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National Provider Call Transcript

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Centers for Medicare & Medicaid Services
Medicare Acute Care Quality and Reporting Programs
MLN Connects National Provider Call
Moderator: Charlie Eleftheriou
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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 Charlie Eleftheriou. Charlie, you may begin.

Announcements and Introduction

Charlie Eleftheriou: Hi, this is Charlie Eleftheriou from the Provider Communications Group here at CMS. And as today's moderator, I would like to welcome everyone to this MLN Connects National Provider Call on Medicare Acute Care Quality and Reporting Programs. MLN Connects Calls are part of the Medicare Learning Network®.

During this call, CMS subject matter experts will provide information on all Hospital Inpatient Quality Reporting and Value-Based Purchasing programs. A question-and-answer session follows the presentation.

Before we get started, there are a few items I would like to quickly cover. You should have received a link to the slide presentation for today's call in an email. If you have not seen that email, you can find today's presentation on the Call Details web page, which can be found by visiting www.cms.gov/npc, as in National Provide Call. Again that's cms.gov/npc. On the left side of that page, select National Provider Calls and Events and then select today's call by date from the list. The slide presentation is located there in the Call Materials section.

Also, please note that this call is being recorded and transcribed. An audio recording and written transcript will be posted to the Call Details web page when it's available. And an announcement will be placed in the MLN Connects Provide eNews when they are available.

Lastly, this MLN Connects Call is being evaluated for — by CMS for CME and CEU Continuing Education Credit. For additional information, please refer to slide 56 of today's presentation for a link to the CE activity information and instruction document.

At this call — I'm sorry, at this time, I would like to turn the call over to Cindy Tourison, who will begin our presentation. Cindy?

Presentation

Cindy Tourison: Thanks Charlie. Hi everyone. Good afternoon, this is Cindy Tourison. I have been with CMS for a little over 4 years now and leading Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing programs for the last couple of years, as well as working on alignment of our EHR Incentive Program with our Hospital Inpatient Quality Reporting Program.

Today's agenda — we are actually going to go ahead and skip to slide number 3. Today you can see that we're going to take a look at Hospital Inpatient Quality Reporting, the EHR Incentive Program, Hospital Value-Based Purchasing, Hospital-Acquired Condition Reduction Program, Hospital Readmissions Reduction Program. And then we will touch upon some program alignment that we are working towards and/or — and certain ways in which we are aligned. I think this is the first time we have actually done a National Provide Call where we have talked about the context of all of these programs across this care setting.

So participants today will be able to identify the purpose and objective of each of these programs, understand the basic program methodologies, and locate our critical program-specific resources. Some of those are aligned and some of those are not. So, hopefully, you will learn a lot today and be able to give us some feedback for future topic areas that you might like to see.

Now I'm going to direct everyone to move down to slide number 7. And we are going to start to talk about Inpatient Quality Reporting.

Inpatient Quality Reporting

Hospital IQR is intended to equip consumers with the quality of care information to make more informed decisions about healthcare options. It is also intended to encourage hospitals and clinicians to improve the quality of inpatient care provided to all patients. The hospital quality of care information gathered through the program is available to consumers on our Hospital Compare website.

Hospital IQR does require subsection (d) hospitals to submit data for specific quality measures for health conditions common among people with Medicare and which typically results in hospitalization. In addition to subsection (d) hospitals, we do have a

voluntary reporting option for those hospitals who are not subsection (d) but would like their quality data to be publicly reported.

Now on slide 8. In November 2001, Health and Human Services Secretary Tommy G. Thompson announced the quality initiative, his commitment to assure quality healthcare for all Americans through published consumer information coupled with healthcare quality improvement support through Medicare's Quality Improvement Organization.

The quality initiative was launched nationally in 2002 as the Nursing Home Quality Initiative, and expanded in 2003 with the Home Health Quality Initiative and the Hospital Quality Initiative.

The Hospital IQR Program was developed as a result of the Medicare Prescription Drug Improvement and Modernization Act of 2003. Section 5001 (a) of the Deficit Reduction Act of 2005 provided new requirements for the Hospital IQR Program, which built on the voluntary Hospital Quality Initiative. Sections 501 (b) of MMA stipulated that Inpatient Perspective Payment System hospitals submit 10 quality starter set measures to CMS during fiscal years 2005 to 2007 on the quality of inpatient care provided to their patients. Then the reporting hospital quality data for annual payment update initiative was developed.

In Section 5001 (a) of the Deficit Reduction Act, which was superseded by the MMA of 2003, a new set of requirements for Hospital IQR was born. The act requires IPPS hospitals to submit additional quality measures for 2007 and each subsequent fiscal year. Hospitals that meet the requirements specified in the final regulation will receive their full annual payment update. Those hospitals that do not submit data for all required quality measures to CMS and meet the IQR requirements would receive at this point a one-quarter reduction in their market basket update for the applicable fiscal year.

And if we can move on to slide 9, we will take a look at what this looks like. Beginning in FY 2015, the funds of market basket update were distributed between IQR and the EHR Incentive programs. Hospital IQR Program maintained a quarter of the market basket update from FY '15 and future fiscal years, whereas the EHR Incentive Program

uses a graduated scale to equal three-quarters of the market basket update by fiscal year 2017.

Requirements of the Hospital IQR Program

Now on slide 10, we are going to overview the basic requirements of IQR. Hospital IQR program has evolved significantly since its starter set in the inception back in 2005, when, you know, we had requirements to submit at least one record to our clinical warehouse by a designated deadline date.

In the most recent fiscal year 2016, hospitals are required to submit 29 clinical process of care measures, six healthcare-associated infection measures, our HCAHPS survey data, four structural measures, complete the data accuracy completeness and acknowledgement — and also are assessed for 17 claims-based measures, which, of course do not require any data submission beyond the claims measures that are submitted. So almost a total of 60 measures.

We will also talk a little bit about our Electronic Clinical Quality Measures, which align with our EHR Incentive Program in our next section of slides. In addition, if a hospital is selected, they must also meet the validation requirements if selected, and they will be notified.

Slide number 11 just gives you an overview of Hospital IQR. You know, we have displayed high participation and compliance rates since our inception in 2005 and up to — including fiscal year 2015, with all programs here receiving at least 95 percent or greater successful participation rate.

Hospitals that choose not to participate in IQR receive the same reduction as those that participate but do not meet all of the requirements of the program. So either you receive that portion of the market basket update or do not if you do not meet the requirements of the program.

In FY 2015, we had 35 hospitals who chose not to participate and 32 hospitals that did not meet at least one requirement for the IQR Program. We had a total of 3,275 hospitals who received their full annual payment update increase in FY 2015.

And now, if we can move to slide 12, this is a resource slide. Our QualityNet.org website is where we house a majority of our resources for Hospital Inpatient Quality Reporting, Hospital Value-Based Purchasing, and a number of our quality reporting programs.

EHR Incentive and the Hospital IQR Program

We can skip to slide 14. We will talk about the incentive programs. In an attempt to provide a baseline understanding with hospitals and IT vendors, we began by discussing our rationale for development.

So in 2009, the EHR Incentive Program was developed as part of the Health Information Technology for Economic and Clinical Health, or our HITECH Act. This act promoted the adoption and meaningful use of health information technology. The EHR Incentive Program provided incentive payments to eligible hospitals and eligible providers when they adopted and showed meaningful use of certified electronic health record technology.

Slide 15. What are eCQMs? ECQMs are electronically specified versions of our more traditional, chart-abstracted clinical quality measures. We have since moved away from creating electronic versions of originally chart-abstracted measures, and we are moving more towards a fresh approach in creating de novo measures, or recreating them anew from information available in Certified Electronic Health Record systems.

These electronically specified measures looked at the intent of chart abstracted measures and utilized technology standards to allow EHR systems to calculate, export, and transmit measure-specific data. And this is the one area where we have been able to align measures between hospital and patient quality reporting and the EHR Incentive Program.

Next slide, slide 16. This shows you the EHR Incentive Program requirements as it currently exists today, which says that you must utilize a Certified EHR system. You must submit a — the structural measure objectives through CMS's registration attestation system, and this includes the core and menu set measures. And then, in addition to that, you must submit clinical quality measure data.

For 2015, hospitals have two options to meet this portion of the program requirements:

- Option 1 is to aggregate reporting of numerators and denominators for these measures, and submit them through CMS's Registration and Attestation system.

- Option number 2 is the submission of QRDA 1 Category 1 Release 2 files. These are files that certified technology can generate. And those files are to be submitted to CMS through our QualityNet website. This is the portion where I mentioned that we do have our measures aligned. These measures can be reported under IQR or under the EHR Incentive Program, and partial credit can be gained in both programs for one submission.

On slide 17. EHs and CAHs that seek to report eCQMs under the Medicare EHR Incentive Program or IQR Program must use the April 2014 version of the electronic measure specifications for 2015 data submission. And the files also must be formatted following the guidelines provided in the CMS QRDA Supplementary Implementation Guide for 2015. Alternatively, if a hospital is not — if their EHR is not certified to the April 2014 version, rather it's on an older version of the electronic specifications, they would need to submit registration attestation information for those measures.

Next on slide 18. The EHR Incentive Program and IQR have aligned to allow hospitals to meet a portion of both requirements with one data submission. There are currently 29 available electronic clinical quality measures, and all except for one of these are eligible for the IQR reporting program. That measure is ED-3, which is an outpatient measure and, therefore, not applicable under the IQR Program. For both programs in 2015, a hospital can report on any 16 of the available eCQMs across three National Quality Strategy domains. And a hospital must report data on at least 16 eCQMs to receive credit in either program.

I think it's important to note that for calendar year 2015, reporting eCQMs under IQR is voluntary. It is not a requirement. Under the EHR Incentive Program, it is a requirement and may be done so either via submissions through QualityNet or through registration and attestation.

On slide 19, we want to just clarify that for the 16 required eCQMs across three National Quality Strategy domains, that if a zero denominator or case threshold exemption is applicable to a hospital's measure count, that they do count as successful submissions

for eCQM requirements for the EHR Incentive Program and also for the Hospital IQR Program.

So, for example, if a hospital were to have three of their measures that were zero denominators and three which — for which they had case threshold exemptions, meaning that they have five or fewer discharges in the relevant EHR reporting period, that would bring us to a total of six. So they could do zero in case threshold exemptions for six of their 16 measures and report either electronically or via registration and attestation the other 10 electronic clinical quality measures.

On slide 12, now this slide depicts what our reporting aligns are. So under IQR and the EHR Incentive Program, we were able to align the policy. The a hospital may voluntarily submit one calendar year quarter of calendar year 2015, so either quarters one, two, or three as an eCQM by our deadline of November 30th, 2015. The EHR Incentive Program and Hospital IQR Program do each have other program requirement deadlines that differ from the eCQM submission deadline. And if a hospital elects to submit their data through the registration and attestation system, there are different requirements for doing that.

Slide 21 is simply a resource slide. You can see where you can get the April 2014 eCQM specs, the HL7 Implementation Guide for QRDA1 Category I Release 2, and then also our CMS Implementation Guide for QRDA Category I. Category III is not applicable to the hospital setting at this point. And also — we also have a list of our most common eCQM submission errors, which we monitor very closely.

The Hospital Value-Based Purchasing Program

We move on to slide number 23. We are going to go ahead into Hospital Value-Based Purchasing. The Hospital Value-Based Purchasing Program is the next step, and a very important step, in redesigning how healthcare and healthcare services are paid for, moving increasingly towards rewarding better value outcomes and innovation rather than volume.

Hospital VBP was required by Section 3001 of the Affordable Care Act and promotes better clinical outcomes for hospital patients, as well as improving their experience of care during hospital stays. HVBP was first implemented and adjusted payments in fiscal

year 2013. And we are currently in our third year of payment adjustments and moving towards our fourth.

Next slide, number 24. Acute care IPPS Hospitals are included in the Hospital Value-Based Purchasing Program. The hospitals may be excluded from the program based on exclusion reasons listed on the slide, including a hospital not meeting the requirements of hospital IQR and, thus, receiving a portion of the market basket update reduction.

In addition, acute care hospitals in the State of Maryland are currently excluded from the program. Excluded hospitals do not receive a payment reduction or payment incentive for the fiscal year. They are not subject to the reimbursement rate associated with VBP.

Other reasons that a hospital may not be included in VBP is:

- Hospitals cited for deficiencies during the performance period with — that pose immediate jeopardy to the health or safety of patients.

- Hospitals with less than a minimum number of domains calculated. Currently, it's three out of four, and

- Hospitals with an approved disaster/extraordinary circumstance exception.

And I think we've mentioned the other reasons for exclusions from VBP.

Slide number 25, VBP Scoring and Future Policy. Hospital VBP Program utilizes measures collected through our IQR Program, including clinical process of care, patient experience of care, or HCAHPS, our outcome, and our efficiency measures to determine hospital payment.

In the first 3 years of VBP, we used 12 to 13 clinical process of care measures, addressing heart attack, pneumonia, heart failure, surgical care, and healthcare-associated infections. In the future of the program, we may choose to remove many of these measures due to their becoming topped out and our emphasis on outcome and safety of patients has increased. For example, in FY 2013 and FY 2014, we did not include any NHSN measures. By FY 2017, we have included CLABSI, CAUTI,

SSI, MRSA, and C. Diff, in addition to our PSI-90 measure, the original 3-day, 30-day mortality measures, and we have included HCAHPS surveys with eight patient experience of care dimensions, and the Medicare Spending Program efficiency measures, in addition to those already listed.

The Hospital VBP Program is scored differently than our other pay-for-performance programs in the inpatient setting because the scoring is based not only on achievement but improvement as well. CMS scores improvement by comparing a hospital's performance period rate to their own baseline period rate, which is typically 2 or more years prior to the performance period.

Slide 26. Hospital VBP is a budget neutral program and is funded through a percentage of withhold from participating hospitals' diagnosis-related group payment. Payment amounts will be redistributed based on the hospital's total performance scores in the program in comparison to the distribution of all hospitals' total performance scores and the estimated DRG payment amount to fund the program.

It's important to note that withholds and incentive payments are not made in a lump sum but through each eligible Medicare claim made to CMS. The funding from this first year of the program, FY 2013, came from a withhold amount of 1 percent. The percentage withhold is increased by a quarter of a percent until FY 2017, when the program reaches the withhold percentage of 2 percent.

In order for a hospital to become eligible for HVP, the hospital must successfully meet the requirements of IQR, meaning that they are not receiving a reduction in their APU. This regulation prevents a hospital from receiving a reduction in both programs.

Slide number 27. The hospital VBP Program has been evolving each year. In 2013 CMS only included two main — two domains in the total performance score. That was the clinical process of care, weighted at 70 percent, and the patient experience of care, weighted at 30 percent.

In FY 2014, CMS adopted the outcome domain, including the 30-day mortality measures for AMI, heart failure, and pneumonia, and weighted the domain at 25 percent. This decreased the clinical process of care domain to 45 percent. In FY 2015, CMS expanded the outcome domain to include the AHRQ PSI-90 composite in the CLABSI measure.

CMS also adopted the efficiency domain to measure the Medicare spending per beneficiary. The domains were weighted at 20 percent for clinical process, 30 percent for patient experience, 30 percent for outcome, and 20 percent for efficiency.

In FY 2016, CMS adopted additional outcome measures — CAUTI and surgical site infections, a new clinical process measure, which was IMM-2, and revised the domain weighting.

CMS adopted their proposal to align HVP's quality measurement domain with the national quality strategy. The patient and caregiver-centered experience of care plus care coordination domain, which contains the HCAHPS dimension, is weighted at 25 percent.

The efficiency and cost reduction domain, containing the Medicare spending per beneficiary, is weighted at 25 percent. The safety domain, containing the healthcare-associated infections listed on the slide and the AHRQ PSI-90 composite is weighted at 20 percent.

The clinical care domain has two subdomains, outcomes and process. The clinical care outcome subdomain contains three 30-day mortality measures and is weighted at 25 percent. The clinical care process subdomain, which contains AMI-7a, IMM-2, and PC-01, is weighted at 5 percent of the total performance score.

When proposing and adopting the new measures listed on this slide, CMS considered which measures are eligible for adoption based on statutory requirements, including the specification under the IQR posting date on Hospital Compare and priorities for quality improvements as outlined in the National Quality Strategy. For FY 2017, VBP program, CMS finalized adoption of three measures, including MRSA, C. Diff, and PC-01.

We're going to move on to slide number 28. This graphic displays the distributions of hospitals receiving reductions to increases over the 3 fiscal years that have been calculated thus far.

In FY 2013 and 2015, more hospitals received net increases than net reductions, whereas in FY 2014 the opposite was true. I would like to note that approximately half of all hospitals participating in the FY 2014 program — over 1,300 — essentially broke even, with net payment changes between negative 0.2 percent and positive 0.2 percent.

Slide 29. Hospitals have an opportunity to review their Percentage Payment Summary Report for HVBP prior to data being publicly reported. Upon the review of the report, if an error in the calculation is identified, the hospital may submit a correction request up to 30 days after the release of the report. CMS will review the request and will respond with a clarification as to why the value is correct or what the correct value would be.

After the review and correction period has elapsed, the data is publicly reported on Hospital Compare during the December refresh. Currently, the FY 2015 data is displayed, with FY 2013 and 2014 being contained in the archive. We anticipate that the FY 2016 HVBP program data will be released in December of 2016.

VBP Resources

Slide 30 is a resource slide for our VBP program.

Slide 31 gives you an overview of resources that we have available. These resources are available to provide answers to questions that you may have on hospital and patient quality reporting, Hospital Value--Based Purchasing Program.

So we have a Q&A Tool that's available, and you can enter a question on any of our programs through that tool. We have email support on IQR and VBP, as well as phone support, which is 8 a.m. to 8 p.m. eastern time, Monday through Friday, with the exception of Federal holidays.

And we also have that same support available in Inpatient Live Chat. We hold monthly web conferences that you can register for by joining our listerves, which are available up on our QualityNet.org site. We do have a listserv coming up very soon on a number of topic areas that this audience might find interesting and want to learn more about.

And we also have our secure fax number listed there, as well as we have an alternate website that we oftentimes publish some of our monthly webinars on because they are recorded, so you can download those and listen to those at your convenience if you are unable to make the regularly scheduled time.

At this time I'm going to turn things over to my colleague Grace Im.

The Hospital Readmissions Reduction Program

Grace Im: Thanks Cindy. Good afternoon everyone. My name is Grace Im, and today I'll be presenting an overview of the Hospital Readmissions Reduction Program and the Hospital-Acquired Condition Reduction Program. And I will start with the Hospital Readmissions Reduction Program, and we can go directly to slide 32.

So the Hospital Readmissions Reduction Program was established under the Affordable Care Act to encourage hospitals to reduce the number of excess readmissions. In the program, a readmission is defined as an admission to an acute care hospital within 30 days of a discharge from the same or another acute care hospital. And the program — it applies to all subsection (d) hospitals that are paid under the IPPS System. The program — it requires CMS to apply a negative payment adjustment that's capped — currently capped at a maximum of 3 percent if a hospital has excess readmissions.

The program, in terms of its goals, is to improve the quality of care while reducing cost. And the program especially addresses the CMS and National Quality Strategy priority of effective communication and care coordination, especially as patients are transitioned to outpatient care or other institutional care.

Now, I'm on slide 33. So this slide, again, it's to emphasize that our goal is to improve the quality of care. And we try to do so by improving the performance of all hospitals as well as to reduce the variation of hospital performance.

Slide 34 shows a list of all of the current readmission measures that we are using in the Hospital Readmission Reduction Program. And this slide, it shows the conditions for which we have readmissions measures. And these conditions have all been chosen because they are either high volume or high cost with respect to readmission.

So currently we are in the FY 2016 program year. And actually, we anticipate that hospitals will be receiving their hospital-specific reports around the middle of next month. And so, in this current program year, we have five readmission measures in the program that focus on the conditions of acute myocardial infarction, heart failure, pneumonia, COPD, and hip — total hip and total knee replacement. And then we have also finalized for next year's program, for FY 2017, the addition of a readmission measure for coronary artery bypass graft surgery.

Now slide 35. All of our readmission measures are — they exclude planned readmissions that are based on a planned readmission algorithm that we have developed and apply when calculating the measures. Also, the measures are risk adjusted for age, sex, and the severity. However, currently the measures do not adjust for complications of care, socioeconomic status, race, ethnicity, hospital characteristics, and so forth.

Now turning to slide 36. In the Hospital Readmissions Reduction Program, we calculate for each hospital their excess readmission ratio for each of the conditions they're focused on in the program. And the excess readmission ratio is a measure of relative performance. So we rank the hospitals based on their national — compared to the national average. And the excess readmission ratio is calculated as the predicted readmission rate over the expected readmission rate. And this is, again, for each specific condition.

The rates are based on 3 years of claims data. And we use 3 years of claims data because it gives us a large enough sample size for more accurate and reliable information. And then the excess readmission ratios are used to calculate the payment adjustment.

Now turning to slide 37. So as I mentioned, around mid-next month hospitals will be receiving their hospital-specific reports by accessing their secure QualityNet account. And the hospital-specific reports include information for each hospital, for each condition, their calculated excess readmission ratio as well as the patient level discharge data that was used to make those calculations.

And hospitals will then have 30 days during a review and corrections period when they can have the opportunity to review the data and the calculations, and then to ask any questions or request a recalculation, if applicable.

Following the review and corrections period, the information at the hospital level will be publicly reported on our Hospital Compare website. And we began publicly reporting on hospital readmissions data back in October of 2012.

Now I'm on slide 38. Under the Hospital Readmissions Reduction Program, we also began making payment adjustments, beginning with discharges on October 1, 2012. So now we are in the fourth year of the program. And for this year — so we are currently running calculations for the FY 2016 program year, and the payment adjustments that

we — will be calculated during this summer, and that will be reflected in the hospital-specific reports that will come out this summer. So those payment adjustments will go into effect for claims on discharges starting this October 1st, 2015.

Now, on slide 29, we want to note that with respect to the payment adjustments, they will apply to all Medicare discharges for that year if applicable, and not just for a hospital's readmissions. In the first year of the program, which was FY 2013, payment adjustments were capped at 1 percent. The following year, for FY 2014, payment adjustments were capped at 2 percent. And then since FY 2015 and for future years, payment adjustments are capped at 3 percent.

HRRP Resources

Now, on slide 40, we have links to several resources for more information on the Hospital Readmissions Reduction Program.

Now, I will move on to an overview of the Hospital-Acquired Condition Reduction Program.

The Hospital-Acquired Condition Reduction Program

And moving on to slide 42, the Hospital-Acquired Condition Reduction Program was established under the Affordable Care Act to encourage hospitals to reduce the number of hospital-acquired conditions, or HACs. The program began last year with the FY 2015 program year, and it applied payment adjustments to discharges beginning October 1st of 2014. The program requires CMS to apply a 1 percent negative payment adjustment for hospitals that rank in the lowest performing quartile for hospital-acquired conditions.

On slide 43, this notes that the Hospital-Acquired Condition Reduction Program applies to all subsection (d) hospitals that are paid under the IPPS. The program does not apply to long-term acute care hospitals, cancer hospitals, children's hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, or critical access hospitals.

Slide 44 shows the measures that are currently used in the program. And all of these measures — they address the CMS and National Quality Strategy priority of making care safer. The measures in the program are categorized into two domains of care. Domain 1 focuses on patient safety. And currently in the program we use one measure, the AHRQ patient safety indicator, or PSI-90 composite measure.

And domain 2 focuses on hospital-associated infections. And so, currently for the FY 2016 program year, we are using three CDC measures in domain 2. And all of the data for these measures come from hospitals reporting into the National Healthcare Safety Network. And these measures are specifically for CLABSI, CAUTI, and surgical site infections, or SSI. In next year's program, FY 2017, we have finalized the addition of two more CDC measures, for lab ID'd MRSA and C. Diff.

Now all of these measures — the measures are risk adjusted and they adjust high-cost or high-volume conditions. Also, each of the measures used 2 years of data in order to have a sufficient sample size for reliability.

On slide 45, this slide provides a visual of the Hospital-Acquired Condition Reduction Program scoring methodology. So, if we kind of work from the bottom, start with the measures — so the measure results are assigned a score from 1 to 10, or they're assigned points, with 1 being the best and 10 being the worst. And then these points are then going to calculating the domain scores. And right now for domain 1, we only have one measure, so the score on the PSI-90 composite constitutes the domain 1 score.

With respect to domain 2, where we have multiple measures, each of the measures have a score, those scores are averaged to create the domain 2 score. And then, the domain score — each of the domain scores are weighted. So for this coming program year, FY 2016, domain 1 is weighted at 25 percent and domain 2 is weighted at 75 percent. And then we take each of the weighted domain scores and add them up to get the total HAC score.

Slide 46 is another visual to try to help you better understand the point assignments that are based on the specific measure results. And again, it shows that for this program year, FY 2016, domain 1 is weighted at 25 percent and right now constitutes one measure, the AHRQ PSI-90 composite, and domain 2, 75 percent. And for this year, we'll include three measures for CAUTI, CLABSI, and SSI.

Now, slide 47 shows more information on how the ranking of the total HAC scores and the ranking of each of the hospitals based on the total HAC score will then help us determine which hospitals are in the lowest performing quartile, or 25 percent. And those hospitals would then be assessed a 1 percent payment adjustment. And again, in

terms of interpreting the total HAC score, it goes from 1 to 10, 1 being best performing and 10 being worse performing.

HAC Reduction Program Resources

Now moving on to slide 48. So like the Hospital Readmissions Reduction Program, this summer, within the next couple of months, hospitals will be receiving their hospital-specific report for the Hospital-Acquired Condition Reduction Program. And the hospital-specific report will contain — for each hospital, for each measure, their measure results, as well as their domain 1 and domain 2 scores and their total HAC scores. And hospitals will have a 30-day review and corrections period where they have the opportunity to review the data and the calculations and to ask any questions, if applicable. And then the information at the hospital level will be publicly reported on our Hospital Compare website.

So slide 48 has the links to where the hospital-level results will be posted publicly. And then, turning to slide 49, there are several more links to resources for program and measure-specific information related to the Hospital-Acquired Condition Reduction Program.

So Cindy, I will turn it back to you.

Cindy Tourison: Thanks Grace.

Aligning Programs

We are going to move on to slide number 52. So CMS is driving quality improvement as a core function. Our commitment is particularly evident as we enhance our partnerships with the healthcare delivery system in which providers are supported in achieving better outcomes in health and healthcare at lower cost for the beneficiaries and communities that we serve.

The vision for CMS quality strategy is to optimize health outcomes by leading clinical quality improvement and health system transformation. All of the programs we've covered today, including Hospital Inpatient Quality Reporting, the EHR Incentive Program, Hospital Value-Based Purchasing, Hospital Acquired Condition Reduction Program, and Hospital Readmission Reduction Program, are all integral parts of CMS in moving us towards achieving this goal. Although we may target different improvement

processes and approaches, we all come together in optimizing health outcomes and reducing cost.

Slide 53 shows you that we are — we're aware of all of our quality reporting programs. And there is a lot that go into helping hospitals be successful submitters of data in order to get assessed under in these programs. And with that, we have been looking to align our measures across our reporting programs in order to minimize the reporting burden that's imposed on hospitals. Additionally, we are taking a look at aligning our measurement periods and deadlines, where feasible, across programs to make it more consistent, so that when you are looking at some of your hospital-specific reports that, you know, it's a little easier to read because it could count across multiple programs. We are not quite there, but we are working towards that as a goal.

We are also working in having some consistency in our reports. We are working towards simplifying our public reporting as our measures are reported for each program out on Hospital Compare, and sometimes it can get a little confusing.

We are also working on aligning policies where possible across programs. So that might mean that, you know, we have a single exemption waiver that is included for multiple programs so that we can reduce your need to submit a form for each of our programs for a waiver. And we are consolidating the forms where possible across programs.

So now I'm going to turn it back over to Charlie for — to start off our Q&A session.

Keypad Polling

Charlie Eleftheriou: Yes. Before we run in — before we move into Q&A though, we are going to pause for a moment to do keypad polling so that CMS has an accurate count of the number of participants that are on the line with us today.

Holley, we're ready to start polling when you are.

Operator: OK. 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 1. 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 9.

Again, if you are the only person in the room, enter 1. 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 9. Please hold while we complete the polling. Please continue to hold while we complete the polling. Again, please continue to hold while we complete the polling.

Thank you for your participation. I would now like to turn the call back over to Charlie.

Questions Submitted in Advance

Charlie Eleftheriou: OK. We are now going to move into the question-and-answer portion of the call. Before we take a call — actual calls, we are going to start by answering some questions that were submitted in advance of the call. So I'm going to kick it back over to our subject matter experts to do that. And then once they're done running through those presubmitted questions, we will start taking calls.

Cindy Tourison: Great, thanks Charlie. So Grace, I'm going to go ahead and start with some that I've identified that were presubmitted, and then I will turn it over to you, as I know you've identified some that you'd like to answer.

The first question that I have is: Are there any special considerations for critical access hospitals participating in MD QIP?

So that is actually a program that is run by our sister agency, Health Resources and Services Administration, or HRSA. So for more specific information, you are going to want to check with that organization.

We do accept data from critical access hospitals under our IQR Program, under our voluntary reporting options. And those hospitals are given the option to suppress their data or have their data publicly reported on our Hospital Compare website.

Next question: Are there any tools that outline performance period guidelines to preview periods of our data estimated or gain or loss based on our scoring? And can you provide any expectations of what changes may be coming to the program?

So, I cannot comment on changes that might be coming to our programs. We do currently have the IPPS proposed rule out there for your commenting pleasure. So,

because we are in proposed rulemaking at this point in time, I can't comment on future changes to our programs.

However, I think what this question is asking about is some of the details that we had in our Hospital Value-Based Purchasing Program, specifically in our Percentage Payment Report. All of our tools are available out on our QualityNet.web — or our QualityNet.org website. And out there you can find resources for Hospital Value-Based Purchasing, Hospital Inpatient Quality Reporting, and essentially all of the measures in all of our programs are available out on that website. Again, that's QualityNet.org.

Next question: Can you highlight any significant changes to these programs as described in the 2016 IPPS proposed rule?

So I did want to let everyone know that we have a series of webinars that we produce under our value incentives and quality reporting support contract. And we have a series coming up on May 29th, which will be an overview of the IPPS proposed rule. Again, to make it a little more seamless, we are going to be covering the proposed rule for IQR — so changes to IQR, changes to HVBP, changes to the incentive program, and also to HAC and HRRP, as well. That's tentatively scheduled for May 29th.

In order to sign up for that webinar, you can head out to our QualityNet.org website and you can go to our listserv registration, and if you select to register for Hospital Inpatient Quality Reporting, Hospital Value-Based Purchasing, or our Hospital EHR Reporting, you will receive an invite to that series.

Next question: Please discuss the substance bundle indicator.

So we have a series coming up on our sepsis measure. We are going to begin kicking that off in our improvement series in June. And then, we actually have a deeper dive on sepsis scheduled for August, September, and October. So again, if you are interested in joining, please go out and join our listserv so you can receive those invites and learn more about the sepsis bundle.

The next one is: Has the communication problem between NHSN and QualityNet been resolved regarding HAI reporting?

So we have recognized some challenges in hospitals reporting their HAI data to NHSN so that it is successfully submitted and that it flows to CMS. So we do have a webinar coming up on that in the July timeframe. So again, I encourage you to go out there and sign up for our listserv.

The next question that we have is: How many quality measures impact reimbursement for hospitals?

So we didn't go into a deep dive on the measures contained in every single one of our programs. You know, we kind of talked about, you know, the number of measures that we have in IQR. And all of our measures that are in HVBP, the Internet program, and HAC and HRRP at this point in time are also measures in IQR, so you can get a sense from it — from that, but we also have out on our QualityNet website a lot of resources that will act …

Charlie Eleftheriou: It seems that we may have lost one of our subject matter experts. I guess we'll go ahead and move into the portion of the Q&A session where folks can actually call in and ask their questions.

Holley, would you like to open that up?

Operator: OK. To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please 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.

Charlie Eleftheriou: While we are compiling that roster, we actually do have a few more questions from another subject matter expert that would like to cover them, so we will do that quickly here.

Grace Im: Thanks Charlie. So we did receive some more questions in advance of this presentation today.

One of them is: Are there any medical conditions that may be added to the list of applicable conditions for the hospital readmissions measure in the future? And if so, what conditions are being discussed for that?

So I can speak to the Hospital Readmissions Reduction Program. And the statute that established this program does require that measures focus on a specific applicable condition. And so, when we are considering and selecting measures for the program, we do try to focus on those high-volume or high-cost conditions where we can make a bigger impact in terms of improving the quality of care.

And I did want to also mention that, currently, our jury system is open for submission of new measures to be considered for addition to the 2015 Measures under Consideration list, or MUCK list. And this actually applies to all of our hospital quality programs. So not only the Hospital Readmissions Reduction Program, but also the Hospital-Acquired Condition Reduction Program, IQR, and the Hospital Value-Based Purchasing Program.

And then, there was another question: So can you discuss the efforts to address the lack of socioeconomic status adjustments in the outcome matrix associated with the three programs?

So I did want to touch upon that. Currently, we are very closely monitoring studies on socioeconomic status, or SES, risk adjustment at the patient level for the Hospital Readmissions Reduction Program, the Hospital-Acquired Condition Reduction Program, and the Hospital Value-Based Purchasing Program. These studies that are being conducted by ASPE, or the Assistant Secretary for Planning and Evaluation. And ASPE is conducting these studies pursuant to the Impact Act of 2014.

And with respect to the hospital quality programs, ASPE will be submitting a report to Congress in October 2016. Also, CMS is cooperating with the National Quality Forum pilot project, where they are looking at risk-adjusting outcome measures based on socio-demographic status.

And then there was a question on the Hospital-Acquired Condition Reduction Program: Could you clarify the overlap in the timeframe for the Hospital-Acquired Condition Reduction Program, which may result in a hospital being penalized for the same HACs as FY 2015?

So each of the measures that we currently use in the Hospital-Acquired Condition Reduction Program uses 2 years of data. So with respect to the — our PSI-90 composite measure, it's 2 years of claims data. And for each of the CDC measures where the data is reported to the National Healthcare Safety Network, again, it is — each measure uses 2 years of data, and that's so that we have enough — a large enough sample size so that the information that's garnered from the measures are reliable and informative.

And at the same time, the Hospital-Acquired Condition Reduction Program is an annual program. So by statute, we have to make — calculate payment adjustments on a yearly basis. And so we do use what we've described as kind of rolling 2 years of data. So in any one program year, there is a year of data where the same data was used for both. In this year's program we will use 1 year of data that was used in calculating the measure results for last year's program.

And let me turn it over to my colleague Mihir Patel.

Mihir Patel: Thanks Grace.

One of the questions we had was: Abstraction techniques of data for many of the core measures seems to be subject to auditor interpretation, making scores amongst institutions vary quite a bit. How is this being addressed?

So we have a hospital IQR validation process in which we randomly select 400 hospitals and 200 target hospitals who are participating in the IQR Program to submit their medical records, and we perform validation on those records. So that is how it's being handled.

And then I'll turn it back to Cindy Tourison.

Cindy Tourison: Thanks Mihir. Actually, I think we were going to go ahead and turn it maybe back to Charlie and start to take some live questions.

Question-and-Answer Session

Charlie Eleftheriou: All right. That sounds good with us.

Holley, you have opened Q&A I guess, but — I just – for everyone that's going to be calling in, just note, again, that the call is being recorded and transcribed. So if you

would like to state your name and the name of your organization before asking your question, we would appreciate it. And in an effort to hear from as many callers as possible in the short time we have left, we ask that you limit yourself to one question at a time. If you do have more than one question, please press star 1 after your first question has been answered to get back into the queue. And we'll address additional question as time permits. Again, that's star 1 to get back in queue.

We're ready to take our first question.

Operator: All right. Your first question will come from Melanie Hoover.

Melanie Hoover: Yes. We're a critical access hospital and we're being told by our — the State Department of Rural Health that we should be having a 3-year plan for value-based purchasing, that the model may be changing on how critical access hospitals are paid. And so we are trying to prepare for that. And I tried to run the Medicare Beneficiary Report in QNET, but since we're a critical access hospital, it's not available to us. In the near future, are they going to be having that report so critical access hospitals can have an idea of where they're at with IPPS hospitals?

Cindy Tourison: So, you're right, we do not produce those reports for critical access hospitals. We could — I haven't heard this at all, so I am not exactly sure what the — what the source is or if somebody's just guessing. As far as I know, there's no requirement that shifts expansion of VBP at this point in time. But I can certainly check with my contacts at HRSA and see if we couldn't get you an answer back to see if there is — if there are plans. There are none that I am aware of at CMS.

Melanie Hoover: OK, thank you.

Cindy Tourison: Um-hum.

Operator: Your next question comes from the line of Ann Leonard.

Ann Leonard: Hi, thank you. I'm calling from Queens Medical Center in Honolulu. My question is for the Hospital Value-Based Purchasing Program. Is there a floor to the percent decrease that a hospital would be at risk for?

Cindy Tourison: So we are — so it is — it's 2 percent because it's budget neutral.

Ann Leonard: So we …

Cindy Tourison: Crosstalk

Ann Leonard: …so any hospital would not get more than 2 percent decrease?

Cindy Tourison: That's correct.

Ann Leonard: OK, thank you.

Operator: Your next question comes from the line of Pat Phelps.

Pat Phelps: Yes. I kind of got the answer from one of the other questions. I was questioning what happens with a patient that comes from an IPPS hospital is discharged from there, but is admitted to a critical access hospital? Would that count as a readmission for that IPPS or can they even track that?

Grace Im: So, thank you for your question. I believe that it would be a readmission to another — either the same or another acute care hospital. And currently, critical access hospitals do not participate in the Hospital Readmissions Reduction Program.

Pat Phelps: All right, thank you very much.

Operator: And your next question comes from the line of Ann Lombardo.

Ann Lombardo: Hi, this is Ann Lombardo at Lourdes, Burlington, New Jersey. My question was about readmissions and how patients who are transferred to tertiary centers and then come back to us after they're discharged from there and are readmitted in that 30-day timeframe. How is that factored into our readmission rates since we've tried to get them to the appropriate care?

Grace Im: I believe that it would still be — the readmission, if it's within 30 days, would still be attributed to the first acute care hospital because the rationale is that, where the patient might be transferred to and all of the communication and the coordination efforts that are involved with the transfer, that the first hospital where the patient was originally admitted has some control in that and can help with all of those coordination and communications efforts.

Ann Lombardo: I'm not quite sure about that. But — so there's no weighting to the fact that they're sent to a tertiary center for care that we're not unable to provide. Like if we send a patient out with an MI for a cath, we've done everything we can do and the discharge from the tertiary center, they've done whatever. It's not as if they were readmitted for lack of something accomplished at our facility.

Grace Im: Well, I mean — I certainly understand your concerns. I think what the program tries to do is — among all of the patient providers — have them all communicating with each other more effectively and — so that ultimately we can lower the risk of that patient having to be readmitted.

Ann Lombardo: OK.

Operator: All right. And your next question will come from the line of Marcia Lewis.

Marcia Lewis: Hi, this is Marcia Lewis. I'm calling from San Gorgonio Memorial Hospital. My question is in reference to the value-based purchasing. And I am looking back on slide 27, and with the addition in the clinical care domain of PC-01. I'm just curious, PC-01 right now is only collected and reported to Joint Commission. How is this then being added to the value-based purchasing that's coming out through CMS?

Cindy Tourison: Actually, that's incorrect. So PC-01 is being collected under IQR. It's being collected as what we call one of our web-based measures. So at this point in time it is to be abstracted, aggregated, and then reported through our web-based tool. And that's how we're assessing the data.

Marcia Lewis: All right. And just one little more question. How about facilities that are not reporting data to the Joint Commission? Does it still mean that they — these facilities will also need to report only PC-01?

Cindy Tourison: I'm sorry, I don't think — I don't think that I understood the question in relation to reporting to the Joint Commission. So PC-01 is a required measure under Inpatient Quality Reporting. So it does have to be reported through IQR, and then we use the data that we collect under IQR for assessment in HVBP.

If a hospital does not perform obstetrics, they are still required to enter a zero each quarter for that measure. Does that help?

Marcia Lewis: Yes, it does. Thank you very much.

Cindy Tourison: OK, super.

Operator: Again, if you would like to ask a question, press star 1 on your telephone keypad. To withdraw a question or if your question has been answered, you can remove yourself from the queue by pressing the pound key.

Your next question will come from Dennise Gitzen.

Dennise Gitzen: I have a very basic question. Why are you waiting until August, September, and October to present sepsis when it's causing a lot of anxiety among a lot of hospitals?

Cindy Tourison: Well …

Charlie Eleftheriou: Could we go to the next question, please?

Cindy Tourison: Well – so, for sepsis, we — we've taken a look at our calendar and what we have available in terms of when we are starting our series. So those are the opportunities that we had in order to put them together and in order to be able to present those.

So you'll note that those months are all leading up to when you would be capturing the data. So I certainly hope that you'll find them useful in the collection of your data. We're going to go pretty deep in our dive. We're going to go through specifications. We're going to go through the trial abstractions. We're going to get into the algorithms.

So I hope that your staff — will find the series very helpful. And I do understand that it is a complicated measure and that there is some anxiety out there. But I did just want to let you know that we had them planned. And I hear you that you'd prefer to have them sooner. And I will certainly take a look at that and see if there is a possibility of us delivering those sooner. But just based on the schedule that we have right now, I don't think it's going to happen any sooner than that.

Dennise Gitzen: The other thing is that on the server group I am with, Midas — the other thing was that we didn't receive notification from CMS of release of the manual

for April 1st. And I am a QualityNet administrator. And I verified that with over 50 people on the phone call. And I don't know if it's new restructure. I've always been notified.

Cindy Tourison: May I ask you — may I ask you one additional question? So we recently just put out a message that said that there will be an addendum to sepsis. Did you receive that?

Dennise Gitzen: I did receive that. But I did not receive — I accidentally — when I went on to look up something, I saw that the new manual was out like 15 days later.

Cindy Tourison: OK. I will certainly look into that to see if we had any other discrepancies. When you said 50 other people, did you mean that those people had also not received it?

Dennise Gitzen: Yes, we were on a call. There were over 50 people. And when the moderator went back to look through her email, she had not received it through CMS like she normally did. The other administrator at the hospital, she keeps every email from QNET, and we both went back through our emails, but we never received an email saying that the release of the inpatient manual — because I kept checking every day. It always traditionally came on a Friday or at 5 o'clock in the afternoon, and I never received it. And I said it must be delayed.

Cindy Tourison: I certainly appreciate your feedback, and I'm going to go back to my team and figure out what happened there. We'll probably — you'll probably be seeing it really soon because we'll be resending it.

Dennise Gitzen: I did get the one about the addendum on sepsis. But I just — we're just kind of disappointed because we're expected to be up and running October 1st at our hospital, and I'm the whole QA department at this moment. So anything you would have on education would be appreciated sooner than August. Thank you.

Cindy Tourison: OK. Certainly, certainly, thank you.

Operator: And your next question will come from Leah Saylor.

Leah Saylor: And this is Leah Saylor with Wilbarger General Hospital in Vernon — in Vernon, Texas. I was — I wanted to ask if the PQRS would be addressed at any time?

Cindy Tourison: So we – for this MLN production we actually chose to focus on hospitals. I know that our PQRS team does hold similar communications, but I don't know what their schedule is at this time.

Charlie Eleftheriou: I'm researching those dates now.

Cindy Tourison: Oh, thank you Charlie.

Charlie Eleftheriou: You're welcome. We can go to the next question. And if I find the date, I'll jump in.

Operator: All right. Then your next question will come from Donn Wolfe.

Donn Wolfe: This is Donn Wolfe from the Christ Hospital in Cincinnati. I'm wondering if you could provide some future plans or any kind of information on the HAC-POA indicator program, the one where reductions are done on a case-by-case basis for things like air embolism, retained foreign object, and on and on?

Grace Im: So thank you for your question. I think sometimes we also refer to it as the DRA, or Deficit Reduction Act HAC program, or HAC-POA, or Present on Admission Indicator Program. Currently, I am not aware of any future plans. So, unfortunately I don't really have any more information for you beyond what's available currently on our website.

Charlie Eleftheriou: I think we'll go to the next question if we have one.

Operator: All right. And your next question will come from Lisa Miller.

Lisa Miller: Yes, I have a question regarding the Hospital Readmission Reduction Program. In the planned readmissions, what is the discharge code for those? It was my understanding that those discharge codes that were originally put out there after October 1st were rescinded, and I haven't seen any new codes that we were supposed to be using for those planned readmissions.

Grace Im: So, I'm afraid I don't know – I wouldn't know off the top of my head. That's a big discharge code. I would refer you to information on the QualityNet website. That has more specific information about the measure specifications. And I believe we also have

more detailed information on there about the planned readmission algorithm that we use. But, I'm sorry, I don't have – I don't know, like, any discharge code information off the top of my head.

Charlie Eleftheriou: Next question, please.

Operator: OK. And your next question comes from the line of Frank Getty.

Mike Getty: Hello, this is Mike Getty from Lakeland Health in Southwest Michigan. I have question about — if we are – if we have attested for Meaning Use Stage 2, are we covered in the EHR Incentive Program eCQM reporting measures?

Cindy Tourison: So the attestation of eCQM data is — so are you — let me ask you this first, are you first year or beyond your first year?

Mike Getty: Beyond.

Cindy Tourison: OK, so if you are beyond your first year and you've attested your results — is this — which calendar year is this for?

Mike Getty: For '15.

Cindy Tourison: For '15. So if you've attested your results, you just want to check and make sure that during your registration attestation, that you didn't check that you would electronically submit your clinical quality data. Because if you've checked that you would electronically submit your clinical quality data, we'll be expecting to get your data by November 30th. Does that help answer your question?

Mike Getty: Yes, very much so. And if I could ask just a quick thing, you referenced a group called ASPE when referring to the socioeconomic factors that were being investigated for readmissions. Can you say what that organization is spelled out? I wasn't able to find it online. Thank you.

Grace Im: Oh, sure. It's the Assistant Secretary for Planning and Evaluation. It's under the Health and — Department of Health and Human Services, so A-S-P-E.

Mike Getty: Thank you.

Operator: OK. And your next question will come from the line of Jennifer Olson.

Jennifer Olson: Hi, this is Jennifer Olson from Allina Health. And we are interested in some clarification around the payment impact for the IQR Program. Slides 11 and 54 refer to a quarter percent of the market basket update. Yet on slide 11, it still shows a 98 percent payout. So we were under the impression it's a 2 percent of your base operating dollars that are at risk. Can you just provide some clarification, please?

Cindy Tourison: So I'm definitely not a payment expert, but what I can tell you is that the portion of the market basket update generally comes out to about 2 percent. So it has to do with the economic growth and the rate of inflation. But it — so it does fluctuate, though, as you see, between — so it is a quarter of the market basket update from this point forward. And then the other portion is attributable to the incentive program.

And if — I'm sorry – if I didn't answer your question, certainly please go to the resource slide and submit your question through our question tool, and we'll make sure we get you a proper answer.

Jennifer Olson: I think I'll do that. Thank you.

Charlie Eleftheriou: And I think we have time for one more question. But before we do that, I did find out for the caller asking about the next PQRS call. There is a National Provider Call on Medicare Physician Fee Schedule Proposals for PQRS, Value Modifier, and EHR on July 16th. And any other information about upcoming calls can be found on cms.gov/npc, as in National Provider Call.

We'll take our last question.

Operator: All right. Your final question will come from the line of Elaine Scorza.

Elaine Scorza: Well, the focus of this presentation has been on inpatient. Do you have any information about when outpatient measures will be adopted? Particularly I am interested in psychiatric outpatient measures and what those might be or where I might find that information.

Cindy Tourison: So I would encourage you to go visit our listerserves. We do have our outpatient listerserves up there. And we also have these same resources available for

our outpatient and our — and our inpatient and psychiatric quality reporting programs. So you could submit a question and they should be able to help get you more information on those topic areas.

Elaine Scorza: Thank you.

Cindy Tourison: Thanks.

Additional Information

Charlie Eleftheriou: All right. At this time, we have reached the end of our call. If we did not get to your question, please refer to the resource slides in today's presentation.

On slide 55, you'll find information on how to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. But we hope you'll take a few moments to evaluate your experience with today's MLN Connects Call.

I'd like to thank our subject matter experts and all participants who joined us for today's call. Have a great day and we'll talk to you next time.

Operator: This concludes today's call.

-END-


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