Centers for Medicare and Medicaid Services
First Friday Call
Clinician Outreach Meeting
Moderator: Eugene Freund
June 2, 20171:30 p.m. ET

Operator: Good afternoon, my name is (Sally) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services First Friday Call Clinician Outreach Meeting.

All lines have been placed on mute to prevent any background. After each speaker's remarks there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Dr. Eugene Freund, you may begin your conference.

Eugene Freund: All right, this is Gene Freund, welcome to our Clinician Outreach meeting. We are actually having a little bit of technical difficulty because we have currently have a room scheduling conflict, but I want to continue with our call and get things started. I do want to remind you that this call was informational only and not intended for the press.

I will also want to ask people to think about the July meeting. Send me an e-mail in the next day or two if July 7th is the date when you are going to be out of town or otherwise not calling in or joining.

And the other quick announcement I have is especially if we don't have the July 7th, after June 30th, check for the open payments data update, but we'll have an update of that as soon as those are released.

Meanwhile, I want to turn it over to our first speaker who is Lisa Wilson from (Inaudible), who will be updating us some on the marketplace.

Lisa Wilson: Hi folks, it's good to talk to everybody as usual. I've really have just a few things to provide updates on. I think it's useful even though some of these things aren't directly, you know, affecting like it's, you know, doctor-patient relationship or anything like that. I think it's still very useful for you to hear some of the updates that they're join on in the marketplace.

So far this year, this administration has taken a number of incremental steps toward reducing administrative burdens and providing more flexibility by finalizing changes over the pass several months that (what you say was) the individual in small group market for 2018. While also returning primary oversize authority to state.

Last time I was on the call, we talked about the marketplace stability rule that was published in the federal register on April 8th – I mean, yes, April 18th. And that will make several changes that I intended to have the effect in the 2018 benefit year, the couple of them this year even starting this month in June around the special enrollment period kind of tightening up of that process.

Obviously, those are, you know, intended to attract young and healthy consumers to enroll in health insurance as a means to improve the risk pool. So, you know, we already kind of talked about, I'm happy to answer any other questions. But I did want to note a couple of the other things that, you know, have – we have provided guidance on. That was perhaps the most; well-publicized of these additional steps that we've taken.

We also, you know, kind of simultaneous to that publication of the rule published to additional guide on the QHP certification process that CMS relies on for states that performed plan management functions.

So if you would kind of remember that, you know, there's the SBM, the State-based marketplaces. There's the FFM, the federal-financial – federal marketplaces. And then there's some folks who are FFM, some states that are

FFMs but do perform many of that plan management function. So they're kind of the more traditional DOI, Department of Insurance and function.

We kind of check the steps further and are letting many of those states who do plan management function, we are relying on the states for the review of the QHP standard including some where we had previously conducted reviews before including service area, prescription drug formulary, outliers, and none discrimination and cost sharing.

The idea is really that, you know, instead of having to answer the two regulators, the (Inaudible) state DOI side and CMS because those regulators are, you know, examining similar issues is that you really go to the folks who have that closer relationship in the community.

And couple other things I just wanted to, you know, mention really quickly. We did take additional steps around the providing an improved consumer experience with enrolling through our direct enrollment partners that you may know some of these websites that facilitate enrollment through healhtcare.gov. The idea which kind of streamline that process somewhat and make it a smoother experience for the consumer, what we call through the direct enrollment process.

Additionally, we made an announcement recently about reducing the federal governments role in the health coverage decision in the SHOP which is a small business health options program that was outlined in that original Affordable Care Act legislation. The idea would be making it easier for issuers to use their own enrollment systems for purposes of SHOP or other kind of subsidiaries or even some brokers.

So just wanted to make sure that folks are kind of, you know, keeping all this announcement, you know, in check and, you know, understanding kind of where the things are going. I think it's just help owner to understand some of the administration actions in the past three months around the Affordable Care Act. So I'm happy to take questions.

Operator: At this time, I'd like to remind everyone, if you would like to ask a question, please press star then the number one on your telephone keypad. If you would like to withdraw your question, you may press the pound key. We'll pause for just a moment to compile the Q&A roster.

Your first question comes from the line of (Sherry Witty) with Paycom, your line is open.

(Sherry Witty): Hi, Lisa, I was just checking to say, what if we don't have a provider yet in the state of Tennessee for the marketplace?

Lisa Wilson: So, yes, you bring us a great point, you know. You know every year that we go through sort of the QHP, the Qualified Health Plans certification process and we work closely with our counterparts in the state departments of insurance to make sure that there's coverage available for folks in every state.

Tennessee is actually – I've heard a good new story that Commissioner Julie Mix McPeak recently announced that she had worked with the BlueCross BlueShield at Tennessee to provide coverage to the folks in East Tennessee. They are in Knoxville, I think 16 surrounding counties. I'm actually from that originally, so I have followed this very in-depth. And, you know, sort of appreciate that.

You know, there have been other coverage announcement about, you know, insurers going through different iterations of whether they are claiming to participate or not. And, you know, I can just tell you, in particular, that's the Department of Insurance are working very actively with their insurers right now.

(Sherry Witty): When do you anticipate the announcement?

Lisa Wilson: Well that, you know, the QHP certification process is a lengthy process, so, you know, we don't sign on the final line. I am sorry, I am blanking on the last day for this year, but, you know, a little bit before the information goes live on healhtcare.gov.

(Sherry Witty): OK.

Lisa Wilson: In anticipation of open enrolment period. So I think that's actually a really important note, you know. Certainly, there are important milestones in the QHP certification process that, you know, we have to work very closely with our colleagues in the insurance industry all throughout that QHP certification process to make sure that they, you know, meet all their appropriate milestones in order for that to be certified to go on the exchange.

(Sherry Witty): OK, thank you.

Operator: Again, if you would like to ask a question, please press star one.

And there are no further questions at this time.

Lisa Wilson: Thanks and thank you for allowing me to circle back here and, you know, I look forward to providing the additional updates as we go through this process.

Eugene Freund: Lisa, thank you very much. So let's move on. I believe (Dave Koppel) and (Liz Lebreton) were on talking about some clinician focus to – not issues, elements of the inpatient prospective payment rule and their upcoming comment period closure.

(David Koppel): Yes, hi, this is (David Koppel). (Liz), yes, actually not on today, it's just me handling this. So the IPPS proposed rule came out in April. And Gene asked me to join to talk about a couple of the proposals that we made that would affect eligible professionals for the Medicaid EHR Incentive program.

So essentially, our goal with these proposals was to align the clinical quality measure requirements for the Medicaid EHR Incentive program with the clinical quality measure requirements of MIPS and the QPP Quality Payment Program on the Medicare side. As an agency has a goal of streamlining and coordinating clinical quality measures. And we want to make sure that providers are able to report on the same ones for both programs, and are able to participate in both programs.

So, the first thing that we did was, we proposed to align the actual list of clinical quality measures that are available for the Medicaid EHR Incentive program with those that are available for electronic reporting under the QPP. So that list of total measures was at 64, nine of them I believe have been – or 11 of them, I believe have been removed for a variety of reasons including that they're not clinically relevant, that they're not measuring what we thought they were measuring and so on.

So I think that list is going from 64 to 53. And then the requirement had been to report nine across three national quality strategy domains. And that requirement was change in QPP to reporting any six. And there are some other requirements, but we – about which that you can choose. But in the Medicaid – for Medicaid EHR Incentive program, we're saying that you can report any six that are relevant to the provider scope practice, so any six that that will meet their requirements for QPP will also meet the requirements for Medicaid.

Second proposal was to change the reporting period for providers who report electronically. And so, we proposed to shorten that from one full year to any 90 consecutive days. And we – there were a variety of reasons that the reporting through was made 90 days in QPP primarily because it's a new program and they would, you know, want to take some lessons learned from the first year and figure out how, you know, what were the pain points were and how they can prove the program. And so, we wanted to align with that and make sure that the same data that was reported to Medicare can – Quality Payment Program can be used to submit data to Medicaid.

That note that does not affect providers who manually attest to clinical quality measures under Medicaid EHR Incentive program. So if a provider is manually entering that data, they will still have a full year reporting period. It also does not affect the prior rule that sort of provided in the first year of meaningful use regardless of how they are attesting, regardless of how they're submitting data. They have a 90-day reporting period.

So first year meaningful users 90 days, electronic reporting 90 days, and then, you know, none first year manual attestation. It's one full year of data. So,

the comment period closes on June 14th and we encourage everybody to submit comment if you believe that, you know, you have something to add or, you know, having opinion that you want a voice. We, you know, will consider all the comments when we are finalizing the rule.

So, is there any questions? Now, I'm happy to take them.

Operator: As a reminder, if you would like to ask a question, please press star one on your telephone keypad. And if you'd like to withdraw your question, you may press the pound key.

Again that's star one.

Eugene Freund: And we can …

Operator: And there's no questions.

Eugene Freund: … we can give a little time for questions.

Operator: OK.

Eugene Freund: Again, I want to stress the importance that if you, you know, if you – especially if you like things that we proposed, make sure that you submit a comment in support. Sometimes, it's a little easier to get comments and opposition to things, because that bothers people. So, especially just so (my internal) Lisa Wilson here reminding, you know, that when you like things please comment as well and, you know, because that comment process is very important to establishing any rules we set up. Thanks a lot (Dave) for the information.

At this point, we have Susie Butler on talking about the Social Security Number Removal Initiative or SSRNI as for short.

Susie Butler: Yes, even though that doesn't make it any easier to say. Thanks so much, Gene.

Hi, everyone, thanks for taking time out of a busy Friday, I'm sure, for a little time with us. I'm hoping that on Tuesday, you got the news release that we sent out about the Social Security Number Removal Initiative. But just to be safe, I've asked Debra to send that link out to all of you after this call. But to highlight that news release, we were talking about the fact that we're sending out new Medicare cards to more than 57.7 million Americans. The Medicare card has the recipients' Social Security Number on it and we see this as a fraud issue, so we are removing that Social Security Number and replacing it with a random alphanumeric series of characters.

We're really trying to prevent fraud and make sure that we're protecting our beneficiaries. And we see this as a way to combat identity theft as well as to safe guard taxpayer dollars. And as I said, these new cards will use a unique randomly assigned number and we're calling this a Medicare Beneficiary Identifier, MBI to replace the old card, which was Social Security number base. We are going to begin mailing new cards to beneficiary in – beneficiaries in April. And that meets the congressional deadline for replacing all Medicare cards by April of 2019.

Providers and beneficiaries will both be able to use secure look up tools, different ones for beneficiaries and providers obviously that will support quick access to the MBI when they need them. There will also be a transition period that runs from April 1st of 2018 to December 31st of 2019 where providers will be able to use either the MBI or the HICN further easing this transition.

We are committed to a successful transition to the MBI for people with Medicare and for the healthcare provider community. We have a website dedicated to this where providers can find the latest information, sign up for newsletter, learn about different calls, other things, find fact sheets, find other products and materials. That is also a link which is in the news announcement and we'll make sure that like I said (Debra) sends this out to everyone.

We're just beginning our public education with the provider community. The beneficiary education will happen more toward the fall after the mailing of the Medicare handbook. We're planning regular calls as a way to make sure that we share updates and answer your questions. And we are going to start those

with more intensity now and we'll continue through the mailing of the cards. And with that, I'll take any questions you might have.

Operator: And again to ask a question please press star one.

And there are no questions at this time.

Susie Butler: OK. Thank you so much for you time everyone.

Eugene Freund: So those in the room actually got a copy of a nice little – "Are You Ready" card that's amongst the materials that are there. We could actually send those copies of those out to people who need them. Couldn't we, Susie?

Susie Butler: Absolutely, and there's a way to order those cards online, so.

Eugene Freund: OK.

Susie Butler: And if anybody has a question Eugene, just – or wants to know how to do that, if any of you have that question, contact (Debra), contact Gene, we'll get them to you.

Eugene Freund: Right. And the webpage does have all kinds of things including widgets so that every time you sent an e-mail, you could remind people of and link back to the website.

Susie Butler: And those widgets were just made live this morning, so that you guys are on the inside scoop.

Eugene Freund: Yes, I just noticed them right now. So thank you very much.

Susie Butler: Thank you, everybody.

Eugene Freund: So everybody has a number of web links that were sent out in advance from Robin Fritter about upcoming Medicare Learning Network Events. And I want to give her a little bit of time to talk about them at this time.

Robin Fritter: Great. Thanks, Gene. Hello, everyone. I work in the provider communications group at CMS in the area that provides information and

resources through the Medicare Learning Network or MLN. I'm sure that many of you are very familiar with the variety of products, publications and services through the MLN. We hold National Provider calls and webcasst periodically on a variety of different topics and I just wanted to bring to your attention the three, well, we have two calls and one webcast scheduled for this month.

So the information that you received highlights the National Partnership to Improve Dementia Care in Nursing Homes call that is being held on June 15th. The target audience for that primarily is reaching to the nursing home providers, the surveyor community, certainly association members representing those provider types in the survey or community.

The second call that we are offering, well, the second event which is the webcast, is focusing on the CLIA, the Clinical Lab Improvement Amendments Requirements for Provider Performed Microscopy Testing or PPM.

The CLIA Amendments establish quality standard to ensure the accuracy and reliability of test results and test performance regardless of where the test is performed. And the webcast will be focusing on those requirements and how to ensure that they are being met. Certainly the target audience here is much more broad to physicians and other practitioners, pathologist, lab directors, lab managers, anyone working in offices or labs or areas where this type of microscopy testing could be performed.

And then, the third call that we have scheduled for this month is focusing on the new changes to the Medicare claims appeal process. There was a final rule we published in January of this year which extended the availability of this streamline appeal process to help reduce the backlog of pending appeals and increasing the consistency in making appeal decisions. So the call will be focused on that and there's also been for certain eligible appeals pending at the Office of Medicare Hearings and Appeals, a possibility of using statistical sampling and that will also be address during the call.

So I just want to let everyone know that our calls and webcasts are, of course, certainly free of charge. There is a link to the registration page for each of these events in the e-mail that Gene provided you. If people are unable to participate in a call or webcast as it is taking place, we do provide a written transcript and an audio recording of every call or webcast on our website about a week after – week to 10 days after each event. So that information can be accessed at a later time.

And I just wanted to thank everyone for your time and attention and also in sharing this information about these MLN events with your members.

Eugene Freund: Do we have any questions?

Operator: If you would like to ask a question, please press star one on your telephone keypad.

And your next question comes from the line Jan Towers with AANP. Your line is open.

Jan Towers: If we did not receive the e-mail with some of these lists, how do we get it?

Eugene Freund: If you just send an e-mail to (Debra) or me, we can forward it on. I think we sent the e-mail to the people who pre-registered. So that's kind of how we're, you know, at least keeping things relatively saying with our materials that we send out such as slides and the like, so.

Jan Towers: OK. So what was the deadline to pre-register?

Eugene Freund: Excuse me?

Jan Towers: I did pre-register, but didn't …

(Off-Mic)

Eugene Freund: OK, so if you, you know, so please just send an e-mail to (Debra) or me, and we can forward that on separately.

Jan Towers: OK. Would she mind giving the dates for over the last two the CLIA and the appeals process in the meantime?

Robin Fritter: Sure, I can do that. The appeals process call is taking place on June 29th from 1:00 to 3:00 p.m., that's Eastern Time. And the CLIA call is the day before, on June 28th from 1:30 to 3:00. And I was also going to let you know that on the CMS website, you can always look at the lists of open calls and events and register for them by going to cms.gov in the Outreach and Education bucket, you can get to the Medicare Learning Network or MLN events. And it's very easy, once you get to that MLN homepage to find the list of Events and Training.

Any other questions for me?

Operator: No further questions at this time.

Eugene Freund: Great. Thank you very much, Robin. We actually don't have (Kelly) with us but I do want to present a few of the updates that she was going forward about the Quality Payment Program before Terri provides us with some information too. And I hope this is recently breaking news that we are announcing that about 100 percent of the eligible clinicians in the advanced APMs are predicted to be a qualifying APM participant and we'll meet either the payment or the patient count thresholds.

That means over 85,000 qualifying participants across the country are making changes to their practices to improve care delivery and spend their valuable time focus on what's important to their patients. So that's some good news.

Of those approximately 11 percent or 14,000 are part of a small or rural practice. So we've got evidence coming in at this point that transformation is quickly moving across the country and you don't really need to big a practice to succeed in the Quality Payment Program. And, you know, that's mainly because you don't need to be a big practice to provide high quality care.

I think I'm going to turn it over to Terri for her part and then we'll open it up for questions. And if there are questions that we don't have answers to especially me, I can try to gather information for the next meeting.

Terri Postma: OK. Thank you, Gene. I'm Terri Postma, Medical Officer lead for the Shared Saving Program (Accountable Care Organizations). You might be familiar with this program. It's a permanent part of Medicare. It's a voluntary program in which groups of Medicare, enrolled providers, and supplier can join together to form Accountable Care Organization or ACOs.

We currently have nearly 500 organizations participating in the program and what I want to mention today to you is that in response to a lot of the questions that we've been getting from eligible clinicians that are participating in Medicare Shared Saving Program ACOs and how that interacts with their reporting requirements and the Quality Payment Program, we developed a guidance document that has been posted on QPP website and Gene, I should – if I didn't already, I'll send you that link, if you could sent it out to folks, that'd be great.

We hope that this guidance document helps clarify some of the questions that we've been getting, and that perhaps you've been getting, from eligible clinicians that are participating in Shared Savings Program ACOs and I'll just at a high level walk through some of the key points of this particular guidance document.

The Shared Savings Program ACOs – the Shared Savings Program offers three different Tracks: Track 1, Track 2, and Track 3. Track 1 is an upside only, risks model that means that the practice – that the clinicians that are participating in ACOs in Track 1 are eligible to share and savings that they generate for Medicare but are not held accountable for any losses. We call that a one sided risk model.

Tracks 2 and 3 however, are – oh also Track 1, then because of that, qualifies as a MIPS APM or Advance Payment Model that you may have heard about. And the clinicians that are participating in ACOs in Track 1 are – that are

MIPS eligible clinicians – get special MIPS APM scoring under the QPP. So that's one point.

There's also Tracks 2 and Track 3 that are offered in the Shared Savings Program. These are what we call two-sided risk track meaning that the organizations that have elected to participate in Track 2 and Track 3 are held accountable for, you know, they could – can qualify the shared savings but they're also held accountable for any losses that they generate.

Because of this, Tracks 2 and 3 of the Shared Savings Program are called Advanced APMs. They meet Advanced APM criteria and what that means for clinicians that are participating in Tracks 2 and Track 3 is that they – if they are determined to be qualifying participants or QPs that was just mentioned, then they're eligible to receive a 5 percent Advanced Payment Model incentive payment instead of the MIPS payment adjustment.

OK, so the document that I referenced walks through that distinction and it also goes on to talk about the special MIPS APM scoring. So this applies to eligible clinicians that are participating in Track 1 ACOs primarily. The importance of that is that when these eligible clinicians – to see what their requirements are under the Quality Payment Program for purposes of MIPS, the reporting requirements are a little bit different.

So as a clinician in a Shared Savings Program ACO, the ACO is required under the Shared Savings Program to report certain quality measures through the web interface. When the ACO does that, they're doing it on behalf of the eligible clinicians that are participating in it. So eligible clinicians under MIPS don't have to report anything else for the quality performance category, the ACO should be taking care of that on your behalf.

For the improvement activities category, as a MIPS clinician in the Shared Savings Program ACO, the clinician doesn't need to report any data for this category either. The reason for that is because CMS has already automatically given clinicians full points for this category for their participation in the ACO. The policy rationale behind that is that as part of the ACO the clinician is

doing a lot of these improvement activities already, and has therefore qualified for full points under that category.

Under the cost category, there are – the cost category is weighted at zero percent. So there's no reporting requirements for eligible clinicians participating in the ACOs for the cost category and they're not going to be assessed on cost under the Quality Payment Program.

The only category that eligible clinicians participating in ACOs need to worry about is the Advancing Care Information category. So under this category, all groups that are participating in Shared Savings Program ACOs must report for this category apart from the ACO in the way that MIPS allows groups to report.

OK, that's important and it's not just eligible clinicians or groups participating in Track 1 ACOs, this also applies to groups that are participating in Track 2 or 3 ACOs. Even though you're exempt from MIPS, you still have to report the ACI category as your group practice according to the way that MIPS permits you to do that. The reason for this is because as a part of – well, first of all as a part that MIPS APM Track 1 ACO, we have under the Shared Savings Program, the ACO is held accountable for the level of use of CEHRT of the participating clinicians.

So in order to calculate that measure for your ACO, we need you to submit the data that we then use to calculate that measure. And then that factors into the amount of share – the amount savings the ACO can share in.

Also as a Track 2 or 3 ACOs, so not only is that, it's an important for you to submit that data so that we can calculate the measure for the ACO, but it's also one of the criterion that we use to designate Track 2 and Track 3 ACOs as advanced APMs.

So because of the presence of that measure that we use to assess ACOs in the Shared Savings Program, that is one of the criterion that were used to ensure that Tracks 2 and 3 could be designated as advanced APMs and therefore

permit you as eligible clinicians participating in them to get that 5 percent APM incentive payment.

So regardless of what kind of ACO you're in, what kind of Shared Savings Program ACO, the eligible clinician is in, the reporting requirements are exactly the same. The ACO – once again, the ACO is going to report for the quality performance category. No additional reporting required there. The improvement activities, you're going to get full points just for being part of the ACO, so no additional reporting on your part.

For the cost category, that category is weighted at zero, so no worries there. The only thing that any eligible clinician has to worry about that's the participating in the Shared Savings Programs ACO is the Advancing Care Information category. Submit your data the way MIPS told you to as a group practice, OK?

One other point on the special MIPS APM scoring is that you're going to see charts for MIPS assessing weights to each category. And I just want to mention that as part of special APM MIPS scoring, those weights for the category a little bit different under the MIPS APM scoring. So the quality performance category in our MIPS APM scoring is 50 percent. Under regular MIPS, it's 60 percent. For improvement activities under the MIPS APM scoring, it's 20 percent. And the Advancing Care Information category is 30 percent. So it's a little bit different.

All this information can be found on the QPP website. There's actually a really good chart in the – in one of the webinars that was – that's listed on the Education and Tools page. If you go there and click on Webinars, you will find a webinar that was specifically designed for Shared Savings Program ACO participants. And there's a really nice chart in there that shows you sort of outlines exactly what I just said, as well as this guidance document that you can find on the QPP website.

I think that's all I want to flag for now. But if you are getting these questions from the clinicians that are participating in Shared Savings Program ACOs, please point to them to this document to help clarify and please help share the

message that as a participant in a Shared Savings Program ACO, their reporting requirements under MIPS are drastically reduced because of their participation.

So thanks a lot. I'm happy to take any questions.

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

And your next questions comes from a line of (James Bovispec) with ACC. Your line is open.

(James Bovispec): Hi, thanks for taking my question. I was going to go back to something Gene said actually. He mentioned some of the success rates for people in advanced APMs, pleased to see some people are succeeding in small and rural practice areas. But I – maybe I just missed this announcement and it's out there somewhere and I couldn't find that while you were speaking. Do you have any information on the rates of specialty physicians in the advanced APMs, specifically maybe cardiology?

Eugene Freund: I do not at the tip of my fingers, that’s something that I can go back and look for it. And, you know, I actually do not know how much those data had been sliced and diced at this point.

(James Bovispec): Got it. And was there a report or announcement posted somewhere, or is this the debut of this knowledge?

Eugene Freund: I actually don't know. I got it from (Kelly). And I don't think it's the debut of that knowledge because generally we don't debut new information on this call. Most of what people bring to this call has already been put out there somewhere. What I'll do is I will identify the source of those data and send out probably a link to them.

(James Bovispec): That sounds great. Thank you so much.

Eugene Freund: So we have that. All right.

Terri Postma: This is Terri. While we're on that subject, I guess one other point that I want to make is that the Q.P. determinations (qualifying participant determinations) that are made for clinicians, eligible clinicians that are participating in Tracks 2 and 3 and other advanced APMs, that's made as you know at those three snapshot dates during 2017. So the first snapshot is 3/31, the second one is 6/30 and the third one is 8/31.

And at each of those points in time, CMS is going to take the ACO participant list and they're going to determine, based on the ACO participant list, whether the participants that are in that ACO collectively have met the Q.P. threshold so that Q.P. threshold determination is done as a collective group. We call – we say it's the "ACO level", so that Q.P. determination isn't made clinician by clinician, or even, you know, group practice by group practice. It's actually made based on the totality of Part B claims that are submitted by the – all the clinicians participating in the ACO and then patient count method is based on the beneficiaries that are assigned to the ACO.

So I just want to make that point, as well as the low volume threshold, by the way, which you also might have heard about. That's also determined at the – what we say, the "ACO level", so with all those clinicians together as a group. And I just want to make that clear because there's been some confusion about that.

Operator: And again, if you would like to ask a question, please press star one.

And there are no further questions at this time.

Eugene Freund: OK. Well, thank you all for participating. I'm pleased that we have managed to eliminate the noise and the interference that was really getting in the way of the other calls and we really didn't planned that those problems to overly encourage in-person participation, but we do want to encourage, you know, those of you who choose and are in the area to visit us here. We're in the same, you know, the same office on Friday afternoon that you've been coming to before. Thanks to those of you who did come in in-person.

And let me know how the call is working, suggestions for topics. We always send a request out and also comments on how it's working for you as they

come to you. And look forward to hearing from you and hearing about other issues in the interim and don't forget to let me know about the July 7th and whether that's a problematic date. We're never sure exactly what's going to be coming out, so it maybe worth having that meeting regardless of people's vacations and the like around the 4th, but I appreciate feedback about that.

And again, thank you very much for calling in.

Operator: Thank you for participating in today's first Friday call, Clinician Outreach Meeting. This call will be available for replay beginning at 4:30 Eastern Time, June 2nd through midnight on June 7th. The conference ID number for the replay is 30481487. Again, that is 30481487. The number to dial for the replay is 1-855-859-2056. Again that is 855-859-2056.

This concludes today's call. You may now disconnect.

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