Transcript

[Please stand by for real time captions] welcome and thank you for standing by. [Operator Instructions] today's conference is being recorded. I would now like to turn the meeting for. You may begin.

Good morning and good afternoon everybody. Today we are hosting a Webinar on impact of the CMS readmission reduction in value based purchasing programs for rural PPS hospital. For those of you not familiar, gateway is a website with easy and timely access for research and findings of the federal office of rural health policy funded rural health research centers. Our goal is to help move new findings of the research centers to various end-users as quickly and as efficiently as possible. The site can be used to find abstracts of both current and completed research projects, publications resulting from those projects, and information about the research centers themselves, as well as individual researchers. You can find gateway at www.ruralhealthresearch.org. You can also join Gateway Research Alerts to receive periodic e-mail updates when new publications become available, including the future archive of our webinar today. The link for signing up for research alerts is included on the left-hand side of your screen. We have muted all lines but I encourage you to use the Q&A chat box at the bottom of your screen to type any questions you have. At the end of today's presentation, the operator will open up the meeting for questions. Those written in the checkbox will be read if there are no questions online. If we have remaining questions left in the chat box at the end of our meeting today, we will send out responses to questions through our research alerts.

Thank you for joining us today, and now I want to introduce our presenters. Michelle Casey is a Senior Research Fellow and Deputy Director at the University of Minnesota Rural Health Research Center. She is an investigator for policy relevant rural health research projects on a variety of rural health issues for over 20 years. She received a national rural health association outstanding rural health researcher award in 2006. Her current research interests include rural quality and patient safety, critical access hospitals and the Medicare rural hospital flexibility program, access for care for rural Medicare beneficiaries and underserved populations, rural women's health issues, rural pharmacy service, and end of life care in rural communities.

Ira Moscovice is a professor in the division of health policy and management and director of the University of Minnesota's rural health research center. Dr. Moscovice has served as the principal investigator for numerous rural health research projects funded by federal and state agencies, as well as private foundations. He was the first recipient of the distinguished researcher award from the national rural health Association in 1992. His current research interests include the development of rural quality and patient safety measures, implementation of quality and patient safety initiatives in rural environments, the operation and financing of small rural hospitals, and the evaluation of alternative rural healthcare delivery systems. You can learn more on the Gateway website. Thank you for presenting and I now turn the webinar over to Michelle Casey.

>> Thank you. For we get started I would like to acknowledge our colleague Peiyin Hung, he was a key part of the research team that we will discuss today and she is also with us here today.

>> We would also like to thank the federal office of rural health policy who supports the research that we will discuss today.

>> Historically the centers for Medicare and Medicaid services paid hospitals based on volume, rather than on their performance. With the passage of the affordable care act, a number of efforts were authorized to help realign financial incentives for rural hospitals to provide high-quality care. Two of those efforts included the hospital readmissions reduction program and the hospital value-based purchasing program. The readmissions reduction program reduces Medicare payments for hospitals who are determined by CMS to have accessory admissions for specific medical conditions; the goal of the program is to motivate hospitals to reduce preventable readmissions, both to reduce costs for Medicare program and also to improve the quality of care for Medicare beneficiaries. The value-based purchasing program raises or lowers Medicare payment rates for hospitals depending on how they score on a range of quality measures. The goal of that program is to motivate hospitals to provide the best value care to Medicare beneficiaries, taking into account both quality and cost. Both programs apply to perspective payment systems or PPS hospitals but critical access hospitals are exempt from them.

>> The research we will talk about today focuses on how rural hospitals have fared under each of these programs. I'm going to start by talking about the readmissions reduction program and then Ira will talk about the value-based purchasing

>> There have been a number of studies in California as well as nationally that have examined one or both of these programs and most of these studies have focused primarily on the extent to which large

urban safety net hospitals have received penalties under the program. And the studies have generally found that safety net hospitals are more likely to be penalized under both of the programs in other hospitals. More recently the government accountability office or GAO, looked particularly at small rural hospitals in comparison to other hospitals. They looked at median payment adjustments in penalty and bonuses for the value-based purchasing program. They defined small rural hospitals as hospitals with less than or equal to 100 beds. They found the payment adjustments are similar between the small rural hospitals and all other hospitals in the first two years. In fiscal year 2015 small rural hospitals on average had had larger bonuses and smaller penalties as a percentage of the Medicare payment.

A few basics about the readmissions reduction program. Readmission rates in the program are based on three years of Medicare data that the rate a risk-adjusted for patient demographic characteristics for the frailty of the beneficiaries and for a number of different comorbidities. In the first two years of the program they were three conditions that readmissions were analyzed for; Acute myocardial infarction or heart attack, heart failure and pneumonia. In fiscal year 2015 chronic obstructive pulmonary disease or COPD was added as well as elective hip and knee surgery. In fiscal year 2017 there will be another condition added which is a coronary artery bypass graft surgery. The maximum Medicare payment reductions that hospitals can receive under this program were 1% in the first year, 2% in the second year and will go up to a maximum of 3% for fiscal year 2015 and thereafter. Payment for all Medicare inpatient admissions in the hospital are reduced by this amount.

>> We had three research questions we wanted to look at as part of our research. The first one was how did the proportion of rural and urban hospitals that receive penalties under the readmission reduction program change over time? We also wanted to look at the hospital and County characteristics that were associated with a higher likelihood of receiving readmission penalties and finally we look at some of the condition specific hospital readmission rates to see how they differed between rural and urban hospitals. The data that we used for this part of the research included from CMS hospital level readmission penalty data for the three years from the American Hospital Association annual survey. We had organizational characteristics of hospitals from the area health resource file. We had characteristics of the counties in which the hospitals were located. Our sample consisted of 2471 urban and 861 rural PPS hospitals. All of the hospitals eligible for the programs in all those years. In terms of methods we used descriptive and varied statistics. We used two group t-tests to identify significant differences in the condition specific readmission rates between urban and rural PPS hospitals. This shows the percent of hospitals penalized with the world in the dark purple in the urban and the gold. You can see from this that over the first three years of the program, the percentage of hospitals, both rural and urban that received penalties has increased. With about two thirds of both urban and rural hospitals in the first two years that were penalized and that has gone up to almost four and five of rural and urban hospitals in fiscal year 2015. So now the aggregate penalties in this program are based on summing up penalties for all of the specific conditions. So it could be that the higher number of hospitals that were penalized in 2015 might be due to the fact that new conditions were added. Basically almost all of the hospitals who got

penalties in 2014 also had penalties in 2015. Over half of those that did not have penalties in 2014 and then got penalized in 2015 and we did note they were several specialty hospitals that do hip and knee replacements. One of the new conditions received fines for the first time in 2015. Overall there was no significant difference between rural and urban hospitals and the likelihood of receiving readmission penalties in 2015, but when we looked at some of the hospital organizational and County characteristics, there were significant differences between rural and urban hospitals. In terms of size, among those hospitals that had less than 50 beds, penalties were more likely for those smaller hospitals in rural areas than in urban areas. In terms of ownership, among the for-profit hospitals penalties work and more likely for the rural ones then for the urban ones. There were also some regional differences. In the northeastern part of the country, that census region and penalties or more likely for urban hospitals than rural but the situation with the opposite in the South where rural hospitals were more likely to be penalized than urban hospitals. And when we look within the group of rural hospitals there are also several significant differences in the likelihood of being penalized based on characteristics of the hospitals in the counties they are located in. In terms of hospital size, we see that larger rural hospitals are more likely to receive admission penalties. Among hospitals with less than 50 beds it's just around 70% that are penalized and that goes up to 90% for the largest rural hospitals. And these results were also similar for urban hospitals. In terms of ownership, the for-profit rural hospitals are more likely to be penalized than either public or other not-for-profit rural hospitals. This is one place where rural was actually different than urban and for-

profit urban hospitals are less likely to be penalized than other urban hospitals.

>> We also looked at payer mix and within rural hospitals there was a significant relationship between having a higher portion of Medicare inpatient days as a proportion of total inpatient days. Those hospitals that had more Medicare days were more likely to receive the readmission penalties. This is also true for urban hospitals. Medicaid was similar where rural hospitals with a higher proportion of Medicaid inpatient days were also more likely to get penalties. And again this was similar for urban hospitals. We saw census region differences where within the group of rural hospitals the region where they were most likely to have readmission penalties was in the South and the West was the least likely. When we look at County characteristics, penalties are more likely for rural hospitals located in counties that have fewer primary care physicians per 1000 population. You can see here that the highest rate is for counties where there is fewer than one primary care physician per 2000 people. And these County differences were also true for urban counties. Penalties are also more likely for rural hospitals in counties where there is a lower median family income among the residence of that County.

>> When we look at readmission rates by condition comparing rural and urban hospitals, we see that urban hospitals had significantly lower (which is better) readmission rates for AMI patients, but rural hospitals had significantly lower or better rates for pneumonia and COPD and heart failure. There was not significant difference between urban and rural hospitals for patients did not receive the elective knee replacements. The focus of our study builds on previous research. We

show that rural as well as urban hospitals that have fewer resources and greater needs are more likely to incur readmission penalties.

>> It is not just the large safety net hospitals that are being penalized under this program. It is also rural hospitals, many of which were also part of the safety net for their communities.

>> There have been a number of concerns about readmission rates that are factors that may be largely outside of the control of the hospitals such as the socioeconomic status of the patient. Research has shown there is a relationship between patients socio-economic status and the likelihood of hospital readmission. Hospitals have argued that the rates should be adjusted or otherwise they are being unfairly penalized for factors that may be largely outside of their control. In the national quality forum recently endorsed doing sociodemographic adjustments for some quality measures under certain conditions but they recommended a trial period to test the impact risk adjusted measures on both quality reporting and patient outcome.

>> CMS has taken the position that adjustments of the rates may mask potential disparities in quality of care so they have not been in favor of socioeconomic adjustments. Other concerns that have been raised about the way penalties calculated for the Readmission Reduction Program. The Medicare payment advisory commission of MedPAC has expressed concerns about the fact that aggregate penalties for this program remain constant, and that means that some penalties and some hospitals will basically always be penalized even if the national readmission rate improves substantially. There is also significant random variation in condition-specific readmission rate. This is because of small numbers. Small numbers are specially a concern for rural

hospitals, of course, because many role hospitals are on the smaller end in terms of the number of admissions. MedPAC recommends that the readmissions reductions program have a fixed-target for readmission rates set at the beginning of the year, so penalties and hospitals would know what targets there aiming for. MedPAC recommends an all condition readmission measure and that would have a much greater volume than individual medical conditions and that would help reduce the random variation problem that occurs for small numbers, and clearly this would be especially important for smaller hospitals, many of which are rural. The third MedPAC recommendation of interest is they've also recommended that hospitals be evaluated against a group of peer hospitals that has a similar share of low income Medicare beneficiaries.

>> They feel that readmission rates should still be reported without adjustments so that can be tracked, but penalties would be calculated within these peer groups and that would get at the issue of hospitals not being unfairly penalized for having a higher proportion of low-income beneficiaries that have socioeconomic disadvantages.

>> I'm going to turn it over to Ira out to talk about the value-based program.

>> Let me give you the punchline before we go through the slides. What we're going to see in terms of results for value-based purchasing are a bit similar to some of the results that Michelle showed and presented for the readmissions program. The additive impact of these types of programs, although each individual program might have modest impact, when you put it all together the additive impact of these programs, and others out there now, can have somewhat a

substantial impact on hospitals. The other part that I think that you will see throughout the slides that is really important also, related to the comment that Michelle had about the socioeconomic status of the population served and how can we address that. And that is a key issue for value-based purchasing. We are also going to talk a little bit about the structure of the VBP program in terms of how that is influencing the results we see. A little bit of information in terms of an overview of the value-based purchasing program.

>> Maximum bonuses and penalties increase from 1% in fiscal year 2013 so it will be 2% in 2017 and these bonuses and penalties are based on achievement relative to other hospitals or improvement over the hospitals own baseline performance; whichever higher. That is an important distinction, that we are looking at not only achievement but looking at improvement if hospitals were starting at a lower point.

>> The next slide shows us the way that the value-based purchasing performance is calculated, there are a number of domains considered with quality measures for each domain. Each domain is given a weight we will show you in detail in the next slide but let me talk a little bit about this before we get to the next slide. Over time there will be a decreased emphasis on process measures, which seems appropriate, and consistent focus on the patient experience and on outcome measures as measured by mortality. The efficiency domain which is measured by Medicare spending per beneficiary and patient safety measures were added starting in fiscal year 2015. And just a little bit more information about these measures, that the process measures used up until now included measures for hospital compare for AMI, pneumonia, heart failure, surgical care improvement, perinatal measures. The main measures include HCAHPS survey measures and

for FY 2018 they are proposing to add a three item care transition measure which is publicly reported as part of HCAHPS. The outcome domain includes a 30-day risk-adjustment of mortality measures of Ami, heart failure, pneumonia, and patient and safety in healthcare inquired infection were added in 2015 and 16. They will be moving to a separate safety domain in 2017. The efficiency domain has only one measure, it includes all party and Part B claims for period from three days prior to hospital mission to 30 days after discharge.

>> And so if they are going to show the scoring domains, and the waiting but the fiscal year, what you will see over time, as we said the process measures in terms of clinical care, it started out as 70% of the overall scoring and it will be down to 5% FY 17 and it will not be part of the process by FY 2018. The patient experience of care has stayed constant. Started out at 30% and HCAHPS will be 25% of the measure. The clinical care of the outcome perspective has been rising from 25% to 40% but they will go back down to 25% as we moved to incorporate the safety and the efficiency measures. The efficiency measures starting in the past year they were be about 25% for 3 years and then safety measures will be starting year after next and they will go up to 25%. As of now by FY 2018 went up four domains, no process measures being considered. Focus on the patient experience, outcomes, efficiency and safety. We are going to look at the next slide which outlines the three research questions that we try to address which is the first question. Over the first three years of the program what proportions of rural hospitals and urban hospitals receive penalties and bonuses? How did the probability of receiving penalties vary is a function of hospital characteristics and County characteristics? And

how the probability of receiving bonuses and penalties change over time?

>> Data we used for our analysis came from three different sources. The hospital inpatient prospective payment system final rule impact file, for the three-year period to FY 2013-15, the AAH survey prior to when we were measuring results, 2011-12 and the area health resource file for County characteristics over a three-year period.

>> Once again our samples were all eligible general surgical and medical acute care hospitals that came out to 2213 urban hospitals 748 Rural hospitals and we excluded 141 specialty care hospitals from the analysis. The methods that we used basically focused on simple Chai square test to look at key factors associated with a bonus or penalty and different effects of the program on rural and urban hospitals over time. The expected payment penalty was calculated conditional on the hospital's likelihood of being penalized in a year. if you are penalized and how large is the penalty going to be? And the same thing for payment bonus. And the first slide showing results in terms of hospitals that receive a bonus or penalty over three-year period FY 2013 to FY 2015 in which you see for urban hospitals it started out for bonuses 51% and has stayed in the 50% range now for rural hospitals slightly lower in the first two years and then a big jump in the increase in bonuses for rural hospitals and FY 2015 is quite evident in what we are going to see here is that as the efficiency measures that added to the process that led to rural hospitals benefiting from the value-based purchasing program. What that basically boils down to is that it is cheaper. For controlling for everything else you can, it's cheaper to take care of patients with a particular condition in rural hospitals, on

average, then rural hospitals. They really benefit from the efficiency domain being added to this program.

>> For the bivariate results, amongst rural and urban hospitals, in terms of the likelihood of a penalty significantly more likely at what kind of characteristics? The penalties were more likely for larger sized facilities, for publicly owned facilities. For those facilities with a higher proportion of Medicare and Medicaid inpatient days and facilities located with lower median family income, higher uninsured rates, and fewer primary care physicians per 1000 County residents. That is similar to what we saw under the readmission program and it is important to understand that we are getting similar results across these programs. If we look at it geographically, once again we see a variation across the country. For urban hospitals the highest percentage of hospitals with the penalty which is what this is showing, were in the northeast and several hospitals the highest percentage of hospitals with penalties were in the South. But once again the rural hospitals in all of these regions had lower penalty rates than their urban counterparts.

>> For the multivariate analysis, we try to figure out which hospitals were less likely to get penalized during this 3 year period. The kind of characteristics were where they are located (rural vs. urban), what kind of ownership, were they in the system or not, were they accredited, how large of inpatient volume did they have, What percentage share of their overall inpatient days were Medicare and Medicaid, what geographic region they were in. For County characteristics, uninsured rate amongst non-medicare population and also the availability of primary care physicians in their environment.

>> What we saw now for the multivariate results were the following. The rural hospitals had a higher probability of receiving penalties for FY 2013 and FY 2014 than their urban counterparts. But a real change in 2015, rural hospitals were much less likely to receive a penalty. As I said before the main reason for this is the efficiency measure coming into play and this is controlling for all of the other variables we talked about: Ownership and system affiliation etc. It sets a very large change in fiscal year 2015 and should be noted. So they were 16% less in that year less likely to receive a penalty if you are in a rural location. In terms of other hospital characteristics, the hospitals that are more likely penalized if they are not accredited and system affiliated and they have higher volume or adjusted inpatient days, higher portion of Medicare Medicaid patient days and lower nurse staffing ratio. What that says, statistically, if you are an accredited hospital, youre 5% less likely to receive a penalty. If you are in the system your 5% less likely. If you are in the system and accredited you are close to 10% less likely to receive a penalty. And you see lower a bit lower effects for the volume. The percent of Medicare and Medicaid inpatient days, for every 10% difference you see a 1.4% change for the Medicare side and a 4.7% change for the Medicaid side.

>> In terms of County characteristics, hospitals and counties with lower supply of County physicians they were more likely to get penalized. Higher uninsured rates are associated with higher expected amounts of penalties. Same direction as we saw for the readmission program. Now, if we go to looking at changes over time and we look at bonuses first. What this chart says is of the 1134 urban hospitals that received a bonus and FY 2013, 68% received a bonus in 2014, 64% received a bonus in 2015. So you have a core group that are receiving two thirds

to three quarters of a hospitals and they're receiving bonuses over the three-year period. Of the 328 rural hospitals that received a bonus and FY 2013, 68% received a bonus in 2014, 75% received a bonus in 2015 once again you are seeing over time the likelihood of receiving a bonus is fairly stable.

>> If you look at the counterpart in terms of penalty status, what we see is for urban hospitals of slightly more than 1000 urban hospitals received a penalty in 2013. 73% received one in 2014 and 64% in 2015. We see a large difference on the rural side and of the 326 hospitals that received a penalty in 2013, 82% received a penalty in 2014 and low and behold were down to 40% receiving a penalty in 2015 and that is the effect of the efficiency measure come into play and that really helped rural hospitals. And so we have a couple of discussion points we want to speak about before we wrap this up and open conversation for questions. The first is which hospitals are more likely to receive penalties under value-based purchasing? The hospital characteristics and once we talked about and Michelle talked about are very similar in terms of the characteristics of the readmissions program in the County characteristics in the same way and the question that gets raised is how much control do hospitals have over these factors? The real concern is the effects of value-based purchasing a poor and disadvantaged populations. And what we are seeing is that substantial questions do exist in terms of whether the characteristics that patients are being taken into control as we consider the impact of these programs.

>> On the next slide, it is important to recognize that value-based purchasing budget neutral. The total bonuses have to week we total penalties. So it is a zero sum game and that influences the outcomes across all facilities. What we want to understand is which factors are

responsible for the differences in terms of urban or rural hospitals. The question we raised that we think is important is it is not at all clear that what we are seeing in terms of the impact of the program is due to changing performance. From our perspective it may very will be due to the changing metrics that have occurred over time. And that can be misleading. And our results are consistent with what the recent GAO report showed and I think we plan on raising this issue with federal policymakers. Having a stability for program like this is really important. As we get better quality measures in the outcome arena it's important to introduce them into this kind of a program but we need to understand in the first three or four years of the program are changes over time which may well be due to the kinds of metrics and the different weights rather than necessarily improved or poorer performance over time.

>> And then, finally, the amount of penalties may not seem large. Our point is that hospitals can be incurring penalties under the readmission program, hospital acquired conditions, meaningful use. If you look at all of those programs and the situation that in 2012 the average Medicare acute inpatient margin for rural PPS hospitals was negative 2.6%, 56 rural hospitals have closed since 2010. 36 were rural PPS hospitals and 20 were critical access hospitals. Overall the efforts of these programs may have an impact to these program and it may be rather substantial for smaller facilities. We will stop there. We have a brief note on our website and Shawnda's group, we look forward to any questions. Will stop here and pass it back to Shawnda.

>> Are there any questions for the presenters

>> [Operator Instructions]

>> We have a question from Connie.

>> Connie, you have an open line.

>> This is Paula Watson. I had a question regarding critical access hospitals. If we are exempt from the perspective payment penalties and bonuses -- [indiscernible-low audio]

>> Critical access hospitals are not currently part of either one of these programs.

>> Okay. Thank you.

>> I should add, this is Ira. My own belief that in the long run I don't think critical access hospitals will continue to be excluded from all of these programs. It because we move forward and come up with an overall picture of quality measurement performance, I think it's important for critical access hospitals to be part of these programs. I would be cautious and thinking that not being part of these programs is going to continue in the long run. We really tried to advise critical access hospitals to get involved as much as you can in terms of performance measurement weather it's through MBQIP or hospital compare or opportunities that are available, and if you continue to do that it's really important.

>> This is Michelle. I will just add that the Affordable Care Act did include a provision that there was to be a demonstration program for value-based purchasing for Critical Access Hospitals. That has not yet been implemented by CMS.

>> [Pause]

>> There are no further questions.

>> [Operator Instructions]

>> [Pause]

>> One moment. We have another question. This question is from Mary Ellen Pratt.

>> Hello. I was just wanting to know if you guys are planning on commenting on the macro legislation related to NITZ and basically the performance plan there for physicians and how that might have an impact on rurals for some of the same reasons that you discovered here with your research in terms of the populations that we served in the small numbers that we represent and it being based on quality metrics. Just wondering if you guys are going to respond to CMS with regard to how to craft that legislation so it is balanced for both urban and rural physicians.

>> So we had not necessarily planned on doing it ourselves. What usually happens in these cases is we will work with other organizations like an NRHA that they American Hospital Association or other groups and provide them input for their responses. We will look at this carefully. I'm glad you raised it and what we will do is either independently set in a comment, but sometimes it is more effective if we help craft the comments that are being done a larger organizations. I do appreciate your bringing that up and we will take a look into it.

>> Next question is from Danny MacCallum.

>> I wonder if you know if any work is being done to help critical access hospitals know where they would stand if and when the program applies to them

>> That is a good question and that would be a very nice project for us to do. And we have not modeled that. We just finished up this work were finishing up this work that I think it is a good suggestion and we will take a look at that because we think it would be valuable.

>> Great. Thank you.

>> Craig Kaplan. I was wondering, do you know and do not think this data is released yet for fiscal year 2015 but I do know that it is possible that total performance can be comprised of only the two of the four domains. I'm just wondering which ones and which domains were dropped for rural beneficiaries, and computing the performance scores. I don't think the data is released yet but I'm just wondering if you have any insights on that

>> Craig, if I'm understanding the question, this is Michelle. There is a minimum number of domains that each hospital has to have to update on.

>> In fiscal year 2015 they have a minimum of two of the four domains. So the total performance score can be comprised of two domains, three domains, or all four domains.

>> There are minimums within each domain in terms of the number of cases you have to have. Gift of 25 cases for mortality measures for outcome. And so what you are asking is among the rural hospitals that we looked at, which with the domains that they were more likely to have?

>> Yes. That I do not think that data is out there yet. And just giving you a heads up to keep an eye out for that data. I think that will be an

interesting analysis. I don't think you can answer it right now. But I have not checked. I used to work on this.

>> That's a good point, Craig. Thanks for bringing it up, and we will look at it. If hospital does not have enough data for a particular domain to be counted then the other domains are reweighted.

>> Yes. Exactly.

>> That does change into even have more wait on the domains when you don’t..

>> I'm not sure. For example, Medicare spending per beneficiary. How many of the rural hospitals have that domain included in computing the total performance score and how many of them were dropped? I don't think we can know this information yet until CMS releases the state of..

>> Yes. We will definitely follow up on that.

>> Okay. Thank you.

>> There are no further questions at this time.

>> [Pause]

>> [Pause]

>> Thank you, Kathy. If there are no further questions I've looked at our Q&A box and we have no other questions for our presenters at this time. So I do want to thank Michelle and Dr. Moscovice for presenting today and also for those of you wondering the PowerPoint and the archived Webinar will be made available on our website and will be disseminated through our research alerts at a later date. The research team presented today is currently working on a publication related to

the presented data. As such after they submit the information the slides will then be made available. However, in the meantime, there is a current policy brief you can access now through the Gateway website or at the link shared on your screen right now shared by the research center. The title of this brief is on your screen and which rural and urban hospitals have received readmission penalties over time. You can visit the link on the left-hand side of your screen for more information. There are no further questions and if there is else from the operator I want to thank you all for joining us today and thank you again to both Michelle and Doctor Moskowitz.

>> This concludes today's conference. Thank you for your participation. You may now disconnect. [Event concluded]