This document has been edited for spelling and grammatical errors.

Centers for Medicare & Medicaid Services
End-Stage Renal Disease Quality Incentive Program Payment Year 2015 Final Rule
National Provider Call
Moderator: Aryeh Langer
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Contents

Operator: At this time, I'd like to welcome everyone to today's National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Aryeh Langer. Please go ahead.

Announcements and Introduction

Aryeh Langer: Thank you, Holley. This is Aryeh Langer from the Provider Communications Group here at CMS, and I'll serve as your moderator for today's call. I would like to welcome you to the End-Stage Renal Disease Quality Incentive Program, or ESRD QIP, Payment Year 2015 Final Rule National Provider Call.

Today's National Provider Call is part of the Medicare Learning Network, your source for official CMS information for Medicare fee-for-service providers. Today we have CMS subject-matter experts here to discuss the final rule, as well as address related information on this topic.

Before we get started, there are a few items that I need to cover. Number 1, the link to the slide presentation for today's call was e-mailed to all registrants earlier this afternoon. If you did not receive this e-mail, please check your spam or junk mail folders for an e-mail from the CMS National Provider Calls Resource Box. If you did not get today's presentation, I'm going to give you the URL where you can access it now. It's www.cms.gov/npc. Again: www.cms.gov/npc, as in "National Provider Call." Once you're on that page, if you'll see on the left-hand side, there's a link to National Provider Calls and Events, and you'll see that today's call is the fourth one listed on that page.

Number 2, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the CMS National Provider Calls Web site that I just mentioned within 2 days of the—within 2 weeks, excuse me—of today's presentation.

I'd also like to thank those of you who submitted questions when you registered for today's call. Your questions were shared with the speakers to help prepare slides and remarks for today's presentation. They may also be used in the future to help produce outreach products, including frequently asked questions.

I'd just like to mention that there was some technical difficulty with the slides. So unfortunately the slides that are posted on the National Provider Calls page that I mentioned are not numbered. But if you follow along and number the slides as the presenters go ahead, if there are any questions once the Q&A session starts, we'll be able to reference the slides that way.

At this time, I'd like to introduce our first speaker for today. Rick McNaney is the Deputy Director of Quality Improvement Group at CMS. It is now my pleasure to turn the call over to Rick, who will begin our presentation.

Presentation

Introduction

Richard McNaney: Thank you. Well, good afternoon, everyone. I want to welcome you to this National Provider Call. Today we will review the CMS final rule for implementing the End-Stage Renal Disease Quality Incentive Program for payment year 2015.

This final rule is published in the *Federal Register* on November 9th, 2012. The performance period for payment year 2015 began on January 1st of this year. And so to help dialysis facilities and other stakeholders understand the program and their responsibilities during this performance period, we will cover the following topics: the ESRD Quality Incentive Program legislative framework and how it fits into the National Quality Strategy; changes reflected in the final rule based on public comments; the measures, standards, scoring methodology, and payment reduction scale that will be applied to the payment year 2015 program; and finally, where to find additional information about the program when you need it.

So, our lineup of speakers today from CMS are: Jim Poyer, Director of the Division of Value Incentives and Quality Reporting; Joel Andress, Measure Development Lead for ESRD, Division of Chronic and Post-Acute Care; Anita Segar, ESRD QIP Policy Lead in the Division of Value, Incentives, and Quality Reporting; and Brenda Gentles, ESRD QIP Communications, and Monitoring and Evaluation Lead in the Division of ESRD, Population, and Community Health.

So, up first is Jim Poyer, the Director, Division of Value, Incentives, and Quality Reporting. Jim?

Value-Based Purchasing Objectives and the Six Quality Measurement Domains

Jim Poyer: Thanks, Rick. I thank everyone for participating in today's call. Today we are going to discuss the final rule for payment year 2015 in the ESRD Quality Incentive Program. I am going to refer to it as the ESRD QIP.

We'll be presenting a lot of information over the next 90 minutes, and we intend to provide you with a clear and thorough explanation of the program. Some of you might want additional information that we won't be able to cover today, unfortunately. So I would strongly encourage you to review the online resources listed in the slide deck. If you still have questions after the presentation, please send them to our mailbox. That's esrdqip@cms.hhs.gov.

Payment year 2015 represents the fourth payment year for the ESRD QIP, and that program began with payment year 2012. And the program has grown over time and includes more areas of clinical focus and corresponding coverage of the six national quality strategy domains. It's more comprehensive than ever and covers a larger population of ESRD patients, as evident by the inclusion of pediatric patients in the

clinical measures for the first time. We also use more data sources from which the program draws, not just claims data.

And now I'm going to walk through the slides. The slide is called—titled "CMS Objectives for Value-Based Purchasing." And, in general, our value-based purchasing or VBP programs incentivize better care across settings. And our beneficiaries expect cost-effective quality care. And VBP is an avenue to assist us in achieving this goal.

VBP also promotes CMS's three goals: better health care for individuals, better care for populations and communities, and lower cost through improvement. And the ESRD QIP was the first Federal pay-per-performance program. And rather than paying dialysis facilities based on the volume of services they provide patients, Medicare can now pay dialysis facilities based on how well those services help keep patients safe and healthy. And the ESRD QIP uses the Government's purchasing power through Medicare to incentivize improvements in the treatment of patients with ESRD. These incentives drive care throughout the health care sector, not just to the Medicare patients.

And, next, I'm going to walk through the six domains of quality measurement based on the National Quality Strategy. And the ESRD QIP for payment year 2015 addresses now three of the six National Quality Strategy domains—safety, patient- and caregiver-centered experience, and clinical quality of care. And in the next few slides we will provide an overview of the legislative aspects of the program.

And for that, I will turn the presentation over to Anita Segar, our ESRD QIP Quality Policy Lead. Anita?

Background

Anita Segar: Thanks, Jim. Thank you all for joining us today on this call. I will briefly go over some background to the legislative authority of the QIP, and I will briefly outline the process, from rulemaking to implementation. MIPPA amended the Social Security Act to mandate the creation of the ESRD QIP. The ESRD QIP is intended to promote patient health by encouraging renal dialysis facilities to deliver high-quality, cost-effective patient care.

MIPPA provides a mechanism for establishing standards of care and authorizes payment reductions for facilities failing to meet those standards. MIPPA also give CMS the authority to establish standards by which ESRD facilities will be evaluated. The ESRD QIP also sets down the way individual measures are used to create an overall score. CMS will impose a payment reduction of up to 2 percent if the facility score does not meet a minimum Total Performance Score [TSP]. Information about a facility's performance in the ESRD QIP is contained in the Performance Score Report.

Public reporting of the results is a key component because it allows consumers to select facilities based on care, and it provides a mechanism by which facilities may judge their performance compared to the performance of other facilities. The Performance Score

Certificate is also a prime vehicle for communicating the facility's performance under the ESRD QIP to its patients.

DFC, which is the Dialysis Facility Compare Web site, also provides information about facility performance to the public. CMS releases detailed facility performance information in a large spreadsheet, as well, and posts it on the Web. With the structure of the program in mind, we can now look at how it evolves from year to year through the rulemaking process.

I am currently on the slide that is titled "From Rulemaking to Implementation." CMS has been outlining payment year programs by creating rules on an annual basis. So every year to date, CMS proposes a rule that specifies measure selections, scoring and weighting methodologies, and payment reduction. A public comment period follows, and CMS considers these comments in preparing the final rules for publication. As the program evolves, CMS will continue to establish measures that reflect standards of quality in the care of ESRD patients.

Moving on to the slide titled "Proposed Rule Comments: Changes in the Final Rule": During the 60-day comment period, we received, last year, about 55 public comments, comprising over 200 questions. Based on those public comments, we made significant changes to the final rule, including postponing the implementation of the hypercalcemia clinical measure, establishing a method for scoring partial reporting compliance, and applying an 11-case minimum for clinical and reporting measures alike.

And with this, I'm happy to turn the presentation over to Joel Andress.

Clinical Measures

Joel Andress: Thank you, Anita. As Anita has already—or as has already been indicated, my focus here is on the clinical measures that were finalized for payment year 2015. So, my portion of the presentation will focus primarily on the definitions for individual clinical measures, the scoring directionality associated with each of those measures, the exclusion criteria specific to those measures, and then, finally, we'll run through an example of how one of those clinical measures is scored and how that score is then incorporated into your TPS.

And for those of you who are attempting to stay oriented with the sequence of slides on the line, the cover sheet for this section is on slide 10. And I am now moving over to slide 11 to discuss the Clinical Measures Summary.

The first thing to note is that we have substantially expanded our clinical measures in 2015 from the payment year 2015—or 2014 rule. We are now including six clinical measures divided between three measure topics. Two of those measure topics, Anemia Management and Vascular Access Type, are unchanged, substantively, from the payment year 2014 rule. However, we have replaced the Urea Reduction Ratio measure with three Kt/V Dialysis Adequacy measures, and this is incorporated as a new separate measure topic, the primary advantage of which is that we are now able to address the dialysis

adequacy across multiple modalities. The scores for the applicable clinical measure topics will be weighted equally, and will—and as Anita has already indicated, will comprise 75 percent of the TPS when taken in combination with one another.

For slide 12, we move to the Anemia Management measure. Again, this measure is unchanged. It calculates the percentage of Medicare patients with a mean hemoglobin value greater than 12. A lower percentage on this measure is accepted to indicate higher quality of care, and the exclusions that you see laid out before you help define the population toward which this measure is applicable.

On the next slide, 13, we start to look at the Kt/V Dialysis Adequacy measures. As I previously mentioned, these are taking the place of the Urea Reduction Ratio measure that was present in payment year 2014. For each of these three measures, a higher score is considered to be a higher level of quality for the reporting dialysis facility. Individually, these measures are taken to address a particular population of dialysis patients within the dialysis population.

If you look at slide 14, you'll see that our first Kt/V measure addresses adult hemodialysis adequacy. It does so by assessing the percent of hemodialysis patient-months with an spKt/V greater than or equal to 1.2.

On the next slide, the—number 15, we see the Adult Peritoneal Dialysis Adequacy measure, which calculates the percent of peritoneal patient-months with Kt/V greater than or equal to 1.7 during a 4-month study period.

And then, finally, on slide 16, we see the Pediatric Hemodialysis Adequacy measure, which calculates the percent of pediatric in-center hemodialysis patient-months with spKt/V greater than or equal to 1.2.

On the next slide, slide 17, we see the final—we begin the final measure topic, that of Vascular Access Type. As in payment year 2014, this topic is comprised of two measures, the first of which assesses the percentage of patient-months on hemodialysis during the last hemodialysis treatment of the month using an autogenous arteriovenous fistula with two needles. The second measure assesses the percentage of patient-months for patients on hemodialysis during the last hemodialysis treatment of the month with a catheter continuously for 90 days or longer prior to the last hemodialysis session.

It's important to note here that the directionality of these two measures is not the same, or are not the same. A higher score is preferable for the AV Fistula measure, while a lower score indicates higher quality for the Catheter measure. These two measures were present in payment year 2014, and they remain substantively unchanged in their implementation for payment year 2015.

On slide 19, we look at our adjustments that we've incorporated to address issues related to low-volume facilities. We have previously incorporated a minimum of 11 eligible cases to receive a score on a particular clinical measure, and we are retaining that for

payment year 2015. However, in recognition that a small number of cases may still present bias in the results of a dialysis facility, we are also incorporating an adjuster for those facilities on individual measures where only 11 to 25 qualifying cases are present. It's important to note that this adjuster will never hurt the facility's score; it will only ever increase its score.

Moving on to slide 20: Having discussed the particular clinical measures and the adjuster that will be applied to them for case size, we're now going to be discussing the issue of scoring for the measured topics, and afterward we'll discuss scoring for individual measures within those topics.

Each topic has its own score assigned to it. So you should expect to receive a score from the Anemia Management topic, from the Dialysis Adequacy topic, and from the Vascular Access topic. The scoring for these domains will be similar to that—to what was used for the Vascular Access–type measures in 2014. Each individual topic will be weighted by the measures in that topic, and we'll explain the way in which that is weighted shortly.

This weighting will allow us to account for the fact that not all facilities are going to qualify for all of the measures in their area. And so it will not be penalized in terms of the points accrued in the event that your facility does not, for instance, have—meet the minimum number of cases for pediatric patients in the dialysis domain.

Moving to slide 21, we will discuss the scoring for the measure topics, specifically using an example. And for this example, we're using the Kt/V Dialysis Adequacy topic. In order to weight appropriately, we take all of the measures for which a facility meets the minimum number of cases, and we weight these facilities based on the denominator for each individual—we weight the measure scores based on denominator for each individual measure as it contributes to the entire topic.

In the example here, you will see that there are—that the hypothetical facility has 60 patients qualifying for the Adult Hemodialysis measure, 20 qualifying for the Peritoneal Dialysis measure, and 20 qualifying for the Pediatric Hemodialysis measure. In each of these cases, the denominator for a particular measure is divided by the total number of cases for all of the measures, and then this is multiplied by the measure score.

So, for instance, with the Adult Hemodialysis measure, a measure score of 7 is multiplied by a factor of 60, divided by 100, and this results in a modified or weighted score of 4.2 for the Adult Hemodialysis measure. Similarly, the Peritoneal Dialysis measure is what provides a weighted result of 1.6. You will notice that this score is much lower than the overall measure score of the Peritoneal Dialysis measure, and that is because it has relatively few patients when compared to the Adult Hemodialysis measure. And, again, we receive a weighted score of 1 for the Pediatric Hemodialysis measure.

These three are then added together for a modified score for the topic of 6.8, and this has been rounded to the nearest whole number for a Kt/V Dialysis Adequacy topic score of 7.

And this would be this facility's contribution to its TPS from the Dialysis Adequacy topic.

Moving to the next slide, number 22, we'll discuss the calculating of each clinical measure score. So we talked before about how the hemodialysis measure received a measure score of 7, so the next several slides will explain how that number was arrived at.

It's first important to note that facilities are assessed on two different scores—one on achievement and one on improvement. The purpose of this is to recognize not only the overall performance of dialysis facilities relative to their peers, but also the fact that dialysis facilities have potential to improve their performance from past years. And so, the highest score received from either of these two factors—achievement and improvement—will be considered for inclusion in the TPS.

If a facility has no data on a particular measure for calendar year 2012, it will not receive a score for improvement, but it will still be eligible to receive a score for overall achievement. And then, in the following year, improvement may be considered.

We'll be using the AV Fistula rates of a hypothetical facility to illustrate the scoring method. If you look on slide 23, where we begin to lay out the illustration: As I've mentioned, we are using the AVF clinical measure. It's important to note four key factors that are used to identify or to contextualize the performance of a facility in a given year.

In order to assess the achievement score, we first calculate an achievement threshold. And this is based on the overall performance of all facilities in calendar year 2011, and it's set at the 15th percentile of performance. The benchmark is set at the 90th percentile during calendar year 2011 and defines the upper bound of the achievement range, while the threshold defines the lower bound. And we'll discuss that in a moment, the importance that plays in determining your score.

The achievement range runs on a scale from 0 to 10 and defines what your score for achievement will be and, as I said, is bound by the threshold and the benchmark set by the population's performance for 2011.

Finally, not included on the slide, but of relevance to calculating the minimum TPS, is the performance standard. This is defined as the 50th percentile for each individual measure. And while it is not relevant to the calculation of your achievement and improvement scores, it is a set of context toward how you are performing overall. If you achieve the 50th percentile on each of your clinical measures, then you will not experience a penalty as a result of your performance in the clinical measures on your TPS.

So, moving to slide 24, you'll see, first, that we have a hypothetical facility. We'll call it Facility A because we're imaginative like that at CMS. The—Facility A's performance rate for payment year, or for calendar year 2013, is 54 percent. The threshold is defined

as the 15th percentile of all facilities' performances—is defined—is set at 46 percent. And the benchmark, or the 90th percentile, is set at 74 percent.

What this means is that Facility A will fall somewhere—because Facility A did not achieve past the benchmark, it will not receive the full 10 points for achievement but will fall somewhere between 0 and 10 for the score. And we'll discuss momentarily the formula that is used to calculate that.

And you'll see at the bottom of this page—and we'll get back to—we'll discuss shortly how these are calculated. You'll see the two orange scales at the bottom labeled as the Achievement Range and the Improvement Range. And this is defining where—this defines where this facility is scoring on each of these two scores. The next several slides will be explaining how that was determined.

Now, slide 25, you should see a header that—or a title that says "Calculating Achievement Scores" and a box that provides you with a formula. Now, this formula is what is used to calculate the achievement score for your facility, and it is designed so that the highest score you can achieve is a 10.

I should note that this formula is only used if a facility's performance rate falls within the achievement range—so between the threshold and the benchmark. If the performance rate falls below the threshold, the score—the facility's achievement score will be zero. If the rate falls above the benchmark, then the score will be 10 for achievement.

On the next slide, we see the—on slide 26, we see the calculation for the results that were provided on slide 24. You'll see at the bottom that the formula has the—has input: the facility performance rate, achievement threshold, and benchmark; and a formula for a total result of 3.07. This is rounded to the nearest whole number, which provides the facility with an achievement score of 3.

And on the next slide, we begin to calculate the improvement score. So we know that the lowest possibility score this facility may now receive is a 3, but it's possible to receive a higher score as a result of improvement. Again, we will have an improvement range, which is defined on the lower bound by a facility's performance during calendar year 2012. The benchmark, or the 90th percentile of all facility performances, remains the upper bound for this improvement range.

Now, it's important to note that the distinction here is that you cannot score higher than a 9 for your improvement range. So the only way to score higher than a 10 is to exceed the benchmark at the 90th percentile.

On slide 28, we see, again, a familiar scale set. However, we have an additional piece of information in that we have defined the improvement threshold at 26 percent. What this means is this facility scored only 26 percent on the AV Fistula measure in calendar year 2012. As a result, that is the base of its improvement range. Any performance above that will result in a potential score in improvement above zero.

On slide 29, we see the formula that is used to calculate the improvement score. And, again, this is calibrated so that it can never derive a score that is higher than 9 for improvement. If the facility's performance rate is below the improvement range—that is, below last year's score, so the facility has in fact declined in its assessed quality of care—the improvement of score will be zero. And if the score is above benchmark, the score will be 10. And anywhere in between, a score will be assessed on a sliding scale from 0 to 9.

So on slide 30, we see another example of the calculation. The formula is filled in using the improvement threshold and the facility's performance period and the benchmark. And as a result of this—the result this of this calculation is 5.33, which is again rounded to the nearest whole number for an improvement score of 5. Now, taking this in comparison with the achievement score of 3, we see that this measure score, which will be incorporated in the measure topic score, is 5 for calendar year 2013 and for the payment year 2015.

On the next slide, we see an example of what would have happened if another facility—in this case, imaginatively referred to as Facility B—scored 86 percent. The score is above the benchmark, and so this facility will receive a full 10 points on the achievement range, and it's functionally unnecessary to assess the improvement range at this point because the facility has scored its highest possible score.

On slide 32, we see what happens when a facility scores below both the achievement threshold and the improvement threshold. In that case, that facility will receive a score of zero for both the achievement and improvement. And so the facility—this measure's contribution to that facility's topic score will be zero.

And finally, you'll see on slides 33 and 34 a listing of the calculated thresholds, benchmarks, and performance standards for each of the individual clinical measures. And these will be the standards against which any facility's performance will be assessed for the purposes of calculating the TPS.

And now, I will hand off the discussion for the reporting measures to Anita Segar.

Keypad Polling

Aryeh Langer: And just before we move on with the presentation, at this time, I'd like to pause for just a few minutes to complete keypad polling so that CMS has an accurate count on the number of participants on the line with us today. Please note, there may be a few moments of silence while we tabulate the results.

Holley, can we start the keypad polling, please?

Operator: CMS greatly appreciates that many of you minimize the Government's teleconference expense by listening to these calls together in your office using only one 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 between 2 and 8. 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 between 2 and 8. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling.

And thank you for your participation in today's polling session. I'll turn the conference call back over to Mr. Langer.

Presentation

Reporting Measures

Aryeh Langer: OK. Let's continue please with the presentation. Anita?

Anita Segar: Thank you. In this next section, we'll examine the four reporting measures for payment year 2015. We'll also discuss the provisions for new facilities that will receive their CCNs in calendar year 2013.

Note that the performance period is calendar year 2013 for all reporting measures, and facilities are to report events that occurred during this year only. The Anemia Management reporting measure is new. The NHSN and Mineral Metabolism reporting measures have been extended from attestations to actually providing data. The ICH CAHPS survey reporting measure remains the same as it did in payment year 2014.

Moving on to the slide titled "Reporting Measures: Summary (Continued)": In payment year 2015, the Anemia Management, the NHSN, and the Mineral Metabolism reporting measures require reporting actual data rather than attestation. If a facility reports data for every eligible month of the year, it will earn the full 10 points available for that measure.

Now, based on comments received, we developed ratios for computing partial compliance, and in order to incentivize reporting with the Anemia Management, with the Mineral Metabolism, and the NHSN reporting measures, we want to encourage facilities to submit data for as many eligible months as possible. So this method, the utilization of ratios, actually allows facilities to earn some points even if they did not report data for each eligible month of the year.

Eligibility for some of these measures is based on how your facility is categorized. So you should make sure the record of modalities you treat are up-to-date. Please ask your network for more information. We also established an 11-case minimum for reporting measures, which is consistent with the minimums for clinical measures. The weighting of reporting measures in computing the Total Performance Score has increased in payment year 2015 to 25 percent.

Moving on to the next slide: The final rule demonstrates how the scores for the reporting measures will be calculated if they are not eligible for a full year of reporting. The new ratios will apply, and if a facility reports on a measure for every eligible month, again, it can receive the full 10 points.

Moving on to the Anemia Management reporting measure: Some patients and claims are excluded from the reporting calculation. Further information can be found in the links provided at the end of this presentation. The inclusion of out-of-facility lab work is encouraged; it is an important example of coordination of care.

Now, if a facility administers an ESA, then it must report the HCPCS code and corresponding unit for that patient. CMS will interpret an empty HCPCS field to mean that no ESA was administered. Reporting 99.99 is not considered a valid hemoglobin or hematocrit unless the patient is in his or her first month of treatment. Again, to earn the maximum 10 points on the measure, the facilities will need to report data for every eligible patient for every month a facility has a valid CCN.

Moving on to the NHSN Dialysis Event reporting measure: The mechanics of this measure is substantively the same as it was in payment year 2014, but now we are requiring 12 months of reporting. There is a bare minimum requirement as far as the measure. A facility will need to report a minimum of 6 months of data in order to begin receiving points. Participation in the NHSN system is done in accordance with CDC practices and requirements. You only report if you treat in-center patients.

The final rule applies a 1-month grace period for reporting NHSN data. But according to the CDC, to maximize data completeness and accuracy, facilities will be allowed to add to and modify the reported data until the performance period reporting deadline. Data for the entire performance period must be reported by April 15th, 2014.

Moving on to the next slide, which is the Mineral Metabolism reporting measure: Now, a form of this measure was in place for payment year 2014. Instead of a simple attestation, facilities must now deliver actual information via CROWNWeb.

Again, as with the clinical measures, certain patients were not counted when we see if the reporting requirements are met. Further information on this measure can be found in the link that will be provided at the end of this presentation. The 1-month grace period applies here as well. And, again, the inclusion of out-of-facility lab work is encouraged; it is an important example of coordination of care.

Moving on to the ICH CAHPS reporting measure on the next slide: This measure remains unchanged from payment year 2014. It is still an attestation through CROWNWeb. The ICH CAHPS survey specifications are established by AHRQ. So be sure to follow those guidelines, because you can only attest to administering the survey if you follow those specifications. You will find more information on AHRQ's Web site. Facilities treating fewer than 11 eligible patients do not have to administer the survey. They only need attest to that fact via CROWNWeb.

Let's move on to the next section, which is the "Calculating of the Total Performance Score and Determining Payment Reduction." The process for calculating the Total Performance Score is similar to the one we used for payment year 2014. The Total Performance Score ranges from 0 to 100 points. In payment year 2015, clinical measures will account for 75 percent, and reporting measures will account for 25 percent.

For payment [year] 2015, we also require that a facility have a score on at least one clinical measure and at least one reporting measure in order to participate in the ESRD QIP. So, as mentioned, any facility that receives a CCN after June 30th, 2013, will not receive a Total Performance Score and, therefore, will not receive a payment reduction.

Moving on to the slide on payment reduction structure: Again, just like the TPS, the payment reduction structure is also the same as in payment year 2014. This slide describes how the minimum TPS will be calculated. Note that the clinical and reporting measures are weighted. So, for example, in a case where only two of the four reporting measures apply, these two scores will be weighted equally, to create the 25 percent reporting portion of the TPS. Thus, facilities are not at a disadvantage when compared to the minimum TPS if they do not have scores on every individual measure.

We calculate the minimum TPS by scoring a hypothetical facility as if it reached the performance standard, which is the 50th percentile nationally for each clinical measure, and scored half of the available points on each eligible reporting measure. This, again, is a change from the proposed rule, which assumed zero points for reporting measures.

Moving on to the next slide, you will see a table that demonstrates the ranges for payment reduction based on a facility's TPS. As you will see here, the minimum TPS is 60 points. For every 10 points a facility falls below the minimum TPS, there is a 0.5 percent payment reduction, and the maximum reduction is 2 percent.

Moving on to the next slide, the last slide in this section, titled "Scoring and Payment Reduction Methodology": This slide basically provides a summary graphical interpretation of how facilities will be scored and how those scores will translate into a TPS. This table identifies the data sources, the measures, the forms those outputs will take for reporting measures, the category weights, and the scale for the payment reduction that applies, if any. I think this is a great snapshot of the scoring and payment reduction methodology.

And, with that, I will turn over the presentation to my colleague, Brenda Gentles.

Additional Rules

Brenda Gentles: Thank you, Anita. We want to start here with the additional rules. And now that we've covered the mechanics of scoring and assessing payment reductions, we'll take a moment here to identify some additional points that are addressed in the final rule and identify topics for future measure development.

Moving to the next slide, "Changes to Payment Year 2014": The rule addresses activity besides the payment year 2015 program here itself. We finalized applying the payment year 2015 rule for the 11-patient minimum for the material—for the Mineral Metabolism reporting measure, as discussed in the previous section, for payment year 2014 as well. This change gives more flexibility to facilities in their attestation.

We modified requirements for posting the PSC each year. CMS will provide a Spanish version of the certificate in addition to the current English document, and both will be required to be posted by the first business day of the calendar year starting January 2014. Both documents were released for payment year 2013. Facilities at this time are strongly encouraged to post both.

Moving on to our next slide, "Payment Year 2015 Additional Comments": We are conducting a Data Validation Project. The Data Validation Test Project does not impose a penalty for participation or non-participation in payment year 2015. Slide 50 here outlines the details of the Data Validation Pilot Project.

We also established rules for transferred facilities. For transferred facilities, CMS relies upon the CCN to confirm the dates on which operations began. If the CCN remains the same after the transfer, CMS will treat it as the same facility for the purposes of the ESRD QIP, and all prior rates, scores, and payment reductions, if any, will continue to apply. If it receives a new CCN, as a result of a change in ownership, then CMS will treat it as a new facility as of the date of certification.

We're going to move to the next slide, which is titled "Topics for Future Measure Development." Slide 51 here outlines future measure development. You see listed here the Standard Mortality Ratio, the Standard Hospitalization Ratio, 30-day readmissions, and so forth.

As part of our outreach to stakeholders in the community, we want to take a moment here to reiterate the kinds of measures we're working on for future payment years. CMS plans to expand the ESRD QIP to include more in NQS domains and refine its set of measures to better reflect the quality of care provided to patients with ESRD.

For future SMR and SHR measures, CMS anticipates using data from the facilities' 72X form for ESRD claims for the purposes of risk adjustment. This will allow CMS to apply more accurate and updated information about comorbidity. Therefore, facilities must make sure they are reporting comorbidities accurately as part of their current operation.

Summary: PY 2015 Compared to PY 2014

OK. We're going to move on to the next section here on slide 52, which is the "Summary for Payment Year 2015 Compared to Payment Year 2014." To recap today's presentation, the final rule for payment year 2015 shares a lot of structure with payment year 2014.

Moving on to slide 53, "Similarities with Payment Year 2014": This slide, which is actually slide 53, lists the similarities between the two program years. As you can see, overall the structure has not changed, and several measures remain in place today. So on slide 53, we're looking at the general program framework, and we're also looking at the measures retained.

And I'll move us on to slide 54, which is "Payment Year 2015: Measure Changes from Payment Year 2014." We see that we have the clinical measures that have been listed out, that we've spoken about in the previous sections of this presentation. So we have the URR Dialysis Adequacy System removed, the Kt/V Adequacy measures, Dialysis Adequacy measures, topics that have been added. We see the Adult Hemodialysis, the Adult Peritoneal Dialysis, as well as the Pediatric Hemodialysis measures with this year. The reporting measures, again, Anemia Management reporting measures.

Payment year 2015 does present some evolution, including some—including a more comprehensive measure for the dialysis adequacy, as we've noted here. The new Anemia Management reporting measure allows CMS to report and to monitor care in regards to low hemoglobin results, and present a more comprehensive picture of Anemia Management, in addition to the clinical measures capturing a high hemoglobin result.

Moving on to the next slide, 55, that discusses the program changes from payment year 2014: This information demonstrates some of the updates to the mechanics of the program, including the use of more recent data for the program year. Payment year 2015 re-weights the balance in creating the TPS to 75 percent clinical and 25 percent reporting. The small-facility adjuster creates a new method of scoring low-volume facilities so we can continue to apply the ESRD QIP to the widest possible spectrum of facilities. A facility must have scores in at least one clinical measure and one reporting measure to be eligible for participation.

OK. Moving on to slide 56, the comparison of payment years 2014 and '15: What you notice here is that we do have a nice table that identifies the payment year 2014 and '15 beginning with measures that you see listed here. For payment year 2014, we had a total of six measures, you see there, broken down by three clinical measures and three reporting measures. And for payment year '15, we have a total of 10 measures—six clinical and four reporting measures.

This is a very handy graph that you can certainly share with your staff, with your boards, and with your C-suites, as you'll notice that it does outline the performance period, the comparison period, the performance standards, the weighting that we've been talking about, as well as the payment reduction minimum score.

Resources and Next Steps

So we will move on to slide number 57. And at this time, on slide 57, we're moving onto the next section, which is "Resources and Next Steps." In this section, we will identify resources available to you to learn more about the final rule. We'll also talk about the next steps your facility should take as part—in the participation in the ESRD QIP.

Slide 58 lists some useful content about the program that is available online, including MIPPA, CMS Web site, the ESRD NCC, the DFC, and the DFR. So, again, if you have an opportunity to bookmark these Web sites, you know, please do. I think that will be a valuable tool to you.

Moving on then to pages 59 and 60: As we said before, we've listed the URLs for the technical measure specifications for the clinical reporting measures here. So, again, the clinical measures that we've talked about, the Anemia Management, the Kt/V Dialysis Adequacy measure topic, as well as the VAT measures, Anemia Management, the ICH CAHPS, Mineral Metabolism, the NHSN Dialysis report, Event Reporting.

Moving on to slide 61, we'll begin to talk about our next steps. And here we've listed out a few actions that we recommend you take in the remainder of calendar year 2013:

- Review payment year 2014 preview performance score report, the PSR, which will be available July 15th, 2013, and submit any clarifications, questions, or formal inquiries.
- Comment on payment year 2016 proposed rule when posted.
- Read payment year 2016 final rule when posted, which will be in early November.
- Review payment year 2014 final PSR when available in mid-December.
- Post payment year 2014 performance score certificate by the first business day 2014. And, remember, please post the English version as well as the Spanish version.

And at this time, I will turn the presentation back over to Anita Segar.

Anita Segar: Thanks, Brenda. Now that we've actually come to the end of our presentation itself, we'd like to provide some time to allow questions related to the QIP payment year 2015 final rule. Again, as we mentioned earlier on the call, the program has grown in complexity; it is comprehensive. And most certainly, during this presentation, we've tried to provide some of the high-level overview and some of the important specifics. The presentation concluded with a number of online resources that attendees can employ to learn more about the program, including DFR, DFC, and CMS.gov. I think most importantly, facilities can contact their individual networks for more information and assistance in understanding the QIP.

I also want to point out that the ESRD QIP mailbox is an important avenue to send in your questions so that you can get answers to specific questions directly from the program staff here at CMS. We're happy to answer your questions. I would just like to call out that any questions requiring detailed responses or additional specifics and clarifications, in order to understand the question or individualize it to your facility, would probably be best addressed through the mailbox.

Having said that, we can—let me hand this over to Mr. Langer for the question-and-answer session.

Aryeh Langer: Thank you very much. At this time, we're going to open up the lines for the question-and-answer portion of the call. Holley, would you like to start that process, please?

Question-and-Answer Session

Operator: To ask a question, press star, followed by the number 1 on your touchtone phone. To remove yourself from queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your questions, so anything you say or any background noise will be heard in the conference.

Please hold while we compile the Q&A roster.

Aryeh Langer: Let me just take this time to remind everyone that the call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization, and, in an effort to get as many of your questions in as possible, we ask that you limit your question to just one. Thank you.

Operator: Your first question comes from the line of Shane Perry.

Shane Perry: Oh, hello. This is Shane Perry with ESRD Network 4. I am just looking at the source of your data sources, and I'm just a little concerned and confused as to why you're using two data sources for most of the same information—the Medicare claims data, you're getting Anemia Management, Kt/V, Vascular Access, as well as Mineral Metabolism—and yet you're using CROWNWeb for just the Mineral Metabolism piece. Is there any thoughts to consolidate the data source, and if so, at what time period?

Joel Andress: Hello. This is Joel Andress. We are giving consideration to the employment of measures that move toward the use of CROWNWeb as a source of data. The use of Medicare claims at this time is a result of the need in past years to stand up CROWNWeb and begin data collection.

As we move forward with the implementation of CROWNWeb, and we start transitioning measures from claims into a CROWNWeb-based format, we'll be able to, I think, consolidate that—the data and collection more completely. Our hope is that eventually we'll be able to capture as much data as possible from a consolidated data source.

Shane Perry: Thank you.

Operator: Your next question comes from the line of Joan Simard.

Joan Simard: Yes, this is Joan Simard. I'm calling from Salt Lake City. I'm affiliated with Intermountain Healthcare. My question regards vascular accesses. We have a number of patients that have successful AVGs and do not require replacement with an

AVF. Subsequently, our AVF percentages are not at 74 percent. Why are we—will we be penalized if we do not need to replace the patient's grafts with fistulas?

Joel Andress: This is Joel again. This is an issue that has been raised to us during the comment periods. We have proposed before—we took to the MAP, the NQF pre-rulemaking body, a measure that addresses the issue of grafts as well as fistulas, and this is something that we are currently considering for implementation in future rulemaking. The simple answer at this point is that the measure as currently constructed for the AV fistula simply does not include the graft in its specifications at this time.

Our measure development efforts will seek to assess the appropriateness of incorporating that into any future rules. And once we have gone through our development process, and we've brought the measures through the consensus endorsement processes as well, we'll be able to respond, I think, more directly to the appropriateness of incorporating the consideration for the graft in the quality measures for the QIP.

Joan Simard: Thank you.

Operator: Your next question comes from the line of Julius Heilman.

Julius Heilman: Hi, my name is Julius Heilman. I am from UCSF's Pediatric Dialysis Unit. As a small unit, my question is about the requirements for the minimum of 11 patients. Specifically, in the NHSN dialysis event reporting, it says that facilities treating fewer than 11 in-center hemodialysis patients must attest to the fact. Is that at any one time? Or during the calendar year?

Anita Segar: Hi. This is Anita Segar. So, one of the reasons why we have—and you probably already know this—is we adopted this adjuster for small facilities just to account for some of the bias that can result from having a low volume. For the NHSN measures, as well as some of the other measures, if you are below the case minimum, I believe that you would attest in CROWNWeb to that on a monthly basis.

Julius Heilman: OK. Sounds good.

Operator: Your next question comes from the line of Patrick Ayers.

Patrick Ayers: Hi, my name is Patrick Ayers. My question is about the changes that happen from 2014 to 2015 and whether they'll be carried on. I know that for the 2014 Minimum Metabolism amendment made in the 2015 final rule, you explicitly said that Medicare Advantage and Medicare Railroad will be included in that reporting measure. And I was wondering, will Medicare Advantage and Medicare Railroad also be included in the 2015 Minimum Metabolism reporting measure? And will they also be included in the other clinical and reporting measures? And if there's an exhaustive list of different types of Medicare programs I can see that will be included for each measure?

Aryeh Langer: Can you give us 1 second to confer?

Anita Segar: Hi. This is Anita Segar. The ESRD QIP program and its requirements apply to facilities that are paid through the ESRD Prospective Payment System, the PPS. So I would say that facilities that are paid through the PPS submit 72X claims, and so your billing department should be able to confirm whether you use those claims.

Patrick Ayers: OK. OK.

Operator: Your next question comes from the line of Robyn Nygard.

Robyn Nygard: Hi, this is Robyn Nygard from Fort Peck Tribal Dialysis Unit, and we are a small unit, and my question is with non-compliance: Where do we go with—is there anywhere to attest if a patient refuses to get a fistula and chooses the catheter? Same along with anemia management?

Aryeh Langer: We're going to take 1 more second to address that in the room.

Anita Segar: So thank you for that question. As it pertains to non-compliant patients, in calculating measure rates and scores, the ESRD QIP does not control for non-compliant patients. We definitely here at CMS realize that patient compliance can be an issue at every facility, but we also believe that it is incumbent upon facilities to educate patients about the importance of compliance.

So one thing I would say is that, in order to create a balance, what we've done to account for some variability is that the ESRD QIP measures themselves do not require a rate of 100 percent on all measures in order to avoid a payment reduction. In addition to this, we've also ensured that small facilities' scores on measure are not unfairly affected by outlier compliance patients, which is why we have the small-facility adjustor.

So really all of this can only raise the facility's scores. But I would just—we receive some questions about this through the mailbox from time to time, so what I would say is that patient compliance can be an issue, but then we expect that facilities would educate patients and work with them in ensuring better compliance.

Aryeh Langer: Does that address your question, Robyn?

Robyn Nygard: Yes. We just—it's when it's a small group. We don't meet the low volume. I believe we did like 4,600 treatments. And we have a couple of patients that are unable to get any other vascular access in, and we have a couple that choose not to, no matter how much education we've done. So—and we may have some that may come, you know, three times a month to treatment. So, to control some of their hemoglobins, it gets a little bit difficult.

Anita Segar: Hi, Robyn, this is Anita again. So, one of the other avenues I would suggest is to work with your network and the NCC, and, you know, maybe putting

together some interventions to address this issue of patient compliance. I definitely see that, you know, the low-volume adjustor does not apply there. I think that the—not requiring a 100 percent on the measure is going to help in this situation, but I think that the networks can do an awesome job in actually taking care of some of these types of issue.

Robyn Nygard: OK. Thank you.

Operator: As a reminder, to ask a question, press star 1. Your next question is from the line of Jeanette Bridges.

Jeanette Bridges: This is Jeanette Bridges from DaVita in the Detroit, Michigan, area. I had a question about why there's an exclusion for the VAT measure topic if there's a fistula and a graft?

Aryeh Langer: Give us 1 moment, please.

Joel Andress: Yes, this is Joel Andress. So, I think the answer to that is probably a little more detailed than we can get into here. What I would suggest is that you send this question in to the mailbox, and what we will do is we'll confer with the measure developer who worked with us on developing the measure, and we will look back at the documentation for the development of the measure and its endorsement process. And I think we can probably get you a more complete answer as to why that exclusion was included for the AVF.

Aryeh Langer: And just as a reminder, that e-mail address resource box is esrdqip@cms.hhs.gov. We'll take the next question please.

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

Beth Witten: Hi, this is Beth Witten. I am a nephrology social worker. And one thing that I hope that you are considering with the QIP is that, regarding the patient who is non-compliant and the facility's responsibility to educate the patient, I do agree that that's very important. However, it's also important that facilities understand that the regulations provide patients the right to choose to follow the recommendations or not. And when the QIP was instituted, there have been facilities since the institution of the QIP and the loss of revenues, there have been facilities that refused to accept patients with catheters, and there have been physicians that have discharged patients for non-compliance even though the regulations do not allow a facility to discharge a patient for non-compliance, and I'm not sure if that has come to your attention or not, but those are concerns in relation to patients' access to care.

Joel Andress: I was going to say that we—I'm sorry, this is Joel Andress—and we have actually heard some concerns recently about some of these issues, both in terms of potential dropping of patients who are considered difficult. We certainly agree that that

is a serious issue, and we are working to address that as quickly as we can. But certainly we appreciate your raising the issue with us.

Operator: Your next . . .

Aryeh Langer: Let's take the next question, please?

Operator: Your next question comes from the line of Jennifer Holcomb.

Jennifer Holcomb: Hello, thank you. My name is Jennifer Holcomb. I'm calling from Greenfield Health Systems in Detroit, Michigan. Can you hear me?

Aryeh Langer: Yes, go ahead, Jennifer.

Jennifer Holcomb: Oh, I'm sorry. My question is regarding the example for calculating the Kt/V Dialysis Adequacy—I had actually two questions. The first part is that the patient population—is that a 100 patient-months or 100 patients? The second one is if you could walk me through the Hemodialysis measure and getting the measure score, that would be helpful.

Joel Andress: I'm sorry. This is Joel Andress. Can you repeat the second part of your question, please?

Jennifer Holcomb: Sure. The second part is I'm looking at, you know, the three different patient populations. The hemodialysis has a measure rate 50/60 and a measure score. And I'm not understanding where the measure score of 7 comes in.

Joel Andress: OK. Sorry. Let me try this for you. First of all, the question of the denominator, that is patient-month. I think when I went through the description, I said patients . . .

Jennifer Holcomb: Thank you.

Joel Andress: . . . but that would be incorrect. It was patient-month.

Jennifer Holcomb: Thank you.

Joel Andress: So I apologize for the lack of clarity. In terms of the measure score: When we start describing—on slide 22, so essentially the next slide after that, we start describing the calculation of each clinical measure score. And so, if you will recall, we come to a—our example brings us an achievement score result of 3 and an improvement score result of 5.

And so, the measure score for that measure in that circumstance is 5. And that is what you see incorporated for in the Kt/V example, where it says measure score. So, for Hemodialysis, it's 7; for Peritoneal Dialysis, it's 8; and for Pediatric Hemodialysis, it's 5.

That's the score. It's the highest of your improvement and achievement scores. Whichever of those two is higher is incorporated here, and then it's multiplied by the weighting factor to determine what its contribution to your topic score will be.

Does that answer your question?

Jennifer Holcomb: I think so. Thank you.

Joel Andress: All right. Thank you.

Operator: Your next question comes from the line of Eduardo Lacson.

Eduardo Lacson: Hi. This is Eduardo Lacson from Fresenius Medical Care in Massachusetts. My question is about the changeover from URR to the Kt/V measures, whereby in the old URR measures, we were allowed up to seven treatments or more before we report the—were required to have the URR measure taken.

With the new Kt/V measure, it's only—it's down to two treatments in the month, and we need to come up with a Kt/V measure. And the overall 2015 rules went to great length to explain that they were going to change some of the other measures requirement from two—minimum of two treatments to seven treatments. And this is just not as intuitive to me and to many people in the community, why it was kept at two for the Kt/V measurement.

Hello?

Anita Segar: Hi, Dr. Lacson. Yes. Hi, Dr. Lacson. This is Anita Segar. I know we've communicated a little bit via e-mail surrounding some of these issues. The one thing I would say right now—I know that I probably couldn't go into a really detailed response, you know, to address this situation—but the one thing I would say is that all of the actual specifications and the reasons are outlined in the final rule. And one other thing I'd be willing to do is actually, if you wanted to send this question to the mailbox or to me personally here at my CMS I.D., I'd be happy to talk to you about it.

Eduardo Lacson: Thank you, Ms. Segar. Thank you.

Anita Segar: You're welcome. Thank you.

Operator: Your next question comes from the line of Julius Heilman.

Julius Heilman: Hi. Actually, my question was already answered. Thank you.

Operator: Your next question is from Patrick Ayers.

Patrick Ayers: Hi, this is Patrick Ayers from DaVita again. My question pertains to HD Kt/V. I noticed in the patient exclusion criteria that home hemo is not listed as a

modality to be excluded, but they do have treatment exclusions of—basically, you have to have three treatments per week to be included. And I was wondering, considering that home hemo patients can dialyze more or less frequently than three treatments per week, would that measurement only therefore include home hemo patients that dialyze for exactly three treatments per week? Or are those home hemo patients exempt from that—those treatment exclusions?

Joel Andress: Yes, this is Joel Andress. So to be explicitly clear, they are not—home hemodialysis patients are not explicitly excluded from the measure, but because most of them do not fit within the three sessions of dialysis per week, then they would by that criteria be excluded from this measure. We are currently considering the development of measures that will address frequent dialysis provision among dialysis patients. This measure simply isn't intended to capture that, and that was by intention.

Patrick Ayers: OK. So, on the rare chance, though, that a home hemo patient does average three treatments per week, he would then be included, though, right?

Joel Andress: I'm sorry. Can you repeat that?

Patrick Ayers: On the rare chance that a home hemo patient does average three treatments per week, he would then be included though, right?

Joel Andress: By the definition of the measure, yes.

Patrick Ayers: OK. Thank you.

Operator: As a reminder, to ask a question, press star 1. Your next question is from the line of Eduardo Lacson.

Eduardo Lacson: Hello. Good afternoon, again. Just wanted to expand on the …

Aryeh Langer: Can you give us 1 second?

Eduardo Lacson: … initial question on Kt/V Dialysis Adequacy. The clarification from Dr. Andress was that the measure is based on patient-months as well. I was under the impression, from reading the rule, that, for example, in your pediatric hemodialysis, 10/20 would—that would mean 20, a total of 20 patient-months. So that could be just two patients. Same with PD: If you only have two or three patients that contribute that, then that will be enough? Because I thought the principle for these small numbers was based on aggregate patients treated during the year. Could you please clarify?
Thank you.

Joel Andress: Sure. Yes. So, I think that the—further clarification on this measure is probably something that we should take offline. If you have a set of specific questions relating to the weighting of the measures, I would recommend sending them to the mailbox, and then we can take them in total and provide you with a comprehensive

response to those methodological questions an—instead of hitting on them piecemeal here, which I think, you know, increases the chance of confusion, and that is certainly something to be avoided here. We want to be clear as we possibly can.

Operator: As a reminder, to ask a question, press star 1. Your next question is from the line of Lena Chambers.

Joel Andress: I'm just going to jump in here 1 second, I'm sorry, before you ask your question. We just wanted to respond to the prior question to that, in addition.

Anita Segar: Sure. Thank you. This is Anita Segar. I just wanted to add a little more information to, I believe, it was Patrick's question about home dialysis patients. I do want to say that for payment year 2015, there are several measures that apply to home dialysis. This is the Hemoglobin Greater Than 12, for both home hemo and peritoneal. We have the Kt/V, both home hemodialysis and peritoneal. The Vascular Access Type is the home. The Anemia Management reporting measure is the home hemodialysis and the Mineral Metabolism reporting measure.

So I believe the question was answered, but I just wanted to, for the benefit of everybody else on the line, kind of call that out. But I do want to say that we are exploring additional home hemodialysis—I'm sorry—home dialysis measures for future years of the QIP. Thank you.

Operator: The last question comes from the line of Lena Chambers.

Lena Chambers: Hi. I just want a clarification on the attestation for the NHSN, I believe it is. Do you attest to that in CROWN? Or is there—how do you attest to that? Or do you attest to that?

Anita Segar: So let me clarify your question just to make sure I understand it right. Are you asking if the attestation for the case minimums is done in CROWN for NHSN?

Lena Chambers: Yes. What do you attest to in CROWN for the NHSN?

Anita Segar: So in CROWN you would attest if you have a case minimum of below 11, then you would attest to that fact, that, yes, you have less than 11 patients—you would attest that to that fact in CROWNWeb. And if you do, then we would not score you, you know, negatively on that measure.

Lena Chambers: So, if we have greater than 11 patients, that's not an issue for us to be concerned with?

Anita Segar: You would not attest if you have more than 11 patients.

Lena Chambers: OK. Thank you.

Anita Segar: Thank you.

Aryeh Langer: Holley, was that our last question?

Operator: Yes, sir.

Additional Information

Aryeh Langer: OK. Well, I'd just like to point out that on slide 63, or the third-to-last slide of the presentation, you'll find information and a URL to evaluate your experience with today's call. Evaluations are anonymous and strictly confidential.

I should also point out that all registrants for today's call will receive a reminder e-mail from the CMS National Provider Call's resource box within 2 business days, regarding the opportunity to evaluate this call. You may disregard this e-mail if you have already completed evaluation. Please note, evaluations will be available for completion for 5 business days from the date of today's call, and we appreciate your feedback.

We would like to thank everyone for participating in today's call. An audio recording and written transcript of the call will be posted to the CMS Web site listed on the final slide of the presentation in approximately 2 weeks.

Again, my name is Aryeh Langer, and it's been a pleasure serving you as the moderator today. I'd like to thank our CMS subject-matter experts for participating in the call and delivering a great presentation. Thank you so much and have a wonderful day.

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

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