Centers for Medicare & Medicaid Services
Open Door Forum: Physicians, Nurses and Allied Health Professionals
Moderator: Jill Darling
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3:30 pm ET

Coordinator: Today's conference is being recorded. If you have any objections you may disconnect at this time. All participants are to listen-only mode until the question and answer session of - at the end of today's presentation. To ask a question at that time please press Star 1 and clearly record your name for question introduction. I would like to now turn the call over to our host, Miss Jill Darling. Miss Darling, you may begin.

Jill Darling: Thank you (Dexter). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications and welcome to today's Physicians, Nurses and Allied Health Professionals Open Door Forum. We appreciate your patience as always as we wait to get more folks in and speakers as well as they had a previous call.

Before we get into the agenda today I have one brief announcement. This Open Door Forum is open to everyone but if you are a member of the press you may listen in but please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries please contact us at press@cms.hhs.gov. And I will turn the call over to our co-chair, Gift Tee.

Gift Tee: Thanks Jill and good afternoon everyone and happy summer. So, a little thing happened a couple of days ago that I'm sure no doubt you all are pouring over, I think about 1700 pages of interesting, riveting material specifically, the Medicare Physician Fee Schedule Proposed Rule for CY 2022.

So, it was placed on display at the Federal Register on July 13. And this proposed rule as you all know doubt know updates payment policies, payment

rates and other provisions for services furnished under the Medicare Physician Fee Schedule for again January 1, 2022.

The comment period for this rule closes on September 13, 2021. So please, please, please, please send in your comments. We are very interested in hearing what you have to say about some of the topics that we've discussed in this rule.

And with that, I'll turn it over to a number of my colleagues who will touch on various topics within the rules starting with policies around E&M split share, critical care and teaching physician services. So with that, Sarah Leipnik and Christiane Labonte. Thank you.

Sarah Leipnik: Thank you Gift. I'm going to discuss our specific proposal regarding evaluation management visits and split or shared E&M visits. So, for the evaluation and management visits:

CMS is engaged in an ongoing review of payment for E&M visit code sets. For CY '22 we are making several proposals that take into account the recent changes to E&M visit codes as explained in the AMA CPT code book which took effect January 1st of 2021. We are also proposing to clarify and refine policies that were reflected in certain manual provisions that were recently withdrawn. Specifically, we are proposing a number of refinements to our current policies for a split or shared E&M visit, critical care services and services furnished by teaching physicians involving residents.

Now I'm going to go into split or shared E&M visits. We're proposing to refine our longstanding policy for a split or shared E&M visit to better reflect the current practice of medicine, the evolving role of the nonphysician practitioner, NPPs, as members of the medical team, and to clarify conditions

of payment that must be met to bill Medicare for these services. In the CY '22 PFS proposed rule we are proposing the following.

A definition of split or shared E&M visits as evaluation and management visits provided in the facility setting by a physician and the nonphysician practitioner in the same group. The practitioner who provides the substantive portion of the visit which is more than half of the total time spent would be the one to bill for the visit. Split or shared visits could be reported for new as well as established patients and initial and subsequent visits as well as prolonged services. We are proposing to require reporting of a modifier on the claim to help ensure program integrity, documentation in the medical record that would identify the two individuals who performed the visit, the individual providing the substantive portion must sign and date the medical record. And then we are codifying these proposals and revised policies and new regulations at 42 CFR 415.140.

I'm now going to turn it over to Christiane LaBonte to discuss the critical care services as well as teaching physician services. Christiane:

Christiane LaBonte: Thanks so much Sarah. Good afternoon everyone. This is Christiane LaBonte. And as Sarah mentioned I will briefly discuss the proposals for critical care visits and teaching physicians.

So first, critical care, similar to what Sarah talked about for split or shared visits we're proposing to refine our long policies for critical care services. And these proposals include to use AMA Current Procedural Terminology prefatory language as the definition of critical visits to allow critical care services to be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty and that critical care visit can be furnished as split or shared visits.

That no other E&M visit can be billed for the same patient on the same day as the critical care service and when the services are furnished by the same practitioner or by practitioners in the same specialty and same group to account for overlapping resource costs. And finally, that critical care visits cannot be reported during the same time period as the procedures with a global surgical period.

The second topic I'll be discussing is teaching physicians. And in here to give you a little bit of context. In the new AMA CPT office/outpatient visit E&M visit coding framework that CMS finalized for 2021 under which practitioners can select the office or outpatient E&M visit level to bill was based either on the use of total time or a medical decision making.

And under our existing teaching physician regulations if a resident participates in the service furnished in a teaching setting a teaching physician can bill for the service only if they are present for the critical or key portion of the service. And these regulations also include an exception for primary care practitioners for which Medicare makes separate physician fee schedule payment in certain teaching hospital primary care centers for certain services furnished by the resident without the presence of the teaching physician.

So that's the contact for these two proposals which we're making to update our teaching physician rules to take into account this new AMA coding framework. So first, we're proposing to clarify the time when the teaching physician was present and can be included when determining E&M visit level.

And second, under the primary care exception, specifically, we're proposing that only medical decision making would be used to select a visit level to guard against the possibility of inappropriate coding that reflects residents

relative inefficiencies rather than a measure of the time required to furnish the services.

That's it for E&M. Now I'm turning it over to Pam West.

Pam West: Thank you Christiane. This is Pam West and I'm going to be talking about therapy services and the rules. CMS is implementing the final part of Section 53107 of the Bipartisan Budget Act of 2018 which requires CMS through the use of new modifiers, CQ and CO to identify and make permanent 85% of the otherwise applicable Part B payment amount for physical therapy and occupational therapy services furnished in whole or in part by physical therapist assistants and occupational therapy assistants for dates of service on and after January 1, 2022.

In response to numerous stakeholder questions and to promote proper therapy care CMS is proposing to revise that the minimum standard established to determine whether services are provided in whole or in part by therapy assistance. Specifically, we are proposing to revise a de minimis policy to allow a time service to be billed without the CQ, CO modifier in cases where a therapy assistant participates in providing care to a patient with a therapist but a therapist meets the Medicare billing requirements for the time service without the minutes furnished by the therapy assistant by providing more than half of a 15 minute midpoint, so that's also known as 8-Minute-Rule.

Under this proposal any minutes of the therapy assistant furnished in the scenario as previously described would not matter for the purposes of billing Medicare. In addition to cases where remaining, one remaining unit of a multiunit therapy service remains to be billed this revision to the policy would apply in a limited number of cases where more than one unit of therapy with a

total time of 23 to 28 minutes is being furnished. On the fact sheet there is a typo in the total number of minutes which should be 23 and not 24 minutes.

So, for these limited number of cases we are proposing to allow one 15 minute unit to be billed with a CQ, CO assistant modifier and one unit should be billed without the CQ, CO modifier in billing scenarios where there are two 15 minute units left to bill when a therapist and a therapy assistant provides between nine and 14 minutes of the same service.

Overall, that de minimus standard would continue to be applicable in the following scenarios. One, when a was therapist independently furnishes a service or a 15-minute unit of service in whole without the therapist furnishing any part of the same service. Two, in instances where the service is not defined in 15-minute increments including supervised modalities, evaluations, reevaluations and group therapy.

Three, when the therapy assistant furnishes eight minutes or more of the final unit of a billing scenario in which the therapist furnishes less than eight minutes of the same service. And four, when both the therapy assistant and the therapist each furnished less than eight minutes for the final 15 minute unit of a billing scenario. At this point I'd like to turn the call over to Liane Grayson.

Liane Grayson: Thank you Pam. Good afternoon everyone. This is Liane Grayson. I will briefly discuss proposed changes to coinsurance for colorectal cancer screenings. CMS is proposing to implement Section 122 of the Consolidated Appropriations Act of 2021. Section 122 of the CAA amends statute by providing a special coinsurance rule for procedures that are planned as colorectal screening tests but become diagnostic tests when the practitioner identifies the need for additional services such as removal of polyps.

Currently, the addition of any procedure beyond the planned colorectal screening, for which there is no coinsurance, results in beneficiaries having to pay coinsurance. Section 122 of the CAA reduces over time the amount of coinsurance a beneficiary will pay for such services. That is, for services furnished on or after January 1, 2022 the coinsurance amount paid for a planned colorectal cancer screening test that requires additional related procedures shall be equal to the specified percent of the lesser of the actual charge for the service or the amount determined under the fee schedule that applies to the test.

Thus, coinsurance will be 20% for calendar year 2022, 15% for calendar years 2023 through 2026, 10% for calendar years 2027 through 2029 and zero percent beginning calendar year 2030 and thereafter. This reduction over time of the coinsurance percentage holds true regardless of the code that is billed for establishment of a diagnosis, removal of tissue or other matters or another procedure that is furnished in connection with and in the same clinical encounter as the screening.

I will now pass the baton to Donta Henson who will talk about telehealth proposals.

Danta Henson: Thank you Liane and good afternoon everyone. for CY 2022 CMS is proposing a number of policies related to Medicare telehealth services. First, we are proposed, we're proposing a revised timeframe for consideration of service added to the telehealth list on a temporary basis. Specifically CMS is proposing to allow certain services added to the Medicare telehealth list to remain on the list until December 31, 2023 so that there is a glide path to evaluate whether services should be permanently added to the telehealth list following the end of the COVID-19 PHE.

Second, Section 123 of the CAA of 2021 removed the geographic restrictions and added the home of the beneficiary and permissible originating site for telehealth services when used for the purposes of diagnosis, evaluation of treatment of a mental health disorder and requires that there be an in-person non-telehealth service with the physician or practitioner within six months prior to the initial telehealth service. Thereafter the service intervals will be specified about secretary.

Third, CMS is proposing to amend the current regulatory requirements for interactive telecommunications systems which is defined as a multimedia communication equipment that includes, at a minimum, audio and video equipment permitting two-way real-time Interactive communication between the patient and the distant site practician or physician to include audio only technology when used for telehealth service for the diagnosis, evaluation or treatment of mental health disorder furnished to an established patient in their homes.

Fourth, CMS is proposing to limit the use of audio only interactive telecommunications systems to health services furnished by practitioners who have the capability to furnish two-way audio video communication but where the beneficiary is incapable of using or does not consent to use the use of two-way audio video technology. CMS has also proposed to require the use of a new modifier for services furnished using audio only communications which will serve to certify that the practitioner has the capability to provide two-way audio video technology but instead used audio only technology due to the beneficiaries choice or limitation.

Lastly, CMS is soliciting comment on whether additional documentation should be required in the patient's medical record to support the clinical appropriateness of audio only telehealth and whether we should or - we should

preclude audio only telehealth for some high level services such a Level 4 or Level 5 E&M visits or psychotherapy with crisis. And lastly, any additional guardrails we should consider putting in place to minimize program integrity and patient safety concerns. And now I'll be turning it over to Kati Moore. Katie?

Kati Moore: Great, thanks. Good afternoon everyone. I am Kati Moore. And I'm going to be giving you all an update on Quality Payment Program proposals in the PFS Proposed Rule.

And so for folks that are new to QPP there are two participation tracks for the program. There's a Merit-based Incentive Payment System, MIPS, so I'll be giving some updates on those first and then I'll transition into giving a brief update on our Advance Alternative Payment model track of QPP.

So first to continue progressing further towards the future state of MIPS maps we really focused the majority of our proposals on MIPS Value pathways, which are MVP, and MVP presentation and reporting requirements beginning with the 2023 performance year. In addition, for 2022 performance year we have proposal updates, proposed updates to both the traditional MIPS and Advanced Alternate Payment models or APM track of QPP to continue reducing burden, respond to feedback that we received from clinicians and other stakeholders, and really to align with some statutory requirements that we have coming up.

So, for MVPs as I said our big highlights are our MIPS Value Pathways which are a subset of measures and activities that are established through rulemaking that can be used to meet MIPS reporting requirements. And they're really intended to provide a way for clinicians to participate in MIPS that's more meaningful to how they practice.

So, with this proposed rule we are proposing to introduce subgroups as a voluntary participation option for MVPs and the APM Performance Pathway. APPs, will begin with the 2023 performance year. So we've proposed seven MVPs again for the 2023 performance year. These will not be available for 2022 but we're trying to give people enough time ahead of time to understand these different MVPs and figure out if they would be a good way for them to participate beginning in 2023.

And the seven MVPs align with the following clinical topics so we have rheumatology, stroke care and prevention, heart disease, chronic disease management, emergency medicine, lower extremity joint repair so hip and knee replacement and anesthesia. We also proposed some reporting requirements and scoring policies for MVPs and registration requirements for reporting MVPs that will include participation as a subgroup.

So, another big update we have in this proposed rule is related to performance threshold. So, using the mean final score for the 2017 performance year and the 2019 payment year we were using that mean final score to establish the performance threshold for the 2022 performance year and the corresponding 2024 payment year.

So, the performance threshold will be 75 points. And then the additional performance threshold for exceptional performance will be 89 points. And these will help determine whether clinicians in the program receive a positive, neutral or negative payment adjustment.

So, related to that is also our performance category rate. So, for 2022 they will be 30% for the quality performance category, 30% for the cost performance

category, 15% for the improvement activity performance category and 25% for the promoting interoperability performance category.

We are also proposing to add clinical social workers and certified nurse midwives to the definition of eligible clinician. We are adding five new episode based cost measures for 20 2 performance period and proposing a process of external cost measure development and a call for cost measures that will begin in 2022 for earliest adoption into MIPS by 2024.

We've also updated MIPS improvement activities inventory largely to help increase our focus on health equity. We've also made some revisions to our reporting requirements and automatic re-weighting policies for promoting interoperability performance category. We have two RFIs that are - that we've issued where we're soliciting a number of different comments on different areas some related to health equity and then transition timeline that we would like comments on related to transitioning from traditional MIPS into MVPs.

And then another important proposal that we've made, we have proposed to extend the CMS Web interface as a collection type and submission type for quality measure reporting into the 2022 performance period for registered groups, virtual groups and APM entities that are reporting through traditional MIPS.

And then we're also proposing the same extension CMF Web interface be extended into 2022 as well as 2023 performance years for the Shared Savings Program, Accountable Care Organizations, or ACOs, that will be reporting via the API. And we have some more shared savings program updates coming up in a few minutes too.

So, shifting gears a little bit into APMs update. We are proposing that beginning in the 2023 MIPS performance period we would only score the CMS Web interface for those ACOs that have also successfully completed reporting of at least one eCQM on MIPS CQP at the ACO entity level. And this is really an effort to help promote a shift towards all payer digital quality measures.

We've also included only one proposal to update the pay hierarchy for identifying payee TINs, the Taxpayer Identification Numbers, to receive the APM incentive payment. We are proposing to expand the roster of acceptable pay use at each step of the payee hierarchy to include TINs with which the Qualifying APM Participants, or QP, is affiliated during the payment year if no such TIN can be identified for the base year.

We anticipate that this change would enable us to complete incentive payments earlier in the QPP payment year., so that is the goal with that proposal. Additionally, we are codifying the QP threshold freeze for the 2021 and 2022 performance period which was mandated by the passage of the Consolidated Appropriations Act of 2022.

All right, so I know that a lot of information really quick on QPP but just wanted to also flag that you can find additional resources that go into a whole lot more detail than I've done in my few minutes here on the QPP Web site. So if you go to qpp.cms.gov we have a resource library there and available. And the Regulatory Resources section is a zip file that includes an overview fact sheet, a policy comparison table that lists all of the policies in detail as well as some additional MVP resources.

We also have our QPP Service Center is always available to answer specific QPP questions. And then we have a specific QPP proposed public Webinar

next Wednesday on the 21st that will go into detail on all of our 2022 proposed policies with a lot of our subject matter experts available to answer questions. So that is next Wednesday, the 21st from two to three. And there's a registration link available on the QPP Webinar library.

And that is it for QPP. And believe I'm handing it over to (Steven).

(Steven): Thank you Kati. We are proposing modifications to the Medicare Shared Savings Program spanning a number of problematic areas. We're proposing several changes that impact quality requirements for Shared Savings Program ACOs in direct response to ACOs concerns about the transition to reporting on eCQM MIPS QPP quality measures which requires submission of all payer quality data under the APM performance pathway APP.

The policy rule I would like highlight today for quality proposals are the following. As Katie noted earlier proposing to amend the reporter requirement under the APP for performance years 2022 and 2023 by sending the CMS Web interface as a reporting option.

Additionally, we are providing incentives to encourage early adoption of reported eCQM, MIPS CQM all payer measures under the APP in performance years 2022 and 2023. We're seeking comment on options for specialist reporting within an ACO and proposing a freeze the quality performance standard at 30th percentile for performance year 2023.

Under beneficiary assignment. we're proposing revisions to the definition of primary care services as specified in the list of HCPCS and CPT codes that are used for purposes of beneficiary assignment. We're proposing that the changes would be applicable for determining beneficiary assignment for the performance years starting on January 1, 2022 and subsequent performance

years. We are also seeking comment on whether stakeholders believe that there are other codes that should be included in a definition to inform future rulemaking.

In relation to the repayment mechanism requirements, we are proposing that an ACO that'll participate in a two-sided model must demonstrate that it established an adequate repayment mechanism to provide CMS assurance of its ability to repay shared losses for which an ACO may be liable upon reconciliation for each performance year. In combination the policies we're proposing will reduce the repayment mechanism amount and the number of ACOs required to increase the repayment mechanism amounts.

We're also proposing several other modifications to the Shared Saving Program policy that will reduce burden on ACOs and streamline the application process. We are proposing to revise requirements concerning the disclosure of prior participation in a Shared Savings Program by the ACO, ACO participants and ACO provider suppliers in light of a requirement that concern ACOs prior participation.

We are proposing to reduce the frequency and circumstances under which ACOs submit sample ACO participant agreements and executed ACO participant agreements with CMS. We are proposing to amend the beneficiary notification requirement as it applies to ACOs under prospective requirement.

We also have a benchmark methodology comment solicitation. Where we are seeking comments from stakeholders on certain aspects of a Shared Savings Program benchmarking methodology specifically the calculation of regional fee for service expenditures used in determining the regional adjustment and blended national regional growth rates for trending and updating the

benchmark as well as the risk adjustment methodology which can inform future rulemaking. With that I'd like to turn it back over to Jill Darling.

Jill Darling: Great, thank you (Steven). And thank you to all of our speakers today. (Dexter), will you please open the lines for Q&A?

Coordinator: Thank you. If you'd like to ask a question please press Star 1, unmute your phone and clearly state your name for question introduction. If you'd like to retract your question please press Star 2. One moment. Our first question comes from Sarah Warren. Sarah, your line is open.

Sarah Warner: Hi. Thank you for taking my call today. My name is Sarah Warner. I'm calling with the American Speech-Language-Hearing Association. In reviewing the regulatory impact analysis, ASHA is not clear whether CMS accounted for the impact of the discontinuation of the 3.75% to 2021 conversion factor.

We understand the projected 2022 CF is based on the original 2021 CF without the 3.75 % increase. But we believe it's important for providers to understand the full impact of the change in the conversion factor based on actual 2021 payments using the adjusted CF. Can you comment as to whether the regulatory impact analysis does this? Thank you.

Gift Tee: Hi Sarah. This is Gift Tee here at CMS. Yes, we did take into account the 3.75 and the impact table does show that it would not be in effect for quite CY 2022. And we did take that into account when we were calculating the conversion factor. Does that answer your question?

Sarah Warner: So, you're saying it did take into account the 2022 - the proposed 2022 conversion factor takes into account the 3.75...

Gift Tee: Yes, yes.

Sarah Warner: ...in the impact table? Okay.

Gift Tee: The expiration of the 3.75.

Sarah Warner: Thank you.

Gift Tee: You're welcome.

Coordinator: Our next question comes from (Pan Fran). Your line is open.

(Pan Fran): Hi. I'm from the CAP. I had a very similar question to what was previously asked. So, does this mean that the specialty impacts included the - or that the specialty impacts on table 123 took into account the 3.75 that was taken away?

Gift Tee: Yes, that is correct. Specialty impacts take into account the expiration of the 3.75 for CY 2022.

(Pan Fran): So when you're comparing allowed charges for 2021 versus allowed charges for 2022 the changes in the allowed charges for 2022 include the taking away of the 3.75% as well as changes to the RBUs?

Gift Tee: That is correct.

(Pan Fran): Okay. Thank you.

Coordinator: Our next question comes from Jennifer McLaughlin. Jennifer, your line is open.

Jennifer McLaughlin: Hi. Thank you so much. This is Jennifer McLaughlin from the American Medical Association. I had a question about the comment solicitation for impact of infectious disease on codes and rate setting.

The AMA along with many other of the house of medicine specialty societies and state medical societies have submitted extensive comments urging CMS to adopt and immediately pay for the new CPT Code 99072 to account for additional expenses in treating patients during the public health emergency and was surprised not to see a discussion of any of the (unintelligible) extensive input that was provided by the AMA and specialty societies (unintelligible) committee or, you know, respond to the many letters and sign all letters that were sent in support of that code being paid for. I was just wondering if you could provide a little bit more background in your thinking around that comment solicitation and not responding to support for CPT 99072? Thank you.

Gift Tee: Great question, Jennifer, and thank you. We did discuss a lot of our thoughts around 99072 in previous years rule. And as you point out, you know, definitely some things to consider. The PHE is still ongoing. We've met with a lot of stakeholders that provided us with information but wanted a little bit more context and information specifically from that perspective. So we definitely anticipate receiving a lot of information from folks including from the AMA with respect to our comment solicitation.

Jennifer McLaughlin: Thank you Gift.

Coordinator: If you'd like to ask a question please press Star 1, unmute your phone and clearly state your name for question introduction. One moment. I have no additional questions at this time. One moment I just got a question.

Jill Darling: Okay.

Coordinator: Our next question comes from?

(Deb Showenfeller): (Deb Showenfeller).

Coordinator: Your line is open.

(Deb Showenfeller): Hi. Thank you. I just wanted to verify for the telehealth for the audio only visits that starting in 2022 this would be allowed only for behavioral health visits or for patients with limitations. Is that correct?

Donta Henson: Hi. Thank you for your question. So right now what we are proposing is to use audio only for mental health diagnosis other than substance use disorders or co-occurring mental health disorder. So essentially what we're proposing is just to do regulation implement the CAA what was passed. Does that answer your question?

(Deb Showenfeller): I believe so. I think I was asking giving the reverse so that audio only options for telehealth go away except for certain mental health diagnoses other than substance abuse?

Donta Henson: Correct.

(Deb Showenfeller): Okay. Thank you.

Donta Henson: Thank you.

Coordinator: Our next question comes from Ronald Hirsch. Ronald, your line is open.

Dr. Ronald Hirsch: Hi. Thank you. First of all, (Dexter), you have the most amazing voice and you really should be the operator for all of these CMS calls. But my question is, in the discussion about shared visit it refers to patients who are new patients and patients who are established. And it's the second for critical care visits that there's new and established codes but those don't exist. Is that just an error when that was written up or are there new codes that have been proposed to critical care?

Ann Marshall: So this is Ann Marshall. I can take that one. Hi Dr. Hirsch.

Dr. Ronald Hirsch: Hello.

Ann Marshall: No. Hi, We there aren't any new codes it's just the 99291 and two. And I think it was probably just - probably not the best choice of describing the add on code. So...

((Crosstalk))

Ann Marshall: ...would be referring to the base code and then the primary procedure and and then the add on code for critical care.

Dr. Ronald Hirsch: Right. Okay, okay then you'll make sure (Dexter) is the operator for all your future calls please.

Ann Marshall: I'll do my best.

Jill Darling: This is Jill no promises Dr. Hirsch...

Dr. Ronald Hirsch: Thank you.

Jill Darling: ...we'll do our best.

Dr. Ronald Hirsch: Okay.

Coordinator: Thank you. And our next question comes from James Vavricek. Your line is open.

James Vavricek: Yes hi. James Vavricek with the American College of Cardiology. Thanks for doing this. It's always helpful. You guys are so speedy I don't - I feel I'm about to ask an uninformed question but I'm hoping it can be of everyone's benefit as well so digging through a bit.

We've stumbled on a couple of examples of really significant practice expense jobs that were not figuring out what might have driven them. It might not be useful for me to give a specific example but I'll try. If you're working in real-time as I look at 33285 for example which is a supply heavy code, has one rather expensive input. It goes from 147 RVUs to 119 roughly. And if there's any insight you would have to like some significant change in practice expense methodology is because it seems to be in several places that would be really helpful? Thank you.

Gift Tee: Hey James. This is a Gift. So yes, thanks for calling that to our attention. I think if you - as you continue to pour over the rule you'll see our proposed updates to clinical labor, right, that could impact what the P/E looks like across services that maybe have a different mix, i.e., clinical labor versus supply heavy. But that's just one thought so I guess keep reading and see what you think. And certainly, shoot us an email if that doesn't hold up.

James Vavricek: Appreciate that. Thank you. Yes, we'll keep on it and didn't know if there was something else that we were missing, appreciate it.

Coordinator: If you'd like to ask a question please press Star 1, unmute your phone and clearly state your name for question introduction. One moment. I have no additional questions at this time.

Jill Darling: Great, thanks (Dexter). Thanks everyone for joining and I'll hand call off to Gene.

Gene Freund: Hi. And this is Gene Freund and thank you all for your calls and the questions. I didn't hear many comments which is really good because it's very important that comments are submitted formally no later than 5:00 pm on September 13. And that's really important both for your kudos and your complaints so we really appreciate hearing those comments in the formal comment period.

No need to comment about anything having to do with (Dexter)'s voice or the way we run these calls during those formal comments. We can take those back on our own and make no promises. And that's all I have. Thank you very much.

End