

Centers for Medicare & Medicaid Services
Special Open Door Forum:
End Stage Renal Disease Quality Incentive Program
Payment Year 2012: Proposed Rule Overview
For Beneficiaries and Patient Advocates
Tuesday, September 21, 2010
2:00PM – 3:30PM ET
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will hold a Special Open Door Forum (ODF) to discuss the proposed rule for the End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) that will go into effect January 1, 2012.

This Special ODF is designed specifically for ESRD beneficiaries, their families, and advocates in an effort to increase awareness and understanding of the proposed rule. In addition, the discussion will cover potential effects of the ESRD QIP. Most importantly, this Forum provides CMS with the opportunity to engage and listen to the needs and concerns of the beneficiary and advocate community.

The rule went on display at the Federal Register on July 26, 2010, and can be read online at <http://edocket.access.gpo.gov/2010/pdf/2010-18465.pdf>.

During this ODF, CMS will provide a comprehensive overview of the proposed rule and provide key insights to the ESRD QIP, including:

- Why the Quality Incentive Program was needed;
- How it will impact the care beneficiaries currently receive;
- What will change as a result of implementing the ESRD QIP and what will stay the same;
- An overview of the ESRD QIP;
- How the ESRD QIP was designed to improve quality of care; and
- How beneficiaries, their families, and patient advocates can submit comments and play a role in improving quality of dialysis care.

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 September 17, 2010.

We look forward to your participation and comments.

Special Open Door Forum Participation Instructions:
Dial: 1-800-837-1935 Reference Conference ID#: 98957601.

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 October 7, 2010 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 this transcript: <http://media.cms.hhs.gov/audio/ESRDQIPBene092110.mp3> .

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Special Open Door Forum:
End Stage Renal Disease (ESRD) Quality Incentive Program (QIP)
Payment Year 2012: Proposed Rule Overview
For Beneficiaries, Caregivers and Advocates
Conference Call Only
Moderator: Natalie Highsmith
Tuesday, September 21, 2010
2pm-3:30pm ET

Operator: Good afternoon. My name is Sarah. And I will be your conference facilitator today. At this time, I would like to welcome everyone to the Center for Medicare and Medicaid Services End-Stage Renal Disease Quality Incentive Program Payment Year 2012: Proposed Rule Overview for Beneficiaries, Caregivers, and Advocates Special Open Door Forum.

All lines have been on mute to prevent any background noise. After the speakers' 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 press the pound key. Thank you. Ms. Highsmith, you may begin your conference.

Natalie Highsmith: Thank you Sarah. And welcome everyone to today's Special Open Door Forum focused on the proposed rule for the End-Stage Renal Disease Quality Incentive Program. This program will go into effect January 1st, 2012. This Special Open Door today is designed specifically for beneficiaries, their families and patient advocates in effort to increase awareness and understanding of the proposed rule.

The rule went on display at the federal register on July 26th, 2010 and can be accessed on the Federal Register Web site. Discussion materials for this Open-Door are available on our ESRD quality improvement Web site which is www.cms.gov/esrdqualityimproveinit , and you can follow along there. I will go ahead and turn the call over to Ms. Teresa Casey who is the director

of the Division of Quality Improvement Policy for Chronic and Ambulatory Care in our Office of Clinical Standards and Quality. Teresa?

Teresa Casey: Good afternoon everyone. This is Teresa Casey. And before we begin the presentation, I would like to point out a logistical consideration that we have to adhere to regarding this forum. Because we are in the proposed stage of the rule making cycle and we have certain guidelines that we must adhere to, we are primarily in a listening mode during this call.

Again, our focus is the quality incentive program. We will not be addressing payment implementation or speak to topics that fall outside of the Quality Incentive Program Notice of Proposed Rule Making.

That being said, I want to acknowledge the fact that you have many good ideas and thoughts about how we can put the Quality Incentive Programs into action. And we welcome and we are looking for your feedback.

In this context, I'm asking you to please be sure and send those ideas for your formal comments and response to the proposed rule as directed in the proposed rule. And we'll provide further information and details about that later in the presentation.

While we will listen to your thoughts and ideas today, any comments that you have must be submitted in writing. And that could be hard copy or electronically to ensure consideration and to be part of the official record for this proposed rule.

Now, I just want to say that we at CMS – and we have quite a few people sitting around the table here as well as on the call. We're really excited to have this opportunity to speak directly to our beneficiaries and to the beneficiary advocates. So this is an occasion that we have been looking forward to and we look forward to our discussion later in the call.

Let's go ahead and move into the presentation. I'm hoping that you all have the slides in front of you, beginning with slide one. Today, we want to introduce to you to the ESRD Quality Incentive Program and answer any questions that you might have about this new program. We want to tell you

how it came about, and how the program complements the ESRD bundled payment system that will start January 1, 2011.

We will share information about how the Quality Incentive Program will impact you and where you can find information about this program. During this session, we'll provide you with information about how to access the ESRD Notice of Proposed Rule Making. We've already announced how you can – Natalie, thank you for that.

We're going to also talk about how to submit public comments. The public comment period is currently open and runs through to September 24th, 2010. We will explain the rule making process which consists of publication of the proposed rule in the Federal Register, receipt into consideration of public comments and publication of the final rule.

We want you to know that all public comments are very carefully considered by CMS. And a response to each comment is provided in the explanation of the final rule.

Let's move ahead to slide two, your role in the regulation process. We just wanted to give you a picture of the regulation process and highlight your role in this process. The process begins in this case with the passing of legislation by Congress and the initiation of the regulation process which of course for us start with writing of the proposed rule.

We publish the proposed rule in the Federal Register at which time the public has usually 60 days to comment. In this case, it is 60 days. The proposed rule outlines how we intend to implement the legislation and how we propose to set up the quality incentive program. On July 26, we put the proposed rule on display and on August 12, we published the rule in the Federal Register.

Again, the comment period is open just a few more days to the 24th. After the comment period closes, we will review and respond to comments as part of preparing the final regulation. Then we'll publish that final regulation in the Federal Register. It's important to note that the, you know, public comments help us to develop the final rule and we want to hear from you.

In fact, if we don't get a lot of comments, it's not as helpful. So I really, really encourage you to think about commenting because as the commenter, you have a very important role in this process.

Slide three, the ESRD Quality Incentive Program is the first Medicare pay-for-performance program to be implemented in a Medicare prospective payment system. Pay-for-performance means a dollar amount is tied to whether quality care or better care is provided to the patient.

In a pay-for-performance program, rather than pay dialysis facilities strictly based on how many services they provide the patient, Medicare can now pay dialysis facilities based on how well those services help keep patients safe and healthy.

The QIP is a program that builds on a long history of work by CMS to improve the quality of care for beneficiaries with ESRD. And just to mention a couple of those efforts. I'm going to mention the Dialysis Facility Compare Web site. This Web site contains dialysis facility service and quality information on all Medicare approved dialysis facilities in the United States.

This site allows consumers and patients to review and compare facilities and choose the dialysis facilities based on their characteristics and quality of care that best meets their needs.

The ESRD network program works to improve the quality of care of ESRD beneficiaries. They provide technical assistance and resources to dialysis facilities to improve healthcare. The fistula first breakthrough initiative is led by the network. This is an agency-wide quality initiative developed as part of a breakthrough strategy to increase the use of AV fistulas which are the gold standard for dialysis (inaudible) to vascular access.

Another way that we work to ensure proper care is provided is through the ESRD conditions for coverage. These are the federal health and safety regulations that must be met by all ESRD facilities participating in Medicare. These are the rules that are used by surveyors during inspection.

The Quality Incentive Program is intended to complement the existing CMS Quality Improvement Initiative and produce improvements in patient care.

Slide four, how the QIP came about. And of course when I say QIP that's their acronym for the Quality Incentive Program. To say QIP is just a little bit shorter and I just want to make everyone aware that QIP stands for Quality Incentive Program.

In July of 2008 the Congress enacted the Medicare Improvement for Patients and Providers Act. And again here's another acronym, MIPPA. OK. Section 152 of MIPPA of this act changes how dialysis services are paid for. And section 153c establishes the Quality Incentive Program.

I'm just going to briefly touch on how dialysis services are paid, because when we talk about the Quality Incentive Program and paying for quality it's important to have some understanding of how we currently pay for dialysis care and what it will mean when we move to a bundled payment system.

Dialysis care is currently paid for via a composite payment for the dialysis procedure. Separate payments are made for certain lab tests and certain IV medication such as erythropoiesis stimulating agents and vitamin D. This current payment method potentially provides incentives to overuse these medications and overuse separately billable lab tests.

MIPPA Section 153b changes ESRD payments and bundles many of the ESRD services into a single payment and promotes efficient ESRD care. A final rule was published on August 12th as well and then there were two significant rules published that same day. And that rule describes the new bundled payment system that will be effective January 1.

Just in case you're interested in going and taking a look at that rule, the identifier for that rule is CMS-1418-F, as in Fred. The bundled payments along with the QIP will provide financial incentive to dialysis facilities to provide better care and efficient care.

Now, during today's Open Door Forum we're going to focus on the QIP which again is based on Section 153c of the legislation and this section requires the

secretary of Health and Human Services to measure the performance of the ESRD facilities and providers. And starting in 2012 reduce payments to facilities and providers who do not meet performance standards outlined in this proposed regulation which we're about to discuss.

What this means then is that if the facility does a good job, it receives a full reimbursement. If the facility does a poor job of meeting the measures, its reimbursement is lowered by as much as 2 percent.

This congressional mandate required CMS to update how it measures quality and pays for dialysis as I just described. The QIP regulation describes CMS' plans to implement the quality measurement program. And I'm going to go through the steps that we must undertake in order to accomplish this.

First, the measures have to be selected. And this actually is all ready done, the measures have been finalized. The next steps, though, are addressed in the proposed rule. The next steps include establishing performance standards that apply to the individual measures and specify a performance period with respect to a year, to develop a methodology for assessing the total performance of each provider based on the performance standards with respect to the measures for the performance period. OK.

We need to apply an appropriate payment reduction to facilities that do not meet or exceed the established total performance score. And also we need to make available the performance scores.

Let's move to slide five. I mentioned that the measures for the first year of the Quality Incentive Program have been finalized. The ESRD perspective payment system final rule published August 12th includes the three quality measures of beneficiary health that we will use in the payment year 2012 of the Quality Incentive Program.

For the Quality Incentive Program a quality measure is used as the guide to monitor, evaluate and improve the quality of patient care. Not unlike the kind of measures or indicators you might see in consumer reports.

For the Quality Incentive Program CMS has chosen three quality measures. Two measures cover anemia management. One measure covered hemodialysis adequacy. To be more specific – well, let me go back to the reason that we selected these measures. First of all the legislation specifies the areas of anemia management and dialysis adequacy. And so in order to meet the requirements of the law we needed to have measures in at least in two areas.

In addition, these areas are very important to patient health. Also these measures – the measures that we have selected for anemia management and adequacy have been recorded on the Dialysis Facility Compare Web site since 2001. So patients in the renal community have some familiarity with these measures and make the transition I think a little bit easier and help with understanding the QIP.

In addition, another very important factor in selecting measures is that we already have very reliable data available. Now, specifically, the measures, we have – again two anemia management measures, one adequacy measure.

So let's start with the anemia management measures. They are percentage of patients in a dialysis facility with a hemoglobin level of less than 10 grams per deciliter. So that's their first measure. The second measure is the percentage of patients in a facility with a hemoglobin more than 12 grams per deciliter.

For the adequacy measure we're using the urea reduction ratio of equal to or greater than 65. We've provided more detailed explanations about the measures in the appendix at the end of the presentation. And you may want to take a look at slide 17 for that information.

We are proposing to collect data for these measures during calendar year 2010 to implement payment reductions for 2012 which means we are currently in the performance period. The Quality Incentive Program compares the provider's performance on these measures with what the norms are for dialysis facilities across the country.

Now, when we say norm what we're talking about is the national average using 2008 data. Or according to the legislation we can use the facility's own

performance from the previous year and that year has been designated as 2007. And this information is located on slide 18, also in the appendix.

This first year will be the only year when a facility who performs equal to how it performed in the past will not receive a payment reduction. So there is a certain standard they have to meet in the first year. However, in future years of the Quality Incentive Program, the facilities will need to show improvement in order to get a full payment.

The Quality Incentive Program altered payments from the Medicare to dialysis facilities based on how well they're doing over the three measures.

Let's move to slide six, please. MIPPA 153c requires the secretary to develop a scoring methodology for calculating an individual facilities performance score.

And we have proposed to score facilities on each of the three measures over a range from zero to 10 points with the highest number of attainable points being 30 points. As shown in this table for every one percentage point of facilities performance differs or falls below the national average or national performance standard, two points will be subtracted.

And if you want to delve into the numbers, examples of the scoring are given in the NPRM and its page number 49223. After scores are calculated for each measure, we will apply the weights to arrive at the facilities total score. We are proposing to weight the measures differently they will not have equal weights.

The anemia management measure of hemoglobin less than 10 would be weighted as 50 percent of the score while the other two measures be weighted at 25 percent each. The low hemoglobin measure is given greater weight because low hemoglobin can result in poor oxygenation, decrease patient activity, increase hospitalization, and can produce the need for blood transfusion.

And also because of the concern about an inappropriate erythropoiesis stimulating agent use and the need for an adequate incentive to treat anemia under the bundled payment system.

Slide 19 shows how the payment reduction is triggered by the total performance score. So that if a facility scores between 26 and 30 points they would receive no payment reduction. If the facility scored between 21 and 25 points they would have a 0.5 percent payment reduction. If the facility scored between 16 and 20 points they would have a one percent payment reduction.

A score between 11 and 15 would result in a 1.5 percent payment reduction. And then a low score of zero to 10 would equate to a full 2 percent payment reduction.

Now, the NPR goes into some detail regarding the scoring and the numbers and so forth like that. The math is laid out in the proposed rule. So again, I would urge you, if you are someone who would really like to delve into this, to make sure that you take a look at this section of the proposed rule.

Slide seven – measure exclusion. In order to further clarify the measures, I want to take a moment to talk about what measures are not included in the Quality Incentive Program at this time. But, however, I also want to say this does not mean that they won't be considered in the future.

Again, this is the proposed rule and it only addresses the first year of the Quality Incentive Program. For the rule-making, it will be undertaken for future years. So as of just the first year of the QIP, peritoneal, hemodialysis, and pediatric patients are not included in the hemodialysis adequacy measure. The URR is the measure unique to hemodialysis and it's only going to be applied to the in-center hemodialysis patients.

The anemia measures will not apply to patients under the age of 18. Patients receiving dialysis more than three times a week are excluded from the hemodialysis adequacy measures. Patients who are in the first six months of dialysis who might still have some kidney function (lab) are excluded from the hemodialysis adequacy measure.

Patients have to be on dialysis for 90 days and be on erythropoiesis stimulating agents to be included in the anemia measure. All these limitations are specified in the ESRD perspective payment final rule. I had mentioned it at CMS-1418-F. And it's a very long rule. I would not suggest anyone open it up and try to print it out. It's I think 192 pages or something like that.

But if you wanted to take a look at it, this is Section-M of that rule, M as in Mary. And it would be – this information would be found on page – starting on page 49182. The reason that these measures or the reason these limitations are placed on these initial measures, this for here, is that there's a lack of agreement for what the measure outcome should be, what the threshold should be for these measure and these patients.

However, this may change as the program evolves. And we certainly want to have a much more robust set of measures as we go along in the future years.

Slide eight—anticipated changes as a result of the QIP. What kind of things might you notice as you go and have your dialysis treatment? Well, we would anticipate that the quality incentive program is going to influence the quality of care you receive and certainly you know, in a good way.

You may notice that your experience at your facility changes. It is slightly as a result of the new Quality Incentive Program, you might notice that there's an increased focus on the quality of your care. It could be that there's even more attention paid to drawing your blood correctly. There could be an increased emphasis on getting your lab values right and within the target ranges.

You might see changes in how your facility staff operates in order to be more efficient. You will also have access to information about the quality incentive program that will help you make decisions about your healthcare.

CMS will report performance scores in two different ways. First of all, the legislation requires that we provide a certificate to the dialysis facility that shows the performance scores and also shows the comparison to the national scores.

And this certificate needs to be prominently displayed in the facility at a place where patients can see it. These certificates will assist you in understanding the facility's total performance score and how they compare to other facilities. In addition, we will have the scores available online and we are contemplating where that will be. And we are thinking about using the Medicare dialysis facility compare Web site in order to publicly post the scores.

Slide nine—what the Quality Incentive Program won't change. We will continue to hold facilities accountable for minimum health and safety standards which we've referred to as the conditions for coverage.

As a patient, you can continue to have the power to decide how and where you want to be treated. Expect facilities to reach back your rights to include the right to express concerns about your care and to have a meaningful doctor-patient relationship.

Slide 10—how CMS will ensure quality of care for ESRD beneficiaries. We are in the process of planning a monitoring system. We will be continually monitoring the program to evaluate its impact on your access to care and the impact on the quality of care.

Ongoing monitoring will help us (inaudible) any potential changes in quality of care and also help us to discover, you know, what best practices are developing out there and what – how can we spread these best practices. As the program matures, we anticipate setting even higher performance standards in future years of the Quality Incentive Program.

Slide 11, we are committed to additional quality – to putting additional quality measures in place as soon as the complete data sources become available. And this is, you know, it's something that has proven to be a challenge because, you know, we want to have a robust picture of what is the quality of care. We're starting with three measures but keeping in mind that is just where we're starting.

We are going to be considering adopting additional measures such as bone and mineral metabolism, using the Kt/V measure instead of URR for dialysis

adequacy. We're considering adding back the access rates and patient satisfaction measures to the quality incentive program in future years.

We are committed to further development of quality measures in the future to better assess a fuller picture of the quality of care provided to beneficiaries by these facilities.

Slide 12. Now, let's talk about your role, your role in the regulation process. As we stated earlier, we are implanting the Quality Incentive Program through the federal regulation process which is one of the basic tools of government used in order to implement public policy.

Again, the public comment period is open until September 24th. Your written comments matter. Please, please be sure to send them before the comment period ends so that they can be taken into consideration.

Now, let's go back to how to find the regulations, slide 13. Well, not only how to find the regulation, but how to use – how to submit comments because those can be done in the same spot.

The proposed rule can be found on the Web site address that is shown on this slide. It's www.regulations.gov. You'll be – once this page appears that you see on the slide, you can do a search for this particular proposed rule and the identifier is encircled on the slide there, CMS-3206-P.

Any rule ending in a P is always the proposed rule. Any identifier ending in an F is always the final rule – just a little tidbit there, OK?

Please remember that the comment – I'm going to say this so many times because that's one thing that I don't think anyone will forget by the time we finish because there is just a few days left in order to get your comments in.

And I emphasize this because you know, if you were to read the entire proposed rule and it is much shorter than the perspective payment rule – but anyway – comments are requested in 15 places in the proposed rule. We encourage you to submit comments on as many aspects of the quality incentive program as you choose.

Now, although you're more than welcome to send comments on 15 aspects or even more than 15 aspects as you find them, we'd like to point out certain areas where we hope to receive a large amount of beneficiary feedback. And I'm just going to list four of the comment requests that are listed in the proposed rule.

The first request for comment I'm going to mention, "How to make information contained in the certificate as user-friendly and easy to understand as possible." We'd love your comments on that. Also, "How we can educate Medicare beneficiaries (inaudible) the presence of certificates and how information can be used to engage in meaningful conversations with their dialysis caregivers in the clinical community about the quality of America's dialysis care."

Another item that we would love to receive your comments on, "How to best add total and individual performance scores to the Dialysis Facility Compare Web site, how to make it as user-friendly as possible."

Another area, the degree of breadth and detail of the quality incentive information that should be placed on the Web site, on how the Dialysis Facility Compare Web site could be redesigned to make the Quality Incentive Program information useful to beneficiaries as they compare quality of care.

Again, there are additional areas where we're asking for comments. We ask for comments regarding the methodology, the performance period, monitoring and evaluation of the quality incentive program and so on and so forth. But I just wanted to highlight these four areas because I really think that we are looking particularly to beneficiaries to help us in those particular areas.

Slide 14—How to Submit Comments. Details about submitting comments are in the regulations. It's page 49215. And there are several ways in which to submit comment. The most familiar way being via, you know, mail in the regular postal, using the postal service and the other way is to go online and submit those comments electronically.

And again, due to the shortness of time, you may want to think about submitting electronic comments. This slide shows you some information how

you go about doing that. Again, you do a search for CMS-3206-P. There's a link that you click on that says submit a comment, you click on that. And then a window opens up and then they ask you for your name and things like that and then it gives you the opportunity to submit your comments.

Now, a word of caution, once you open this screen, you have 20 minutes to complete your comment submission. So if you want to kind of think through your comment as you're writing, you might find that the 20 minutes is too short. You can paste comments in that you've, you know, put – developed via maybe a word document. You can also submit a file as your comment.

So you might want to think about which way you want to go about doing that. If you do want to, simply type into the window. There's a 2,000 character limit for the comments.

Now, I want to also make sure that, you know, that you can view the comments. Once the comment period closes, CMS makes the comments available for public viewing. It can be viewed either in person or online. And you would go to the same Web site in order to view the comment, www.regulations.gov.

Now, you may not want to include personal or confidential information about yourself because your comment once submitted will be made public just as all the other comments are. So you may want to just give that a little bit of thought.

Slide 15. During today's presentation, we highlighted the various aspects of the Quality Incentive Program and how it relates to legislations. We told you about what measures we'll be using and what the exclusions are at this time. We talked about the changes that you might expect to see as a result of the Quality Incentive Program.

We talked about how we want to move forward and extend our measures in the future. We emphasize your very important role in the regulation process. And we welcome your questions and look forward to your written comments. Now, I'd like to invite you to ask questions.

So I'd like to invite our facilitator, Sarah to open up the lines. Natalie, is that how we do – can we go about it now?

Natalie Highsmith: OK, Sarah if you can just remind folks on how they can get into the queue to ask a question. And everyone, please remember when it is your turn to restate your name, give what state you're calling from, and what provider or organizations you're representing today.

Operator: At this time, I would like to remind everyone, in order to ask a question, please press star then the number one on your telephone keypad. And your first question comes from the line of Barbara Younger from Florida. Your line is open. Barbara Younger from Florida, your line is open.

Your next question comes from the line of William Peckham. Your line is open.

William Peckham: Hi, this is William Peckham. And I'm at Seattle in Washington State. I (inaudible) through the Northwest Kidney Centers, but I'm on the call today representing myself as just a beneficiary. And I guess my blog if you have there, organization as Dialysis From The Sharp End Of The Needle.

My question and I can't recall seeing this in the proposed rules having to do with the lag time right now where we're going to be rewarding – in 2012 performance today. So is there hope in the future to shorten that lag time to, you know, be more on time? And also I'm wondering if you set a total performance score for the facility, but it seems to me that the more powerful way to report quality would be on a patient-by-patient basis so that you could see your performance as a result against the unit and then against the network in the nation.

And so I guess just to complicate a little more of it, it seems like there's two parts of the QIP so there's the withhold part, but there's also the reporting part. And I'm wondering if that reporting part could focus on the individual beneficiaries result. Thank you.

Teresa Casey: Thank you so much for your comment. You made some very good points. Now, just to start out with your first question in regard to lag time. The first

year of the QIP is using measures that are based on claims data. And anytime that we use claims data, we have a good six months plus data lag in order to get a complete set of data. And then, even once we collect the data, we then have to analyze the data. We have to calculate the performance scores.

We have to determine, you know, who met standards who didn't. We have to prepare files in order to implement the payment reduction. And so, you know, there are a number of steps that we need to go through in order to arrive at, you know, that payment reduction starting the first of that next year.

So you know, as long as we're using claims-based measures, we're going to have lag time and we're going to have to allow for a time for us to go through those processes that I just described now. In the future, if we have a different source of the data, and of course there's a lot to talk about you know, CROWNWeb or electronic data collections and so forth like that. You know, if we have another source of data and of course that source has to be valid, reliable, accurate source of data, then certainly, we could consider condensing you know, that with right now is a year long process.

Now, how much we could condense it you know, I'm not sure if we could get to down to anything less than six months. But it's certainly something we would want to consider because, you know, certainly a lag time waiting a whole year, by the time you see the score, it's a year old. And you know, I understand that that is not ideal. And we certainly are going to work for to reducing that lag time.

Now you mentioned the total performance score is again, not really being ideal and that wouldn't it be better to look at, you know, patient level measurement and care and so forth like that.

And what I would say about that is you know, we're (inaudible) somewhat of a continuum here and that, you know, this is the first time that we are holding facilities accountable for facility measures of the quality of care. If in the future we could get the patient level data, I don't know. You get into, you know, all kinds of challenges associated with confidentiality and all that. And I would like to just mention that the ESRD conditions for coverage do call for

the facility to do, you know, individual patient assessments, develop a plan of care, monitor that care.

They also need to have a quality assurance and performance improvement program in place. So in that sense, there should be, you know, a look at patient level of care. Right now, where we are with the QIP and kind of our evolution, we're happy now to be at the facility level. But certainly, we continue – we want to continue to have a better way to measure quality of care and a better way to make sure that we are incentivizing improvements in care.

Natalie Highsmith: OK, Sarah, next question please.

Operator: Your next question comes from the line of Rich Berkowitz from Illinois. Your line is open.

Rich Berkowitz: Good afternoon. This is Rich Berkowitz and I am with NxStage users.

In a perfect world, I guess, we dialyzers would like to see more indicators which providers are held accountable to. However, with 2 percent withhold, it seems that if you add more in and put them into the 2 percent, we'd be slicing and dicing that 2 percent to the point where it's practically meaningless from a financial aspect.

Looking at the way the 2 percent is now in the basic three indicators you're looking at, I'm wondering if CMS can consider cutting those down considering that there has been an overdosing of EPO in the past because it was an unfortunate way of some providers to add to the bottom line. Now, EPO clause will be pure and there will be no added advantage to overdosing. In fact, there would be a disadvantage.

So therefore, I'm wondering if there's a way so the only indicator for hemoglobin would be under 10 and forgetting about over 12.

I also believe – being a believer that URR is not a very good indicator of good dialysis, I'm wondering if that can be taken out as well. One more thing, is that since the bundle is supposed to be budget-neutral, if any providers are

withheld full payment, is there a way of throwing that back into the pot to be redistributed to the providers that have met their targets. Thank you.

Teresa Casey: Rich, thank you very much for your comments. And it seems like you had maybe two or three themes going on with your comment. So let me see if I can go through each issue.

You mentioned that we need – we should have – well, as we move to more indicators to hold providers accountable which certainly sounds like a good thing that you end up slicing and dicing the 2 percent to the point where it isn't very meaningful. And certainly, that is a good point.

And as we develop more experience with the Quality Incentive Program and with the measures, we are going to be evaluating that. We will have the ability to retire measures. You know, if we find that a measure is truly topped out or that we are not going to be able to improve patient care by using a particular measure, we may choose to retire that measure.

Certainly, we are going to pay attention to all the various aspects. And, no, just because we did something the first year of the QIP, doesn't mean that, you know, five years later that same thing is still in place. Each year we're going to be taking a look-in and monitoring even as we go along.

Now, you mentioned that there's no advantage to over-utilizing ESAs. And we actually get a comment on that, from the proposed rule of the PPS – the prospective payment system rules where we laid out the initial proposed measures.

We did receive that same comment, and what we are going to – well, first of all, the legislation mentioned that we do need to utilize the FDA guidance as far as what the range of hemoglobin should be, what range should be targeted, what range is acceptable. So, we keep that in mind. And what we'll do is we'll watch the measure and we'll see what happens.

At this point in time, the measure is finalized and so for the first year of the QIP, we are going to be using the hemoglobin greater than 12 as one of the measures. Now, you mentioned that the URR is not a good indicator, and

certainly – certainly, we realize that (Kt/V) measure is a better indicator, and in the future, when we have that data available, we hope to transition over to a Kt/V measure.

But, again, we have to, you know, go through rulemaking and (inaudible) and so forth like that.

Now, as far as any reduction of funding that produces a – sort of a pool of money being redistributed, I don't know what is being planned for that. I'd have to really have the (inaudible) on whether they would comment on that at this time. But I thank you for your comments and I certainly urge you to submit a written comment on the proposal.

Natalie Highsmith: OK. Sarah, next question please.

Operator: Your next question comes from the line of Beth Witten from Kansas. Your line is open.

Beth Witten: Hi, this is Beth Witten. I am from Kansas and I am at Witten & Associates. And I have actually three questions. One of them relates to data verification. You mentioned earlier at some point having something other than claims data to be able to use. And there has been some concern expressed about whether the data source that will be used for the QIP will – one that goes beyond claims data, whether you can be sure that the data that's reported does not gain.

So, there's the data verification issue.

Another question that has come up relates to patient care and whether when patients have concerns or complaints about patient care that they get related to any reduction and reimbursement, whether those complaints would go to the usual sources, to the network and to the state survey agency.

Then, finally, something that – as a social worker, one of the things that has always interested me is that CMS is reducing payment for bad care as opposed to paying more for better care. It seems like if there was down the road a pool of money that is saved from doing what you're doing it might be worthwhile

looking at whether or not you could start paying for better care instead of withholding payments, which will just make clinics that right now are vulnerable to takeover, being taken over.

Those are my – those are my issues.

Teresa Casey: OK, Beth, thank you very much.

Your first question had to do with data verification and data sources and how can we make sure that the data is not gamed. And certainly, we are concerned with that data's accuracy and reliability. And in starting with the first year using claims, we're very confident that our data is valid and reliable.

As we look forward to the future, those are the kinds of considerations that we will have to think about. And as we undertake rulemaking and we put forward you know new measures using new data sources, we would invite public comment and comments in reference. The gaining would be certainly welcome at that point in time.

Your second question had to do with if the patient has concerns and complaints, who would they make that complaint to, would it be the ESRD network, would it be the state survey agency. And the complaint mechanism remain the same and in fact we are going to be monitoring complaints and grievances because we want to be sure about any perhaps unintended or unexpected effects of the new payment or the quality incentive programs.

So, we want to make sure that we have an idea of the type of complaints that are coming in as we go along. So, the mechanisms remain the same. A patient can make a complaint to the ESRD network or to the state survey agency.

You mentioned that with the quality incentive program, we are reducing payment for (inaudible) wouldn't it be a better thing to pay more for better care? This is not a CMS decision, we are implementing this quality incentive program based on the legislation that we have. So, that's our answer to that question. And I don't – does anybody around the table have anything else to add to that?

I'm getting a shaking of heads. So, no.

So, Beth, thanks very much for your question.

Operator: Your next question comes from the line of Henry Dove from Connecticut.
Your line is open.

Henry Dove: I am curious if any thought has been given to providing incentives to do more homecare dialysis. I know you said that they're taking the measures only from patients that are getting care at dialysis centers.

Is there any thought about trying to give incentives to patients and providers for doing more homecare dialysis?

Teresa Casey: Henry, thank you very much for your comment and your question.

Certainly, if you read the statutory language at 1881, you will see that one of our problematic goals is to improve the use – or have as many people on home dialysis as – are capable of being on home dialysis.

Now, as far as you know will we be providing incentives for home care, we did receive some comments in regard to that as we put forward our initial measures. I would encourage you to continue to comment as we go forward again. This is just the first year of the quality incentive program and we have a limited number of measures.

We had a limited amount of data available to us on a limited amount of time in order to get this program up and running. Certainly, as we move forward, we want to consider measures in many different areas. And certainly, that is something that we welcome comment on.

Operator: Your next question comes from the line of Tonya Saffer from Washington.
Your line is open.

Tonya Saffer: Hi, this is Tonya Saffer from Washington D.C. I'm with Dialysis Patient Citizens. And I just had one concern and question that I wanted to raise in regards to the hemoglobin measures.

Well, I think it is appropriate to exclude Medicare patients that are not receiving ESAs from the above 12 measures. I don't think that the same is appropriate to exclude patients that are not receiving ESAs from the bullet of 10 measures. I think that there needs to be an incentive to treat patients' anemia and excluding patients that are not receiving ESAs from bullet of 10 measures does not provide that appropriate incentive.

And so I wanted to know if CMS had any discussions around – surrounding that issue and of course I will include this in the written comments as well.

Teresa Casey: As far as comments – well, first of all, thank you for your remark. And I think that you make a very good point.

The measure that we're utilizing is very much the same measure that appears on the Dialysis Facility Compare Web site. And as far as it's treating patients not on ESAs, I think that's something that you know we welcome your comment on. We're happy to continue to re-look at that and think about you know what does the science say, is the measure fair, is the measure appropriate and so forth, like that.

Mary, do you have anything to add there?

Mary Pratt: No, that's fine.

Teresa Casey: Please submit your comment and we will certainly give it some consideration and take it back to the expert in the area. And that was Mary Pratt. She is a quality measurement expert from the Quality Health Measure Assessment Group.

Tonya Saffer: I'm sorry, what was her last name?

Teresa Casey: Pratt, P-R-A-T-T.

Tonya Saffer: Great. Thank you so much.

Operator: Your next question comes from the line of Stacy Wright from Illinois. Your line is open.

Stacy Wright: My question is I'm just trying to understand this performance standard that you created these measures from is this the data that you're going to be using as quality incentive as far as how the two percent is going to be penalizing us or you're going to be actually using data from 2002?

Teresa Casey: Let me – let me see if I can clarify, Stacy. The performance period, the time during which we are going to collect data is 2010, calendar year 2010.

Stacy Wright: OK.

Teresa Casey: OK. Once we have the performance rating for each of the three measures, we have you know what is – how many patients in the facility have hemoglobin less than 10. OK, we have that rate. We compare that number to the national average. The national average is computed for the year 2008, OK?

We do also another totally separate comparison. We compare that number to how the facility did in 2007, which is the year we identified for that comparison, OK. Whichever one – the facility's score is whichever one is lower is that's their score.

So, in other words, if you – if you as a facility at least do as well as you did in 2007, you will have no payment reduction, or if you would meet the national average, you would have no payment reduction, either one.

Female: (Inaudible).

Teresa Casey: Does that help, Stacy, or no?

Stacy Wright: Yes, I understand. So, you're comparing the 2010 data to the data from the national of 2008 or 2007.

Teresa Casey: Well 2007 is the facility's own performance.

Stacy Wright: OK. OK.

Teresa Casey: OK? Does that help?

Stacy Wright: That makes more sense.

Teresa Casey: OK. OK, thanks.

Operator: Your next question comes from the line of Eunice Banks from Georgia. Your line is open.

Eunice Banks: Yes, ma'am. You were saying social worker, I'm very glad if you have programs like QIP it is about to be implemented. But I'm concerned about the role of the social worker in it. And it seems like we have to really be cognizant of the ethics as social workers and ethics of how the facilities are going to operate under such a reward penalty system. That's my comment right there. Thank you.

Teresa Casey: Thank you for your comment and I am hoping that you will send that comment in writing.

Eunice Banks: Your comment brings to mind the importance of their monitoring and evaluation of the program. We are going to be taking a look at patient admissions, patient discharges, patient transfers. We're going to be looking at the information, the data that we have at hand to identify whether or not we are seeing some new adverse trends in terms of patient access to care or in terms of patient access to quality, high quality care.

And so I thank you for your comment and encourage you to send a written comment.

Operator: Your next question comes from the line of Roberta Mikles from California. Your line is open.

Roberta Mikles: Yes, this is Roberta Mikles, patient's safety ad...

Natalie Highsmith: Roberta, can you get closer to the microphone?

Roberta Mikles: Yes. How's that?

Natalie Highsmith: Perfect.

Roberta Mikles: Is that better?

Natalie Highsmith: Yes.

Roberta Mikles: OK. I'm a patient safety advocate. And first, I have a question on a couple of comments. I want to fully, fully support that which Bill Peckham and Rich Berkowitz stated. Myself and our group advocates the quality safe care, and fully, fully support that. So, I'm not going to repeat what either one of them said. I was going to until they mentioned it.

My question – one question is I note that patients that will be receiving four treatments a week will be excluded. And that raises a question about there are many patients that get four treatments a week if they're on fluid overload but it's not consistently every single week.

Curious about the process and how that's going to work because if a patient had four treatments for three weeks and then they go back to their regular schedule, how that's going to be determined therefore.

The other thing is my comment. I think they need to do away with the 12 over 12 completely. And I know probably the reality is they won't because it's built into the system already.

But I believe that considering there's no reimbursement for the EPO now, which was a good incentive for facilities to overuse it 20 or 25 percent of their revenue. I don't really see a need for it. The URR I feel is really somewhat useful. It misleads patients into believing that that may be the only indicator if they're getting adequate dialysis, therefore, they need to be educated. And I put all that information in my comment, which I just submitted.

The other concern that I have is very, very much so when it comes to the medication as far as the hemoglobin. Private insurance patients being they will be included in it, there's that concern that they still make it more Epogen if the insurance companies are going to be reimbursing them because they are not a Medicare beneficiary. And so, I'm concerned about a safeguard for those patients and also the Medicare advantage plan patients.

I think the only measure that really is beneficial with this point is lower than 10. I don't think the providers are going to be using Epogen to any extent that

they were before because they're not getting paid. They may even go to using (inaudible) because they can give less of that.

But those are some of – some of my questions. And far as monitoring and someone mentioned surveys, I've reviewed surveys from about 28 states and I remember several years ago when I was analyzing them for a project. I noted that in the deficiencies, I could connect some of the deficiencies to the dialysis facility compare when I went and look and saw that that particular facility was above or below the state or national level.

And then in reviewing facility surveys, there were some connections that could've that. And I want to know if that's going to be part of and I put that in my suggestion if that's going to even be looked at because the survey can identify many, many, many problems including the correlation. Thank you.

Teresa Casey: Roberta, thank you so much for your comments and for sharing your thoughts. We really, really appreciate that. And you make some great graded points and you provide some grade with helpful insight.

As far as, really, I guess really you provide the summary marks but you've really had the one question at the end. And you can correct me if I'm wrong or not. But as far as, is there monitoring when to include information from the surveys and how is that going to work? And will it be considered?

And we right now are at the point of evaluating all of the data sources that exist to and foremost about any effects of the bundled payment and the quality incentives program, positive and negative or both. And certainly, we do have survey information on our list. We're looking into it and, you know, there's a little bit of a challenge in trying to not only find, you know, current information that with information but making it into usable information for our purposes.

But we are working on those kinds of challenges. And I wanted to make sure that we save it for our patient care, you know. Did I miss anything that I'd be...

Roberta Mikles: Well, yes I just had the one other about the three times a week that the patients that are receiving treatments four times a week are going to be excluded.
But...

Teresa Casey: Well, this is a one year performance period. And if you're talking about somebody who, you know, occasionally has some, you know, fluid overload and they get an extra treatment, my thought is that they will be included. And somebody who's more regularly getting the four treatments or five treatments a week and of course the reason for exclusion is that you can't calculate a measure and define a threshold that everybody agreed upon for more frequent dialysis.

Roberta Mikles: OK. So if I understand correctly then, if someone just receives an occasional four treatments a week, they would still be included?

Teresa Casey: Yes. That's correct.

Roberta Mikles: OK. So then there should be some risk adjuster added in to identify such so it doesn't get skewed.

Teresa Casey: I'm not sure what you mean about risk adjuster. I mean...

Roberta Mikles: Well, there should be something to identify because if there's a patient that, let's say, two weeks in a row they get a fourth treatment every three weeks that happens I mean as an example, their URR might be different. Their hemoglobin certainly might be quite different I mean because there's a difference in fluid. If they were going three days a week, it would be different than if they were going four days a week, maybe possibly if they're going because they're on fluid overload.

So there should be something built into that so that it doesn't give a false result, so that there's consistency that everyone is doing three days a week.

Teresa Casey: This is a claims based measure that will be processed over a year's period. And for those claims that are more than three days a week, those would be excluded. The rest of them will be included in the determination of the measure performance. So, in terms of a risk adjuster, it's a simple matter of

whether it's in or out versus actually adjusting I guess in the way that we typically think of adjustments.

Roberta Mikles: OK. And I'd like to offer my help in developing a tool for surveys to surveyors to identify in the survey process if in fact there's a correlation between an anemia management problem and identified deficiency since I've been able to track these in surveys, just to let you know that.

Teresa Casey: Thank you very much, Roberta.

Operator: Your next question comes from the line of Leigh Anne Tanzberge from Texas. Your line is open.

Leigh Anne Tanzberge: Yes. This Leigh Anne Tanzberge. I'm a patient and a patient advocate. I'm noticing more and more information on the home dialysis and how much better it is for the patient. However, as a long-time hemodialysis patient, I've been receiving Medicare benefit for dialysis. But as receiving the Medicare benefits, I'm not eligible for home dialysis. Is there any possible advantage – or not advantage, but possibility that Medicare will allow patients who are on three times a week right now to be able to go to home dialysis? Thank you.

Teresa Casey: Hi, Leigh Anne, I'm not quite sure on your question because Medicare does allow home peritoneal dialysis as well as home hemodialysis. And so I'm not sure what you mean by you're not allowed to go on home dialysis.

Leigh Anne Tanzberge: I've been told that if I'm receiving Medicare right now that I can't go to home dialysis that it would have to be a private insurance.

Teresa Casey: Leigh Anne, how about if you send me an e-mail note and maybe we can have a talk offline, because what you're saying is not making sense to me based what our regulations and rules and then payments and so forth. My e-mail address is mary.casey@cms.hhs.gov.

Leigh Anne Tanzberge: OK. Great. I would definitely do that.

Teresa Casey: OK. Thank you, Leigh Anne.

Leigh Anne Tanzberge: Thank you.

Operator: Your next question comes from the line of Dolph Chianchiano from New York. Your line is open.

Dolph Chianchiano: Hi, this is Dolph Chianchiano, National Kidney Foundation. You had mentioned that patients should feel free to raise issues with their ESRD network. I'm just wondering if you envision a role for the ESRD networks in the ongoing monitoring of the QIP program, and also if that might be reflected in the new statement of work and when we might see the new statement of work.

Teresa Casey: Hey, Dolph. Thank you for your comment. And as you know, I really do appreciate your interest in improving quality of care as well as in the ESRD network program. And, certainly, the ESRD networks are experts in the area of ESRD care and in the area of quality improvement, and so certainly they will have a role in all this.

I have to tell you that we have been working on standing up the quality incentive program and we are still in development as far as what the role, what – specifically what the detailed role of the ESRD networks will be. And as far as the contract, we are still in development, and the new contract will not go into place until July 1, 2012. I think you're referring the new redesigned contract. So, we have all of that in mind. We are working on it and don't have very much to say on that at this point in time.

Dolph Chianchiano: Thank you.

Teresa Casey: Thanks, Dolph.

Operator: Again, if you would like to ask a question, please press star then the number one on your telephone keypad. And your next question comes from the line of William Peckham from Washington. Your line is open.

William Peckham: Hi, I'm back. Just listening here, it sounds to me like 2012's pretty well set, it was in the main PPS rule. And so I'm wondering – you know if I'm thinking about suggesting future measures, I'm a little hesitant because it seems like there's all sorts of possibilities for you know unintended consequences,

validations, collections. I'm not really privy to as a beneficiary to – you know, I know some of it but not enough of it to feel competent.

I'm wondering if there are – I mean do you foresee a comment period in 2011 to talk about the 2013 QIP? And I guess just as a general framework, do the – if I'm seeing the QIP as a two-part process, one is the withhold and one is the reporting of quality – can the measures that comprise the reporting of quality be different than the measures that put payment at risk. So I'm imagining that on hand you have measures that would put payment at risk – and we're talking now for 2013, and then another group of measures that are a part of the reporting and display process I guess.

Teresa Casey: Thank you very much for your question and your comments. First of all, I want to clarify, you said that it sounds like the measures are set for 2012. The measures selection is set. However, the scoring, the performance period, the increments of the payment reduction, et cetera, are not set.

All that is put forth in the proposed rule that was published on the 12th of August, and so we are specifically asking for comments on any and all of those aspects of the proposed rule. So, I just want to make sure everybody understands that which three measures we're going to use, that is set, that is finalized, but all the other aspects of putting the program in place still need to be finalized within rulemaking and we anticipate publishing that final rule in September of this year.

Now, you asked...

William Peckham: This month?

Teresa Casey: I'm sorry. I was thinking December. I don't know what came out, but, anyway, December.

William Peckham: December.

Teresa Casey: Yes. Sorry. As far as the next year, OK, if you wanted to think about measures for the 2013 payment year, we are going to undertake rule making for that payment year and so, certainly, you would have the opportunity to

submit any comments about measures or any other aspects of the quality incentive program that you would like to submit comments on.

Now, as far as your remark that you're not an expert on the data, you know is it valid and reliable and some of the other characteristics. Well, you know, we still welcome your comment and your thoughts because you bring the perspective of someone who is experiencing renal care, and so we want to hear your perspective on what you think is important even in spite of maybe not appreciating some of the finer details because you know, leave that to us, we'll go through all the comments and all the information at hand and we would like to come up with the best program that we can in order to improve care.

William Peckham:OK. And then having measures on one hand put payment at risk and a different set of measures that comprise the reporting part, is that how you see this idea of kind of a two-pronged?

Teresa Casey: Well, the purpose of the measures though is to be able to calculate a payment modification or payment reduction. So, I mean, we've had for years the measures on dialysis facility compare, it was simply reported publicly and there was no other consequence other than those who would have the opportunity to look at your result and say, well, you know, these results were great or maybe these don't look so great kind of a thing.

Now, whether dialysis facility compare will increase its measures is another question. I don't know if there are plans for that. Certainly, you could send that suggestion in your comments. But when we're talking about the quality incentive program, we really do want to correlate the measures to payment.

William Peckham:OK. But it – just back to like what Rick Berkowitz said, when you start slicing and dicing it, you might dilute the impact of the withhold. But I think reporting information out can be pretty powerful. For instance, the supplement to DFR, the Dialysis Facility Report, which are full of information and quite good, you know just making those public would do a lot I think to inform patients on the quality of care at their unit.

And I would just advise that – it seems to me that there's a tendency that I understand to try and simplify things to come up with a total performance for some single number you know that would describe care. But I'm not sure that's possible. And I would just recommend that you not be afraid of giving raw data in you know kind of a complex statistical framework, like something like the dialysis facility report because I think organizations like Dialysis Patients Citizens (inaudible) support that work and the Internet blogs and discussion boards could explain how to use that patient to patient. But if we don't have the sophisticated data, it's hard to go from there to you know understand really what's going on for the quality side.

I'm just in favor of doing the data you have, which (inaudible) reflected in dialysis facility reports, but not putting payment at risk for all those measures.

Teresa Casey: We thank you for sharing your thoughts and I am very hopeful that you will put that in writing and submit a comment that contains that information.

William Peckham: Thank you.

Teresa Casey: Thank you.

Operator: Again, if you would like to ask a question, please press star then the number one on your telephone keypad.

And your next question comes from the line of Beverly Carr from Texas.

Your line is open.

Beverly Carr: Hi. This is Beverly Carr, and I work at a strictly pediatric facility. And we would like to know what will happen to facilities such as ours that may only have one or two patients that are greater than 18 years old because then unless those are Sterling patients, the certificates posted will most likely not be accurate of our patient population. It'll just be – it will just reflect what's happening with the older population.

Teresa Casey: Beverly, thank you for your comment, and you correctly point out the challenges associated with very small facilities and facilities that would have small numbers represented in these measures. And so I would strongly

encourage you to send your comments and what your thoughts are in regard to that.

Beverly Carr: Thank you.

Teresa Casey: Thanks, Beverly.

Operator: And your last question comes from the line of Beth Witten from Kansas.

Your line is open.

Beth Witten: Hi. It's Beth again. I forgot to ask a question related to the complaints. And, that is, you mentioned that the networks were going to be involved in, complaints and so forth and also state survey agency, I understand that networks are tracking involuntary discharges. And the question is how is that data going to be collected nationally so that CMS can look at not only what's happening in a particular facility or perhaps in a particular dialysis provider group, but also what's happening in that network as well as nationally so that we can be sure that patients are not being discharged when they are choosing not to follow the dialysis prescription, which is one of the rights that they are given under the patients rights section of the Conditions for Coverage?

Teresa Casey: Beth, thanks so much for your comment. And you really hit a lot of key aspects of what we need to do and what we are looking to do. Right now, I don't have all the answers as far as how exactly we're going to do that because, again, we are just now finishing our environmental scan of you know what all the data is that we'll have available and starting to categorize and think about how specific, how can we make these kinds of comparisons amongst the network or against the national benchmark and so forth like that.

So, I thank you very much for your remarks. And again, any thoughts that you have in relation to this, I would encourage you to submit in your comments. That would be really helpful.

Beth Witten: Thank you.

Natalie Highsmith: OK, Sarah, since you said that our final comment, I will go ahead and turn it over to Teresa for any closing remarks.

Teresa Casey: I'd like to thank everyone for participating in this call. Again, this was something that we were looking forward to. We want to have a dialogue with our beneficiaries and your patient advocates. We do have a workgroup that is involved in outreach to the community, to the beneficiaries, and I just want to mention that, make you aware of that.

This quality incentive program is going to improve patient care. This is just the start of the program. We look forward to future years where we have a more robust set of measures. But I wanted to just move back to the current year and the current task at hand, and that is the fact that there are only three days remaining in order for you all to submit comments. And I just want to go back to what you know – to the importance of your role and giving us your thoughts. Give us your feedback. Let us know what you think.

Let us know about your experience of care in the dialysis facility out there in the health care community so that we can have the information that will help us in order to put forward a final rule and in order to develop a program that does the best possible job of improving patient care.

Thank you very much, everyone.

Natalie Highsmith: OK, Sarah, can you tell us how many people joined us on the call today?

Operator: At the highest point, you had 260 participants on the call.

Natalie Highsmith: Wonderful. Thank you, everyone.

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

END