open Door Forum website: http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning on or around February 13, 2012 and will be available for 30 days.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at http://www.cms.gov/opendoorforums.

Thank you for your interest in CMS Open Door Forums.

Audio File for Transcript:
http://downloads.cms.gov/media/audio/SODFEndStageRenalDiseaseQualityIncentiveProgram020212.mp3

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**Moderator: Matt Brown**
**February 02, 2012**
**2:00 p.m. ET**

Operator: Good afternoon. My name is (Nicole). I'll be your conference facilitator today. At this time I like to welcome to the Centers for Medicare and Medicaid Services, End-Stage Renal Disease Quality Incentive Program, Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question please press the pound key.

Thank you Mr. Brown, you may begin your conference.

Matt Brown: Thank you (Nicole). Good afternoon and good morning to those on the west coast. As (Nicole) stated, welcome to our End-Stage Renal Disease Quality Incentive Program, Special Open Door Forum with emphasis on the Payment Years 2013/2014 Final Rule and benchmark data overview. Thank you for your patience, as we took a little bit longer to gather. Hopefully you have

received a notice with the slides – with the web link to these slides and you have them in front of you.

Because we're getting started a little later, I'm going to turn this call over quickly to the Chair of this call, Teresa Casey, who is the Director of the Office of Clinical Standards and Quality, Quality Improvement Group, Division of Quality Improvement Policy for Chronic and Ambulatory Care; that's a long one there. So Teresa Casey, you're up.

Teresa Casey: Thanks and welcome everyone. I'm delighted to be able to speak with you on this call. I am the first line manager responsible for the division, which is implementing the Quality Incentive Program and with me in the room is a team of lots of knowledgeable folks. I am hopeful that when we get to the question-and-answer portion of our call, that we have the right staff to answer your questions available. I'd also like to recognize Dr. Priti Patel from CDC who has joined us on the call and will be available also during the last portion of the call as we take questions.

I'd like to introduce (Jordan Vanlare). He is the Advisor to the OCSQ front office in terms of the value based purchasing programs across the agency. Jordan is going to provide an overview and queue up our topic.

Jordan Vanlare: Thank you so much Teresa and thank you all for joining and also for being involved in CMS' truly first national program to link payment with performance. Today we're going to be talking through an overview of the ESRD Quality Incentive Program for Payment Years 2013 and 2014. So hopefully you'll come out of this discussion with a better understanding of what's going to be happening over the course of those program years.

Specifically we're going to touch initially on the program's legislative framework, framing the context of the broader efforts of value-based purchasing at CMS. Then we'll also discuss the measures, standards, scoring and the payment reduction scales for you know Payment Years 2013 and 2014 and then we'll close up with a discussion of resources and be able to answer all of your questions.

On page two of the slide document, we outlined our objectives as an agency for value-based purchasing. This a very exciting time for quality at CMS. For the first time we're able to unify as an agency behind the U.S. Department of Health and Payment Services, National Quality Strategy, which set out a three part aim of improving healthcare for individuals, the health of population and reducing the cost of care. And the Quality Incentive Program is on the frontline of being able to implement that national quality strategy through a payment program.

So specifically what we're doing is a combination of being able to collect evidence of quality performance using the measures that are included, creating transparency and performance across a variety of care settings and provider settings, in this case in the dialysis facilities; and then being able to use that information to drive incentive payments and to be able to refine the payment model going forward, that link quality and payments.

And again, I'd just like to call out that really this program is at the leading edge of payment reform and captures – where we're headed in terms of greater accountability of care and I thank the program committee here and certainly the ESRD and dialysis community for really being leaders in quality of care.

On page three when you outline what the legislative drivers were behind this program, as I mentioned this is one of the leading programs in terms of CMS' efforts to link quality and payment. As it was authorized by the Medicare Improvements for Patients and Providers Act of 2008 and it's described in section 1881(h) of the Social Security Act.

The objectives for the program are to promote patient health by encouraging renal dialysis facilities to deliver high quality patient care and in order to do that, the section authorizes CMS to make payment reductions if the facility does not meet or exceed the total minimum performance score, based on a series of quality measures that are established by CMS.

Payments to a facility can be reduced by up to 2%. So taken in aggregate, this is a great opportunity to be able to drive quality improvements within the

community, so that we're working together for improving the quality of care for all of our beneficiaries.

And I'm going to hand it over to Teresa to walk through the rest of it.

Teresa Casey: Thank you very much (Jordan). We are now on slide four. I am hopeful that the participants have taken a look at the slides, either on your screen or you've downloaded them, because I will be really depending on your being able to look at the slides throughout the presentation, particularly as we get to the examples of the scoring.

So I'm going to start with slide four. CMS has undertaken annual rule making to implement section 1881(h). We know that this legislation requires the inclusion of measures on anemia management that reflect the labeling approved by the FDA; measures on dialysis adequacy and to the extent feasible, measures of patient satisfaction, iron management, bone mineral metabolism, and vascular access.

CMS has proposed and finalized rules for Payment Years 2013 and 2014 of the ESRD Quality Incentive Program; Payment Year 2013 represents year two of this program; Payment Year 2014 refers to year three of the program. The proposed rule was published in early July and the Final Rule was published in early November 2011.

Now while the rules included several topics such as prospective payment system, ambulatory schedule, DME policy, this ODF presentation of the Q&A's are limited to the topic of the ESRD Quality Incentive Program. We have the right experts in the room and we would like to be able to stick with that topic and may not be able to answer those other types of questions.

On slide five, during our August 4, 2011 Open Door Forum, we outlined the content of the proposed rule and during that forum we had asked you for public comment submission. The comment period for the proposed rule ended on August 30, 2011 and we received 88 comments regarding the Quality Incentive Program for years two and three. And although there were

88 commenters and these are individuals as well as organizational entities, the comments covered 364 areas.

Now I want to just take a brief moment to express my thanks and appreciation for the comments submission. You'll see that the comments were summarized and responded to in the Final Rule and the Final Rule specifically articulated what the finalized policy is.

And for just a minute I want to jump ahead to make a point about the impact of public comment. We very much appreciate your input and I'd like to point out that there were in fact several changes made in going from the proposed rule to Final Rule based on your comments. We had originally proposed eight measures. We had gotten comment related to the Standardized Hospitalization Ratio Admissions measure, as well as the claims-based vascular access infection measure, and due to the concerns expressed by the commenters, we did not move forward with finalizing those two measures.

In addition, we had proposed moving forward with the Kt/V measure for our dialysis adequacy measure. Someone pointed out problems with the methodologies used to calculate the Kt/V, and in addition issues in terms of whether or not residual renal function was added into that calculation. And so we are not going to finalize the Kt/V measure; instead we are retaining the Urea Reduction Ratio measure.

However, we did issue change request number 7460, which provides guidance and direction to providers in terms of how to report this information on the claims, such that we then have data that is usable and consistent.

In addition based on comment we finalized a more gradual payment reduction scale, which includes the 0.5 percent increment for Payment Year 2014 and we also adjusted the scoring methodology to use medians and percentiles instead of mean and standard deviations, and this was due to some comments regarding consistency and tier distribution and so on. So I just want to again appreciate our thanks for the comments. We considered them, we responded to them in the Final Rule, and they have made a difference.

Let's focus now on the final policies for the ESRD Quality Incentive Program for Payment Year 2013. Again, this is year two of the Quality Incentive Program. We have finalized the two proposed measures; Percentage of Patients with Hemoglobin levels Greater than 12g/dL, and the aim here is for fewer patients to have a hemoglobin greater than 12; and the second measure that we finalized is Percentage of Patients with the Median Urea Reduction Ratio of 65 Percent or Greater, and of course here the aim is to have more patients with a URR of at least 65%.

Facility's must have at least 11 patients eligible for each measure in order to receive a Total Performance Score in order to be included in this Quality Incentive Program. Facilities that are excluded from the Quality Incentive Program would incur no payment reduction.

Moving to slide eight, this slide presents the exclusion criteria used for the hemoglobin greater than 12g/dl measure and they are – really there's no change from the proposed rule regarding the exclusions. Claims will be excluded from the measure calculation if the patient is less than 18 years old; the start date of the claim is 89 days of End-Stage Renal Disease as of the start date of the claim; has a reported hemoglobin value that is outside the feasible range; if the patient is not treated with ESAs; or has fewer than four months of eligible claims at the facility for the period.

Now I will notate that there was one change when we went to the Final Rule, again based on comments and it doesn't have to do with the exclusion or inclusion criteria, but it has to do with the addition of rounding the values, such that when we take patient hemoglobin levels and round them, we will only allow the use of one decimal space before rounding up or down so that is a change that was made as we went into the Final Rule and for those who sent the comment.

Slide nine, the hemodialysis adequacy measure exclusions are listed here and again, there is no changes going from the proposed rule to the Final Rule in terms of the exclusion criteria, which includes claims where the patient is less than 18 years old as of the start date of the claim; has fewer than seven dialysis sessions per month; is in the first 182 days of ESRD as of the start

date of the claim; or if the patient is a home dialysis patient, if the patient is on frequent hemodialysis (and that's defined as four or more sessions per week) or if the patient has fewer than four months of eligible claims at a facility during the measurement period.

Slide 10, we have proposed to retire the hemoglobin less than 10 g/dL measure. We did finalize the retirement of this measure. This action is consistent with the labeling approved by the FDA that was released back in June. I will say that we did get a large number of comments on this topic, but I would like to bring to your attention, something that was addressed in the Final Rule, because I think it bears repeating and we are happy to have your input.

We are considering ways to incorporate achieved hemoglobin levels, ESA usage and other important factors in their anemia measurement strategy for future years of the Quality Incentive Program. We welcome community input and would like to encourage measure development in this area and so we look forward to your input and make sure that as we continue rulemaking in future years that we will be looking at this.

Moving onto performance standards for 2013. The performance period finalized is calendar year 2011. So for Payment Year 2013 the data is obtained from dialysis facility claims. Now in terms of the scoring, the facility has two opportunities to capture points for each of the measures. One of two performance standards will apply and those are listed here. The facility's performance rate from 2011 is compared to either the facility's performance as of the 2007 data, and we refer to this as our special rule, or the facility is compared to the national performance rate or national average in calendar year 2009.

Now what we do is we score the facility in both ways and whichever score is the better is applied to the facility. So again, in terms of the special rule, as long as the facility score is no worse than they did in 2007, there would be no points deducted for a given measure.

The National Performance Rate, slide 12. The 2009 National Performance Rate for the hemoglobin greater than 12g/dl of measure is 14 percent. Now this 14 percent rate was provided in the Final Rule. The NPRM provided a National Performance Rate of 16 percent, so this is a slight change. The reason for this change may be found on page 70260 of the Final Rule. In response to comment as I mentioned earlier we have adjusted the rounding approach as we calculate the rates and we also had viewed some most recent 2009 data that we had available at the time of the Final Rule's publication.

The 2009 National Performance Rate for the hemodialysis adequacy measures is 70 – 97, excuse me, 97 percent and this was a slight change from the proposed rule where the rate is calculated at 96 percent. Again, we now have more complete data than at the time of the Final Rule publication.

Slide number 13. When the facility meets or exceeds performance standard (either its own performance in2007 or the national performance rate in 2009), 10 points are awarded. If the facility does not meet the performance standard for measure, two points are subtracted from the 10 points for every one percent by which the facility falls short. Once you have the score for each of the two measures, we multiply each measure by 1.5, and the reason for this is we're continuing to use the 30-point scale, but we only are scoring two measures for Payment Year 2013. For Payment Year 2013 the measures are weighted equally. The highest attainable score is 30 points.

Now once we arrive at the total number of points, we can look at the table on slide 14, to see what the correlating payment reduction is. We finalized the scale of payment reduction as proposed without any changes. The table shows how the points or performance score translates into the payment reduction or not.

If the facility scores 30 points, there will be no payment reduction. If the facility scores between 26 and 29 points, there will be a one percent payment reduction. Between 21 and 25 points, there will be a one and a half percent payment reduction and if there will be 20 points or less, that would be the full two percent payment reduction.

Now, I'd like to remind you that providers will have an opportunity to preview the performance rates, the scores as well as the payment reduction, if applicable. There is a 30 day preview period starting in mid-July 2012 and the providers have the opportunity to review all this information as well as submit questions, submit enquiries and CMS will individually respond to any question or enquiry that you might submit.

Now that we've covered our Payment Year 2013 measures and the standard scoring and payment reduction, let's move on to the Quality Incentive Program Payment Year 2014. This is the first year where we've been able to publish the measures, scoring methodology and performance standards before the start of the performance period. This means that we can move away from the use of the special rule and include performance standards that address both achievement and improvement.

Slide 16; the Final Rule broadens the scope of the following Quality Incentive Program measures. Although we proposed eight, we did finalize six. There are three clinical measures that were finalized, one of which is a new clinical measure and not previously in our program; and that new measure is the Vascular Access Type measure.

We also finalized all three reporting measures that were proposed. We finalized a weighting model, such that for facilities that are eligible for both, this one clinical measure and a reporting measure, the rating would be 90 percent of the total performance where weight is the clinical measure, whereas the reporting measure would comprise 10 percent of the Total Performance Scores.

Scoring on the clinical measures is based on the facility's achievement or improvement on a measure, and the facility will receive the higher of the two scores; and we are going to address the scoring in more detail later in the slide.

So let's take a look at the three clinical measures. You will recognize two of them. The first measure is the anemia management measure in terms of hemoglobin greater than 12g/dL. The second measure is the hemodialysis

adequacy measure and as I mentioned at the beginning, we did not finalize the Kt/V measure.

We are continuing with the URR measure for Payment Year 2014. These two clinical measures will get their own individual score that will be added up along with the other scores to get us the Total Performance Score now. I mentioned that, because the next measure, Vascular Access Type measure is comprised of two equally weighted sub-measures. So that the anemia management measure, the hemodialysis adequacy measure and the Vascular Access Type measure will be equally weighted. The Vascular Access Type measure encourages the placement of fistulae and discourages the placement of catheters.

Moving to slide 18, the reporting measures are presented here. The first measure refers dialysis event data submission to the CDC via the National Healthcare Safety Network System. The second reporting measures requires attestation of the patients experience of care survey administration and the survey must be the In-center Hemodialysis CAHPS survey, not a different survey or substitute survey. It would have to be that particular survey.

The third reporting measure is attestation of monthly mineral metabolism monitoring, where serum calcium and serum phosphorous levels are checked monthly for all patients. These are reporting measures or process measures and the actual facility results are not assessed by the Quality Incentive Program for Payment Year 2014; however, in future years where the agency would like to move into performance outcome measures in these areas and we invite your input and comment on how to best proceed and we had asked for your continued input in the Final Rule.

Now moving back to the clinical measures, slide 19, the measure specifications in terms of the exclusions for the anemia management measure, as well as the hemodialysis adequacy measure are unchanged from what we just described for 2013, and so I'm not going to read or review that same criteria now, but refer you back to slides eight and nine if you want to revisit that.

Moving to slide 20, I mentioned the Vascular Access Type measure consists of two submeasures. The first one being the percent of hemodialysis patients using AV fistula with two needles during the last treatment of the month. The second measure is the percent of hemodialysis patients who had a catheter in use for 90 days or more.

Each submeasure repeats a score which is determined as if it were a standalone measure. Each submeasure scores can be either achievement or improvement, depending on which approach gives the better score for a facility. Those scores are then averaged to derive the Vascular Access Type measure score. The facility must have at least 11 hemodialysis vascular access cases in order to be scored on this measure.

Slide 21 walks us through exclusions for the Vascular Access Type measure. Claims are excluded from the AV fistula submeasure if the patient is less than 18 years old at the start date of the claim; is on peritoneal dialysis; or has fewer than four months of eligible claims at the facility in the performance period.

Now I just want to mention that we are talking about vascular access and the claims-based measure. There was a change request for that. It was change request number 6782, which provided guidance in terms of the reporting that should be submitted on the claim and that is pertinent of course to this measure.

Claims are excluded from the catheter submeasure if the patient is less than 18 and 90 days old as of the start date of the claim; the patient is on peritoneal dialysis; or if the patient does not have at least four consecutive months of eligible claims at that facility.

Now let me review the final clinical measures for Payment Year 2014. I will describe the scoring with some examples and then review the Payment Year 2014 performance standards for these clinical measures.

So now we're on slide 23. We finalized the performance period as calendar year 2012, which means we are now one month into the performance period.

The baseline period for the clinical measures was from July 1, 2010 through June 20, 2011. Now I want to make note here that there is only a six-month time gap between the end of the baseline period and the start of the performance period, and so I see this as an improvement from previous years and is something that our commenters wanted to see.

A facility's score for each of the clinical measures will be based on the higher of an achievement score or an improvement score. The achievement score calls for the facility's rate to be compared to the national rate or national performance standard during the baseline period. The improvement score compares the facility's performance rate to their own baseline rate.

Now the national rate of the performance standard is defined as the median of the national facility's' performance. The use of the median is a change from the proposed rule, which had proposed that an aggregate national average is utilized. This change was made in response to comments and we will see how this works as we move forward with the next few slides.

Slide 24; to determine the achievement score, the facility's will receive points along a continuum we call an achievement range; the range goes from one to 10; stretching from an achievement threshold to the benchmark. The achievement threshold represents the 15$^{th}$ percentile during the baseline period. The benchmark or the high end of the scale is the 90$^{th}$ percentile during the baseline period, and the achievement range runs between the two of them. We published the standards on the Web the last week of December 2011 and we referenced the site here. Also we're going to look at that when we get to slide 34.

This example on slide 25 helps me to describe how the achievement score is calculated. So I want to try to orient you to the graphic on this slide. We have the 58$^{th}$ percentile, which is the performance standard; the achievement threshold for this facility (15$^{th}$ percentile) falls at 46%.

Then if you look to the right, the benchmark or the 90$^{th}$ percentile is shown as 74 percent and that marks the high end of the achievement range. So in the

way your eye drops down to the scale towards the bottom of the slide the achievement range that runs from zero to 10.

Now in this example we show that the facility's actual performance rate was 54 percent (meaning 54% of their patients had a fistula). So if your eye follows the dotted line down, you'll see a score of three. As long as the facility score is at or above the achievement threshold (46%), which is the 15th percentile, it will receive achievement points. I will note that the scores are rounded to the nearest whole integer.

Now let's move to slide 26, and this slide shows us the mathematical formula used to compute the score. Now this formula can only be used if the facility's performance falls within the achievement range. If the facility's performance is below the achievement range, it will receive zero points for the achievement score. If the facility score is above the achievement range, it would receive 10 points.

You know I just want to remind everyone that although we are using the fistula submeasure as your example, when we compute the Vascular Access Type score, we are going to also add in your average with that the catheter submeasure score, so we just want to acknowledge that.

Let's move to slide 27. This slide puts together the visual scale as well as the mathematical formula, as it shows the information from slide 25 and slide 26 and you can see that the score would be 3 using the visual scale; the score using the mathematical formula is 3.07, which is rounded to 3.

Slide 28; the second opportunity for the facility to earn points is via improvement. To determine the improvement score, the facilities will receive points along an improvement range. This particular scale is a nine-point range. The improvement threshold at the low end of the improvement range is the facility's own performance rate during the baseline period. The benchmark is again the 90th percentile of the national performance curve and this is the same as what we talked about for the achievement scale.

Let's take a look at slide 29, where we have an example again. Let's look at the graphic for a moment. We see all the way to the right the 90th percentile, which is the benchmark, at the upper end of the improvement range. The facility's baseline rate is 26%, which is what they have to beat in order to earn improvement points.

Although we can identify the achievement range it is not used when we calculate the improvement score. It is strictly used for achievement, but now we drop all the way over to the left and we see the improvement threshold or the facility baseline rate, which is 26 percent as I mentioned.

So this 26 percent is the rate the facility achieved during the baseline period, remembering the baseline period is July 1, 2010 through June 30, 2011. So let's drop down to the bottom of the graphic and if you were to make a dotted line all the way down, you'll see that the lower end of the improvement range correlates with the facility's baseline rate, so that's where it starts; and then you see this top end of the improvement range is marked by the 90th percentile and that's the highest part of the improvement range here. So the improvement range stretches from the facility's baseline rate to the benchmark. It is possible, and even likely that every facility will have a unique improvement range.

So let's look at what our score would be on slide 30. The facility performance rate for this measure is 54 percent, again, let's follow the line down with our eye and we see that it falls in the increment of the number five on the improvement range; and again, if we go to the next slide, we have a mathematical formula that shows how the improvement score is executed. If the facility's performance is below the improvement range it would receive zero points for improvement. If the facility's performance is above the benchmark at the 90th percentile, they would receive the full 10 points, which is the same endpoint on the achievement scale.

Now if the facility is new and does not have a performance rate for the baseline period, then they would not have the opportunity to be scored on improvement, but they would have the opportunity to be scored on achievement.

Now let's move to slide 31. We see the graphic from slide 29 and the formula from slide 30 and in these cases you can see that based on the facility performance rate of 54 percent, the score falls into the 5 section of the improvement scale based on the mathematical formula, the number of 5.33 is rounded to 5 which represents this facility's improvement score.

Now let's move to achievement on slide 32. This slide illustrates what happens if the facility was at or above the benchmark (90th percentile). So again we have the achievement threshold at the 15th percentile mark that's 46 percent, we have 90th percentile benchmark that's 74 percent. This facility has a performance rate of 86%, exceeding the benchmark.

We see along the bottom the achievement range, which goes from zero to 10 and then if you go to the left, here this facility performed at a rate of 86 percent. They will receive the full 10 points for this measure. So this illustrates on how the scoring works and shows our approach in that – the formulas are not necessary if the facility's performance rate exceeds the benchmark at the 90th percentile; the facility receives the full 10 points.

Now slide 33 shows the scoring when the facility rate is below the achievement and improvement thresholds. In other words, this facility did poorer in the performance period than they did in the baseline period, and below the achievement threshold at the 15th percentile. So, again we show as we start from the left the benchmark at the 98th percentile, representing a rate of 74 percent, and moving to the left we see the facility base line rate of 53 percent.

The achievement threshold is at the 15th percentile, 46 percent, and so if you drop down you can see the achievement scale, you can see the improvement range drawn and the facility has a performance period has a rate of 40 percent. The performance rate falls below both the achievement threshold, and the improvement scale. In this case the facility, would it receive no points for this measure.

Moving to slide 34, so in looking at the scoring examples you can see that it's important to understand now where does the 15th percentile fall, where does the benchmark or the 98 percentile fall, and how can the facility plan to make sure that they are going to have a performance that allows you to earn sufficient points and avoid a payment reduction.

So, on slide 34 we have listed for you these thresholds, the benchmarks and the performance standards. When we published the Final Rule in November 2011 we only had access to nine months of data so we had put the numbers in the Final Rule base for the nine months. We had also stated that we would publishing the 12 month baseline data for Payment Year 2014 on a particular Web site and we were obviously within the rule and so we did that, we published the status last week of December 2011, before the start of the performance period, and this slide provides to you these numbers.

So for hemoglobin greater than 12 we see the achievement threshold is 10 percent; the benchmark at the 98th percentile is 0 percent; and 50th percentile is 4 percent. For dialysis adequacy if we read across, we see 94 percent as the achievement threshold; the benchmark is 100 percent and then 98 percent for the national performance standard.

Dropping done to Fistula, the achievement threshold was 46% at the 15th percentile; the benchmark is 74 percent; and the national performance standard is 58 percent; those where the numbers that we use throughout our example.

For Catheter, the achievement threshold is 24% which is again the15th percentile the benchmark (90th percentile) is 5 percent; and the national performance standard is 14 percent.

Now let's move to the reporting measures and the scoring for the reporting measures. I mentioned earlier that the reporting measures, when used in conjunction with a clinical measure would count for 10 percent of the total performance score in terms of the weighting.

Now slide 36, presents information in terms of how to earn points for NHSN Dialysis Event measure. And the scales for this reporting measure enables a facility to earn 0, 5, or 10 points. The maximum is 10 points and in order to earn 10 points the facility must enroll in all three components of the NHSN and complete the required training prior to the end of calendar year 2012, and report at least three consecutive months of dialysis event data during 2012, although you do have until March 31, 2013 to complete the reporting.

To earn five points the facility must enroll in NHSN and complete the required training, but if the three consecutive months of reporting was not done, you know additional 5 points will be lost. The facilities that do not enroll or receive the training (and of course therefore could not report three consecutive months of data) would receive zero points.

If a facility is new and receives their certification number after June 30, 2012 that new facility would only be scored from those measures if it successfully completed the requirement to get full 10 points. So, in other words a new facility would not be penalized if they did not participate in this measure.

Slide 37, calculating the In-center Hemodialysis CAHPS reporting measure. And in this case the options are only to earn the full 10 points or zero points.

To earn the maximum 10 points on this measure, the facility must attest to successfully administering the ICH CAHPS survey during calendar year 2012 and that attestation is done via CROWNWeb; and even though the year end is obviously December 31, there is an additional month provided to allow time to go online into CROWN and just check off whether the survey was successfully administered or not. The facility is not eligible to administer the survey on their own; they must use a third party.

Zero points are awarded to eligible facility's that do not make this attestation and again if the facility is a new facility and has received it's CCN after June 30, 2012 it would only be scored if it has successfully completed the requirements to obtain the full 10 points.

Slide 38, to earn the maximum 10 points on the Mineral Metabolism measure a facility must attest again via CROWNWeb by January 30, 2013 to measuring serum calcium and phosphorus levels of all Medicare patients treated by that facility at least once per month throughout calendar year 2012. If the attestation is not made the points awarded is zero.

Again if the facility is new, they would only be scored if they successfully completed these requirements, they would receive 10 points.

Now slide 39 provides a snapshot of what measures apply to which patient population or which facility types. Now, if you look at the first column here, you see the six measures for Payment Year 2014.

The table is divided to more clearly indicate adult vs. pediatric facilities, since the pediatric facilities are included in the ESRD QIP for the first time in Payment Year 2014. We have put Xs in the box to signify those populations to which the specific measures apply. We've gotten several questions about a facility's participation in the Quality Incentive Program, and if so which measures apply. And so if you look across the bottom, the Mineral Metabolism measure applies to adult populations, home patients, in-center patients, pediatric patients, frequent dialysis patients.

The ICH CAHPS survey applies strictly to the in-center hemodialysis patients only and these will be strictly adult patients. The survey was designed for in-center Hemodialysis adult patients and is not expected to be used for other populations.

The National Health Care Safety Network apples to in-center hemodialysis patients, both adult and pediatric populations; PD and Home HD adult and pediatric patients are excluded.

Vascular Access Type measure is only applicable to adult Hemodialysis patients, whether at home or in-center. The hemoglobin greater than 12 measure is applicable to all adult populations; regardless of wheatear the patient is home patient or an in-center patient. The dialysis adequacy measure

is only applicable to in-center hemodialysis patients who dialyze three times a week.

Slide 40, Weighting of Clinical Measures: Each clinical measure for which the facility is eligible is equally weighted to comprise 90 percent of the Total Performance Score. Each reporting measure for which the facility is eligible is equally weighted to comprise 10 percent of the Total Performance Score.

The facilities will receive scores as finalized in the Final Rule, the facilities will receive a Total Performance Score for as long as they are eligible for at least one measure. The facility is only eligible for one measure that was comprised 100 percent of the Total Performance Score. The maximum number of points that can be earned by a facility is 100 points.

Now let's turn to slide 41, now that we understand what the measures are, how the scores are calculated, and how we come up with Total Performance Score, let's look at what it means. The Total Performance Score will determine whether a payment reduction applies. To avoid a payment reduction the facility must score at or above the minimum Total Performance Score.

Now, I will point out that the minimum Total Performance Score was estimated in the proposal rule, but in the Final Rule it was finalized at 53 points which was a little lower than what was originally proposed. If a facility scores at the Performance Standard which is the 50th percentile for each measure the facility Total Performance Score will be equal or greater than 53 points, and would receive no payment reduction. So, the threshold for the payment reduction is 53 points.

If the facility fell short of the 53 points, there are increments of 10 points under which payment reductions are applied; and as I mentioned early in the presentation due to comments received, we had added back in the 0.5 percent payment reduction increment. So that if the facility scores between 43 and 52 points the payment reduction would be point 0.5 percent, if the facility scores between 33 and 42 points the payment reduction will be 1 percent. If the facility scores between 23 and 32 points the payment reduction is 1.5 percent,

and if the score with 22 points or below the payment reduction will be 2 percent.

Now, I'm going to switch gears, just slightly with slide 42. I think that we all appreciate that at the present time we have three years of the Quality Incentive Program applied.

This slide points out some, I won't really call it timelines, but it points out some important happenings and so I wanted to just run through these – highlight these particular items, things that are happening during 2012.

Effective January 1, 2012 the first year of payment reductions has stated to be applied and it would be throughout this year. Payment Year 2014 performance period is now, we are in that performance period for year three of the Quality Incentive Program.

We have an upcoming preview period for the performance rates and scores for Payment Year 2013 and the performance or the report will be available for download and review in mid July 2012, the facilities will have 30 days in which to review their information and submit questions and send inquiries, and again we will respond to each one of those individually.

Payment Year 2015 rulemaking is going to be happening shortly, but we are expecting to publish a proposed rule to address your, four of the Quality Incentive Program usually raised during the early July 2012.

We expect us to publish the Final Rule along the ESRD (PPS) November 1. Additionally we should look forward to the Performance Score Certificate then coming available for year two the Quality Incentive Program in mid-December of this year; and just as a reminder the facilities have five business days to print and post these certifications, and then the last item here is that the Payment Year 2013 payment reduction could be effective January 1, 2013.

Payment reductions in year one do not affect anything in terms of payment reduction in year two; each year is completely separate in terms of the scoring and applications of the payment reduction. For those of you who are still

awake, I would like to introduce (Michelle Deal) who is the lead within my division for the Quality Incentive Program and she is going to share with you some resources and provide some helpful information to you.

(Michelle Deal): Thank you Theresa. In the next few slides we provide resources to help you further understand and analyze the Payment Years 2013 and 2014 Quality Incentive Program.

If you go to slide 44, the Office of Clinical Standards and Quality monitors an e-mail box specifically for the Quality Incentive Program in which stakeholders can informally ask questions or deliver comments to CMS.

The next few slides will highlight some of the questions that were previously asked along with some of the responses that we provided. Some, of the questions that were very common in the nature, so we wanted to provide you with a sample of the questions and the responses that may be of interest to you.

The question on slide 44 pertains to hemodialysis and peritoneal dialysis facilities and their enrollment and reporting in the 2014 Quality Incentive Program. We received many questions regarding whether the 2014 program applies to hemodialysis only peritoneal dialysis only facility.

As you saw from the chart on slide 39 the Quality Incentive Program applies to out-patient peritoneal dialysis and home hemodialysis facility's as of January 1, 2012, which is also the start of the performance period with potential payment implications for 2014.

Not every measure applies to these facility's, however adult peritoneal dialysis only facility are evaluated on two measures, the hemoglobin greater than 12 g/dl and the Mineral Metabolism reporting measure.

Adult home hemodialysis only facilities are evaluated based on three measures: hemoglobin greater than an 12 g/dl, Vascular Access Type and the Mineral Metabolism reporting measure.

Additional peritoneal dialysis only and home hemodialysis only facilities must attest via CROWNWeb that the ICH CAHPS measure is not applicable because of their patient population. Neither peritoneal dialysis only nor home hemodialysis only facility are required to enroll, train and report via the CDC NHSN at this time.

If we go to slide 45, the question was around registering for the CDCs NHSN. Dialysis facility has to register for all three components of the NHSN and slide 45 contains the link for the CDC Web site which outlines the requirement.

We would like to note that out-patient dialysis faculties must be enrolled separately from there entities which may be enrolled in NHSN for other reporting purposes. So an example of this is that a hospital is enrolled in the NHSN currently, it must separately enroll thier outpatient dialysis unit.

We also received questions around where information for the Quality Incentive Program for Payment Years 2013 and 2014 can be found. The full explanation of the Quality Incentive Program, including public comment and all our responses for those comments can be found in the federal register.

The Quality Incentive Program Final Rule for Payment Years 2013 and 2014 was published Thursday November 10, 2011 and is in volume 76, 218 in the federal register. The link on slide 45 will take you directly to the Final Rule.

We move to slide 46. We've also had many questions regarding the Quality Incentive Program and pediatric facilities. The Quality Incentive Program will apply to pediatric outpatient dialysis facilities as of January 1, 2012, which is the start of the performance period.

To receive full participation for the program, all pediatric facilities included those carrying only for patients less than age 18 must comply with the reporting requirements for the Mineral Metabolism reporting measure.

Pediatric facilities providing in-center hemodialysis must comply with the requirements with NHSN reporting measure. Additionally pediatric only

facilities must attest via CROWNWeb that the Patient Experience of Care Measure also known as the ICH CAHPS is not applicable because of their patient population. Pediatric facilities that care for patient's age 18 or older may be eligible for additional measures.

The last question on slide 46, focuses on the Payment Year 2012, in terms of how facilities were scored. This question was also result of the Payment Year 2012 Quality Incentive Program public data file that CMS posted in December 2011.

For PY 2012 facilities were either score based on the facility's own rate in 2007 or the national performance rate in 2008 based on whichever was more favorable for the facility.

The performance standard that was applied to calculate your facility's performance score can also be found in your facility's Payment Year 2012 Performance Score Report.

As we move on to slide 47, the table on side 47 depicts at a very high level the changes of the Quality Incentive Program over the first three years of the program. The horizontal gray box across the top of the slide represents each of the payment years and the vertical gray bar down the left side captures each of the elements of the program as it pertains to measures, the performance period, baselines, performance standards, weighting, the maximum Total Performance Score, the minimum score for payment reductions, the payment reduction scales and scoring types.

We recommend that you use this table as a reference as it pertains to assisting you understanding the Quality Incentive Program and the policy change across each Payment Year.

Slide 48, we wanted to assist you with some additional resources, to have at your fingertips. We provided a few web sites that will allow you to further review the Quality Incentive Program.

The first link is to the MIPPA legislation, which provides the overview of the statutory mandate for the ESRD Quality Incentive Program. The second link is to our ESRD Quality Incentive Program page on the cms.gov web site. On this site, we provide a high level overview of the Quality Inventive Program, upcoming dates/milestones, links to transcripts and slide presentations from previous listening sessions and open door forums, and public data that CMS has released around the ESRD Quality Incentive Program.

The links for the Final Rule will take you directly to the Federal Register, so that you can access the Final Rule. The Final Rule establishes the rules and policy for the program for the Payment Years specified. Here you will find information on measures, scoring, measures specifications, public reporting requirements, comments addressed as a result of the NPRM, and other important information.

In the Final Rule for the Payment Year (PY) 2014 ESRD Quality Incentive Program, CMS stated they post numerical values for the performance standards, achievement thresholds, benchmarks and minimum Total Performance Score using data from the full 12 month baseline period. These numerical values are now available on this website.

On slide 49, these are the clinical measures in the both 2013 Quality Incentive Program as well as the 2014 Quality Incentive Program. Specifications for the clinical measures can be found on the Dialysis Reports web site at each of the links listed on this slide.

The measure specifications are important to providers, patients and others in the ESRD community as they provide a description of the measure, eligible patients and measure exclusions.

For the two reporting measures, the CDC NHSN Measure, and the ICH CAHPS measure, the specifications for those measures are not on the Dialysis Reports website, as they are not clinical measures.

For the CDC NHSN Measure, visiting the link to the CDC website on slide 49 will take you to a description of the measure, eligible patients and measure exclusions.

For the ICH CAHPS measure, visiting the link to the AHRQ website on slide 49 will take you to a description of the measure as well as information on fielding the ICH CAHPS survey.

Moving to slide50, if you still have additional questions or concerns after accessing any of these resources we encourage you to e-mail us at ESRDQIP@cms.hhs.gov, and again that email address is ESRDQIP@cms.hhs.gov.

Thank you for your time and attention to the presentation today. At this time we will be happy to take your questions and I will turn the presentation back over to Matt Brown for the question and answer session.

Matt Brown: Thank you. (Nicole), if you would remind the callers how to enter the queue and ask their questions.

Operator: At this time, I would like remind everyone in order to ask a question please press star one on your telephone keypad. We will pause for just a moment to compile the Q-&-A roster.

Your first question comes from the line of (David Walsh) from (Health Claims) your line is open.

David Walsh: Yes, who is responsible for submitting the attestation of the use of ICH CAHPS survey via CROWNWeb? Is a vendor able to submit that, on behalf of dialysis facility client or is it dialysis facility themselves supposed to submit that.

Teresa Casey: That would be submitted directly by the facility into CROWNWeb. The facility in the one that – access the CROWNWeb and it is really just a simple tick off, there is three sentences there you, tick off one that is applicable and I would not expect that particular process would take very much time.

David Walsh: OK, thank you.

Operator: Your next question comes from the line of (Dean Morris). Your line is open.

Dean Morris: Yes, hi, I was wondering what preparation is being considered to educate the beneficiary population and how this may affect them.

Teresa Casey: We have from time to time held Open Door Forums that aims at beneficiaries. We do receive comments from our beneficiaries and we will be working through our partners to dissemination information. I wonder, do you have a particular suggest or recommendation that you would like to make?

Dean Morris: No, I don't really have a recommendation, at this time, but you know since I am a Patient Service Representative at the Network level we do get contacts regarding, you know the changes that are taking place at the facility level because of the incentive program and so, I was just wondering if there was an education vehicle that might go to the beneficiaries for ESRD.

Teresa Casey: Well, I'm really happy to hear that you are one of our experts in those area, so I would invite you to send me an e-mail note with your suggesting. Because we very much, would like to hear from you.

Dean Morris: OK, thank you very much.

Teresa Casey: I think you would probably know how to find me, or you can send comments to our mailbox, ESRDQIP@CMS.HHS.GOV.

Dean Morris: I can.

Teresa Casey: Right, thank you.

Operator: Your next question comes from the line of (Edna Final) for SMC, your line is open.

Edna Fina: Yes, hi my question is for about the (CAHPS) questionnaire. The surveys that our company does on a national based would they qualified or is this another step towards online thing that we have to enroll in. I'm not quite clear on that part.

Teresa Casey: There is a survey, that's In-Center Hemodialysis survey, CAHPS survey, that we refer to in the Final Rule and we did provide in our Final Rule as well as on our resource slide here, information in regards to the tool, how to administer the tool. Because the requirements are spelled out online with the parameters for how you can meet this particular measure.

So, I would encourage you to take a look at that. But it's the survey that you are already using is not In-Center Hemodialysis CAHPS survey tool, then that would not meet the criteria for this measure.

Edna Final: OK, I will check with company them. Thank you.

Teresa Casey: Thank you for your question.

Operator: Your next question comes from the line of (Laurie Westerwile) from (inaudible). Your line is open.

Laurie Westerwile: Well, I have a question. We have like demographic in our clinic that – we have patients that are clients with they, either diet of whatever it is that's really improving. Finding difficult on something – measures. And I'm wondering, you know what kind of (inaudible) should that we have done whatever inventions we can that would help bring our measures out.

Teresa Casey: So is there a particular measure, you have in the mind, related to your question or I'm not entirely sure what you are asking.

Laurie Westerwile: So, we've got the measure of the hemoglobin for the, where our – where are patients you know they are not taking care of their diet or taking there of there – or some of the other things. I'm a social worker so, but trying to put in

different – to get them to comply with their own, so I can make a difference for these numbers and I'm not sure how to go about doing that. If it's at a point where, at a 1.5 percent reduction.

Teresa Casey: It sounds like you have some challenges facing you. I don't know that I can provide an answer to your question that would be very, very helpful. Certainly the goal of the Quality Incentive Program is to provide motivation and incentive to facility to improve care.

Now if there are issues with the patients following their care plan– then I think that this might be a good opportunity to think about quality improvement in terms of identifying root causes, and I really would highly recommend that you think about contacting your ESRD Network; the ESRD Networks are the experts in quality improvement.

I think that you might be able to call your local Network and get some ideas. Certainly your facility is not alone in facing these kinds of challenges and working with your patients and so that would be my suggestion to you.

I have received a few questions prior to this meeting and I would like to go through some of them at this point in time. The one question was having to with NHSN data submission and the question was can the NHSN data be submitted directly to CMS, as opposed to sending that data to the CDC. And the answer is that the data must be submitted to the CDC and NHSN system.

CMS will not recognize this data in terms of our quality incentive approach – Quality Incentive Program. Currently we know the events must be submitted manually to the CDC. Our partners of the CDC are working on some other approaches and methods in terms of clinical document architecture reporting and if Priti would you like to share any further information at this point I would invite her to do so.

Priti Patel: I have no additional information to share.

Teresa Casey: Great, thanks so much. Just wanted to give you the opportunity. There was another question in terms of what is successful administration of the In-center

Hemodialysis CAHPS survey and I would have to refer back to the ARC specifications that can be found online. Those are the steps that we would expect as the facilities would follow in terms of how the survey is administered and in terms of the response.

There was a question on – also on the CAHPS that asked, can we provide the survey directly to patients at the facility and just have a drop off box, so that they might be able to just leave it there and the answer to that is, no, that does not adhere to the specification that ARC had put out.

The survey must be administered by a third party in order for the administration of the survey to be considered successful under our Quality Incentive Program. There is a survey administration to be done either through the mail, a telephone follow up or telephone only. We do not accept using a drop box approach.

I do have a few other questions that have come in, but let me go back to the operator and ask if there were additional lines with questions.

Operator: There is a few more questions.

Teresa Casey: OK.

Operator: (Suzanne Cole-smith) from Florida Hospital, your line is open.

Suzanne Cole-smith: Yes, hi. My question is the following. I have – our patient hemodialysis unit only has currently nine patients and we also run a home hemo program, which is actually run out of a skilled nursing facility for patients who are either on a vent or for whatever other reason they cannot go to an outpatient dialysis facility.

How is this going to affect our reporting, because if the facility has less than 11 patients we're excluded from basically all the measures, reporting all the measures.

Teresa Casey: Thank you for your question (Suzanne) and so my understanding is that you have nine in-center hemodialysis patients and then you have – I'm sorry how many …

Suzanne Cole-Smith: Home hemo at a skilled nursing facility and we have I believe eight patients there.

Teresa Casey: OK, so what I would do is ask you to go back to the part that we provided in the side number 39 and take a look at the little X's to see the measure, because certainly the mineral metabolism measure would be applicable to your population.

The task survey for your in-center patients, the NHSN for your in-center patient as well. Vascular Access Type if you have a total of 11, potentially you could quality for this, but it's not just how many patients, you have to meet the eligibility criteria in terms of the number of claims and the number of months and those kinds of things that we talked about before.

So, you know what I would advise you to do is to send an e-mail note to the ESRD QIP box that was listed on the slides again and outline your more specific question, and maybe a little more detail, and well can try to help you have a better idea of what measures and what inclusions or exclusion.

Suzanne Cole-Smith: OK, thank you.

Teresa Casey: Thank you (Suzanne).

Operator: As a reminder ladies and gentlemen, if you would like to ask a question please press star then the number one on your telephone keypad. If you would like to withdraw your question please press the pound key. Your next question comes from the line of (Anastasia Andrew) from DaVita, your line is open.

(Anastasia Andrew): Hello. My question is how do you measure grafts and HeRO? Are they counted in the AVF category?

Teresa Casey: I'm sorry grafts and what?

(Anastasia Andrew): HeRO. *(Editor's Note: The HeRO (Hemodialysis Reliable Outflow) Graft, a vascular access device, is the only fully subcutaneous AV access solution clinically proven to maintain long-term access for hemodialysis patients with venous outflow obstruction.)*

Teresa Casey: Oh, catheters?

Anastasia Andrew: Yes.

Teresa Casey: Well, hold on just a moment. I'm consulting with (Tom Dudley) here, our measures expert.

Anastasia Andrew: Thank you.

Teresa Casey: (Anastasia), (Tom) is going to answer your question. Thank you.

Anastasia Andrew: Thank you.

(Tom Dudley): I'll answer it in two parts here. As far as capturing information about vascular grafts, I'll have to capture them using a code modifier, sort of like for which modified codes are used. As you know with the measures, we are looking at maximizing the use of fistulas and minimizing catheters, so grafts are included with the model they work within that denominator for vascular access types. Think of a graft that's kind of a vascular access – do you know what I mean?

Anastasia Andrew: OK, so it's not counted with the fistula, but not counted against too.

Tom Dudley: Not counted against you.

Anastasia Andrew: OK.

Tom Dudley: I you realize that there are some patients that cannot get a fistula, and the graft doesn't express it and our goal is to maximize fistulas and minimize catheters and to be honest with you, I'm not as familiar with the HeRO. Would you be able to e-mail me the question and we can get back out to everyone as far as how they are handled. I'm just not well versed to answer on the phone right now.

Anastasia Andrew: OK.

Teresa Casey: And let me just mention that you know as we accumulate questions and answer, we do intend to put this information on the Web, so that you know not just one person gets that response, but everybody universally would have that information.

Anastasia Andrew: Sure. Thank you.

Teresa Casey: Thank you.

Operator: Your next question comes from the line of (Allison) from Cleveland Clinic; your line is open.

Allison: We had a similar question as Florida Hospital. We are a hospital-based dialysis unit, but we do have four chronic patients and a number of entrants in, so do we need to submit data and are we – will we see payment reduction or because our number of patients is less than 11, are we not required to participate.

Teresa Casey: Can I just clarify that you are not talking about a hospital outpatient services department that offers dialysis to acute patients. You are actually talking about a certified Medicare dialysis facility offering outpatient dialysis?

Allison: That's correct.

Teresa Casey: OK, so you know what, I can't answer your question at a glance, because as you pointed out, we have to take a look at the number of patients and which measures would be applicable. But again, the reporting measures don't have minimum numbers attached to them.

Allison: OK so the question is about, if you have 11 patients that doesn't matter, I guess.

Teresa Casey: That (the minimum number of eligible patients) applies to the three clinical measures, but not to the reporting measures.

Allison: Is there someone we can get in touch with off line, so that we can make sure that we are participating if we need to?

Teresa Casey: Sure. Please send your question to the ESRD QIP mailbox, ESRDQIP@CMS.HHS.GOV.

Allison: OK, make sure you look for it!

Teresa Casey: Thank you very much for your question. And in fact based on your questions I'm thinking that we may want to publish them, the information on the Web to provide some clarification and we would have to think about that and getting back.

Allison: Thank you.

Operator: Your next questions comes from the line of (Jennifer Todd) from DSS Research; your line is open.

Jennifer Todd: Good afternoon. Will there be list of third party-approved survey vendors for the facilities to choose from?

Liz Goldstein: At this point there are not approved vendors for ICH CAHPS, so the facilities can choose any vendor they wish. They just need to follow on the ARC protocol.

Jennifer Todd: Thank you.

Teresa Casey: And you just heard from (Liz Goldstein) who is the Director of CAHPS within CMS. Thank you (Liz).

Let's take one more question first.

Operator: Your next question comes from the line of (Isabelle Stredman) from (Inaudible); your line is open.

Isabelle Stredman: All right, thanks for a great presentation. My question is about our (inaudible) program comes under the same provider number as an in-center out-patient

unit. So how would I test? Or can I attest if age doesn't apply to that patient population.

Teresa Casey: So you have home hemo and PD, but not in-center hemo.

Isabelle Stredman: So all part of an in-center hemo, they are all together. So they are not standalone.

Teresa Casey: There aren't separate attestations. You would just attest based on the fact that it was applicable even to a subset. Did I understand your question correctly?

Isabelle Stredman: I don't have to give the age attest to the PD patients with the hemo.

Teresa Casey: Correct. But it's only applicable to in-center patients.

Isabelle Stredman: Who I am going to give to, but I can't attest if I didn't give it to the other population, because…

Teresa Casey: Don't worry about the other population, as long as you attest that you gave it to the in-center that is sufficient. Did that help or do you have an additional…

Isabelle Stredman: No, no, that's it. Thanks very much.

Teresa Casey: OK, thank you so much.

Matt Brown: OK, that's our last question. Teresa would you like to offer any closing remarks.

Teresa Casey: I just would like to encourage the audience to utilize the Quality Incentive Program mailbox, ESRDQIP@CMS.HHS.GOV. It could be that you know as soon as we hang up the phone you'll come up with a couple of more questions or concerns and want to figure out some things for your own facility and how the Quality Incentive Program might affect it. So please remember to utilize that mailbox and we will be responding. We will also be posting helpful information as we discover the need for it.

I want to thank everyone for their participation. I don't know when our next open door Forum will be, but chances are with upcoming rule making we'll be

back again and I hope to have your participation again in the future. Thanks very much.

Matt Brown: Teresa. With that, that will conclude our call. Keep in mind there will be an audio recording and transcript posted to the web site on or around February 13 and will be available for 30 days. Thank you.

Operator: This concludes today's conference call. You may now disconnect.

**END**