

Centers for Medicare and Medicaid Services
Rural Health
Open Door Forum
Moderator: Jill Darling
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3:30 p.m. ET

Operator: Good afternoon. My name is (Tiffany) 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 Rural Health Open Door Forum.

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

Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Tiffany). Good morning, good afternoon, everyone. Thank you for joining us today for the Rural Health Open Door Forum.

Before we get into the agenda today, one brief announcement from me, this open door forum is not intended for the press and the remarks are not considered on the record. 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 have any inquiries, please contact cms.press@cms.hhs.gov. And I'll hand the call off to our co-chair, John Hammarlund.

John Hammarlund: Great. Thank you so much, Jill. And on behalf of my co-chair Carol Blackford and me, we're absolutely delighted to have you on today's open door forum call for Rural Health, and thank you for joining.

This is a really reach, robust agenda we have for you today. We're going to be covering some really important topics and we're grateful to all of the speakers from our headquarters who have joined us today to explain various aspects of three very critical proposed rules. Also, we're really pleased to be joined by so many from the CMS regional offices as well.

So, we're going to be highlighting today relevant portions of the Quality Payment Program, Notice of Proposed Rulemaking, the Physician Fee Schedule Proposed Rule and the Outpatient Prospective Payment System Proposed Rule. We will try to highlight the relevant portions for rural providers and stakeholders.

And I just wanted to, before we begin, to just reiterate something that I think is really important for everyone to realize, these are all proposed rules, and they have deadlines coming up to the coming months for us to receive public comment. And I just want to express how much we value your public comments to these proposed rules.

We always know we're going to receive very helpful comments from associations and advocacy groups, and we appreciate those. But we also appreciate comments that come directly from individual practitioners and clinics and hospitals and other providers. There's really is no substitute for just writing to us and letting us know what you think about our proposed policies.

That most helpful way you can comment from our perspective is to let us know how our proposal will impact you in your practice in your ability to deliver high quality health care in your community. And we – the more specific you can be about how a proposed idea is going to impact you, the better. Also, equally helpful is if you have an alternative way that we might go about trying to achieve the same end that we're trying achieve, but that will have, you know, a different sort of regulatory impact on you, you are welcome to suggest those. That is also very, very helpful to us.

We read every single comment that comes in from every single commenter. We take them seriously and it informs our thinking. So I just want to urge

you all to take the time. I know it takes a lot of time to sort of digest these complicated rules if you found them in the Federal Register or on online, but to take some time and think about it and then let us know how it will impact you in the delivery of health care in your community.

We really appreciate it. As I say, we'll read them all and we're going to do our best now during the course of this call to sort of point out the parts of the proposal rules that we think are most relevant for rural providers.

So, I know we'll probably finish this call with Carol Blackford sending out a similar message, but again, I just want to thank you everybody in advance for the comments that we hope to receive from you. We really appreciate it.

So with that, Jill, I will hand it off to you and you can get the agenda started. Thanks very much.

Jill Darling: Thank you, John. First off, we have Adam Richards who have some highlights of the Quality Payment Program NPRM.

Adam Richards: Great. Thanks so much. And good afternoon, everyone.

Again, my aim today is really to provide a high level overview on some of the proposed changes as outlined in the Quality Payment Program Year 2 Proposed Rule; that may be of importance to those who are in both practices in rural settings, but even small practices.

So this will not necessarily be a deep dive into the proposed rule because we could certainly spend the remainder of the afternoon discussing the proposals and I'm sure that's the same with all the proposed rules we'll discuss this afternoon. However, if you are interested in learning more, I certainly encourage each of you to visit qpp.cms.gov and view our comprehensive fact sheet on the rule as well as the rule itself. Also available on qpp.cms.gov are the recordings of our previous webinars to date that focus on the proposed rules. So there's a lot of really good information, a lot of really rich information that is currently available.

Before jumping into some of the more applicable proposals for year two, I do want to take a minute to discuss how we arrived to this proposed rule because I think that's important. We've heard a lot of concerns, certainly a lot of clinician concerns that there are too many quality programs, requirement measures that are getting in the way, getting in between doctors and patients really.

So for year two, we took a hard look at the Quality Payment Program, we looked at what's working, what's not, where we can improve. And we're aiming to continue to reduce burden so that doctors and clinicians can continue to concentrate on what really matters, and that's caring for patients rather than the administrative tasks involved with quality reporting.

So we're going to take it slow into year two. We're going to continue to use your feedback to help shape future program years. So again, I highly encourage each of you to review the proposed changes and officially comment. The open public comment period is currently underway for the Quality Payment Program Year 2 Proposed Rule. The comment period does close on August 21, 2017. So, please make sure that you submit your comment as soon as possible. We do have guidance on how to submit your comments included in both the proposed rule and the proposed rule fact sheet that is available on qpp.cms.gov.

So again, one area that we really focused on was supporting clinicians in small and rural practices under Merit-based Incentive Payment System track of the Quality Payment Program. We made a number of proposals that I believe maybe of some interest to those on the call today.

Starting off, we – and this is just again, this is the MIPS side of the program. We are proposing to raise the low volume threshold from its current level of \$30,000 in Medicare Part B allowed charges and 100 Medicare Part B beneficiaries to \$90,000 in Medicare Part B allowed charges and 200 Part B beneficiaries.

We anticipate that the proposed increase will exempt more clinicians in year two especially those practicing small and rural practices in rural areas which

we believe will help relieve some of the existing burden that may be out there, but also give clinicians more time to potentially prepare for future program years.

We are proposing to implement virtual groups as a participation option for year two. Just so everyone is aware, a virtual group is the combination of two or more TINs, taxpayer identification numbers, which could include both; solo practitioners or group practices with 10 or fewer eligible clinicians under the TIN. We believe that virtual groups provide solo practitioners and small groups with limited resources and technical capabilities, with the ability to join together and really pull their resources.

We have – we've proposed maximum flexibility to help encourage virtual group formation. So for example, those in virtual groups have the ability to determine their own make up without restrictions on geographic area.

So for those of you for practicing in rural areas, we certainly welcome your thoughts on this proposal. There are number of areas, you know, aligned with the virtual group in the proposed rule that we are seeking comment on. So, again, we current – we certainly encourage you to submit your comments to help us shape this important participation option moving forward.

For the MIPS performance categories, and just as reminder that those include quality, cost, improvement activities, and Advancing Care Information. Many of the requirements will remain the same going into year two. I will note that for improvement activities, the improvement activities performance category, we are proposing to continue allowing clinicians in small practices and practices in rural areas to report on no more than two activities to achieve the highest score. For those included in the program this year, you may recall that there are special considerations for small and rural practices. So we double the weight of the improvement activities. So that way, you don't have to report any more than two activities to achieve the completion rate in improvement activities performance category.

For the Advancing Care Information performance category, we are proposing to allow clinicians to use either the 2014 or 2015 certified EHR technology

addition in year two, continuing on with year 1. However, we are proposing to provide a bonus for the use of 2015 certified EHR technology. We are proposing to add a decertification hardship for eligible clinicians whose EHR was decertified through – over the course of the year.

And this is more for small practices but also important because we do realize small practices are also in rural areas. We are proposing to add a new category of exception for small practices to reweight the Advancing Care Information performance category to zero and reallocating the 25 percent to the quality performance category.

We are also proposing additional hardship exceptions under the Advancing Care Information performance category, where the category would generally be reweighted in most instances to quality similar to what we just talked about earlier. And then lastly, we are proposing a new hardship for extenuating circumstances category for the entire MIPS performance category. So, quality, cost, improvement activities, and Advancing Care Information.

There is one that exists today under the Advancing Care Information performance category but we realize that extenuating circumstances, so as an example, you know, natural disasters may exist that would apply for all of the performance categories. So we wanted to make sure that all of those categories were certainly covered.

Moving on, we believe that it is important to reward clinicians who treat complex patients. So we are proposing adding a bonus to the MIPS final score, this may be of some interest to you. We will apply an adjustment of one to three bonus points based on the medical complexity for the patients treated, the patients that you treat using the average Hierarchical Conditions Category or HCC risk score.

Another proposal that I believe that significant to those practicing in rural settings is the small practice bonus. We are proposing to add five bonus points to any MIPS eligible clinician or group who is in a small practice and has at least submitted data on one MIPS performance category.

Now, this is really where those of you on the line can come in because we are seeking comments on whether this bonus should be extended to those who practice in rural areas as well and those practices in rural settings. So that is one major area that we are seeking comments on.

So, those are a number of the high level components and proposals on the MIPS side of the program. Of course, there are additional proposal that we have out there. I think these are more specific to those in rural practices. So, I'm going to move on to the Advanced APM side of the program now. I won't go into great deal of detail for this side of the program because again we could spend quite a bit of time on this. However, I will point to one important proposal that may be of interest in – for you to review and that is the All-Payer Combination Option.

So the MACRA, the Medicare Access and CHIP Reauthorization Act of 2015, the statute created two pathways to allow eligible clinicians to become what we call qualifying APM participants in Advanced APMs. That's how clinicians earn the Advanced APM incentives by earning that qualifying APM participant status.

So there is the – right now, there is the Medicare option and the all – and the All-Payer Combination Option which will be available beginning in 2019, and that's the option that I'm discussing right now.

So, the All-Payer Option allows eligible clinicians to achieve that Q.P. that, that qualifying APM participant status based on a combination of participation and Advanced APM, so within Medicare, and other payer Advanced APMs offered by other payers. So, it's important to note that other payers in this sense may include Medicaid, Medicare health plan. So for example, Medicare Advantage, CMS multi-payer models and other commercial payers.

So, we certainly see comments on the various proposals under this All-Payer Combination Option. Again, I encourage each of you, if you are interested in the Advanced APM side of the program to certainly review our proposals for year two and moving into, you know, the future program years. All – again, all of that information is on qpp.cms.gov.

So that was the very quick and very high level overview of the proposed rule for year two of the Quality Payment Program.

Since we are still in rulemaking, I certainly once again encourage each of you to provide comments on our proposals through the official process. And just as a reminder, please remember that comments are due August 21, 2017.

That's for the entire Quality Payment Program Year 2 Proposed Rule. And as I've mentioned earlier, we do have a number of great resources and materials available for you to review on qpp.cms.gov.

I will just mention very briefly just one last note that this is a proposed rule for year two. I would be remiss if I didn't remind everyone that we are still in the midst of the first performance year, what we're calling the transition year for the Quality Payment Program. So, if you are included in the program and have been actively participating, thank you. We certainly appreciate it and we encourage you to keep up the great work as we chug along toward the end of the first performance year.

For those who are included and are just getting started, I just want to note, there is still a plenty of time to participate for the transition year. And I also want to mention that there is a plenty of support out there to help you. We have plenty of support here at CMS, but we also have some really, really great technical assistance available with some very experienced and professional organizations out there that can certainly help you understand the requirements for the transition year, the first performance year. Or if you're interested in learning more about the proposed year – rule for year two, they can also help you with that.

So with that, I'll turn it back over to Jill. Thank you everyone.

Jill Darling: Thank you, Adam.

Up next, we have some rural highlights under the Physician Fee Schedule Proposed Rule. And first off, we have Marge Watchorn.

Marge Watchorn: Thank you, Jill. Good morning and good afternoon, everybody.

We have several folks lined up today who will share some highlights from the Physician Fee Schedule Proposed Rule. Like the QPP rule, we are in our public comment period. Comments on the Physician Fee Schedule rule are due on Monday, September 11th. And as with all rules, we very much look forward to receiving your comments on our proposals as well as several areas, some of which we will highlight today where we specifically ask for your comments to help inform our thinking as we consider changes in policies moving forward.

So, a couple of areas I wanted to speak about are payment updates to Medicare telehealth services and a couple of other proposals.

First off, this proposed rule would be effective for calendar year 2018. So for next year, we're proposing to add seven codes, both HCPCS codes as well as CPT codes to the lists that we maintain of Medicare telehealth services. Those services include visit to determine low dose computed tomography, interactive complexity, two codes associated with the health risk assessment, care planning for chronic care management, and two codes associated with psychotherapy for crisis.

In addition, in the area of telehealth we're proposing to eliminate the required reporting of the telehealth modifier for professional claims. This is part of our effort to reduce administrative burden for practitioners to provide telehealth services. We're also seeking comments on ways that we can further expand access to Medicare telehealth services within our current statutory authority. We're also seeking comment on whether or not we should consider making payments for several CPT codes that describe remote patient monitoring. I just wanted to note that those services would not be considered Medicare telehealth services as defined by statute.

The last thing I wanted to mention is that for office-based behavioral health services, we're proposing an improvement in the way we set rates that will positively impact these office-based behavioral services with the patients.

The change would increase for these services by better recognizing the overhead expenses for these face-to-face services.

And now, I want to turn it over to Corinne Axelrod.

Corinne Axelrod: Thank you, Marge, and hello everybody.

So in the 2018 Physician Fee Schedule Proposed Rule, we have proposed changing the way RHCs and FQHCs are paid for chronic care management, CCM. And we also proposed payment for RHCs and FQHCs that want to provide general behavioral health integration, BHI, and Psychiatric Collaborative Care Model services which is known as CoCM.

To fully explain the changes we are proposing, we have scheduled a call specifically for RHCs and FQHCs on Tuesday, August 1 from 2:00 to 3:30 Eastern standard time. There is a link on the RHC and FQHC web pages to register for the call, and it will also be in the MLN Connects newsletter which comes out tomorrow.

Briefly, what we are proposing is to create a new general care management G-code for RHCs and FQHCs to use when billing for CCM, and that would include complex CCM or general BHI. And this would be paid at the average of the national non-facility Physician Fee Schedule payment rates for CCM code 99490, complex CCM code 99487, and general BHI code G0507. Using the calendar year 2017 rates, the payment amount for general care management would have been approximately \$61.

We are also proposing to create a new psychiatric CoCM G-code for RHCs and FQHCs to use when billing for either initial or subsequent psychiatric CoCM services. And this would be paid at the average of the national non-facility Physician Fee Schedule payment rates for psychiatric CoCM codes G0502 and G0503. Using the CY 2017 rates, the payment amount for psychiatric CoCM for RHCs and FQHCs would have been approximately \$134.

If you're interested in learning about the requirements for billing these codes and how the payment would work, we encourage you to register for the August 1st National Provider Call. Again, the links are on both the RHC and FQHC web pages and will be included in the weekly MLN Connects newsletter. Thank you.

Jill Darling: Thanks, Corinne. Up next, we have Terri Postma who has some proposed changes in beneficiary assignment for ACOs with FQHCs and RHCs under the Medicare Shared Savings Program.

Terri Postma: Thanks, Jill. And hello everyone. Thanks for having us today.

I'm here to talk about some of the proposals that we're making, one in particular that will impact FQHC and RHC participation on the Shared Savings Program. You may recall that the Shared Savings Program was established in 2011 as a result of the passage of the Affordable Care Act and it provides the forum for providers and suppliers to join together into what are known as Accountable Care Organizations or "ACOs".

The Act required us to assign fee-for-service beneficiaries to an ACO that's participating on the Shared Savings Program based on beneficiaries' use of primary care services furnished by a physician participating in the ACO. So under our rules, we establish beneficiary eligibility requirements for assignment such that if a beneficiary has had at least one primary care service during an assignment window furnished by a physician who is an ACO professional in the ACO, who is a primary care physician or who has a specialty designation used in our assignment methodology, then that beneficiary would be eligible for assignment.

Once we determine the beneficiaries that are eligible, we apply a two-step process to determine if the beneficiary has had enough primary care services, identified by specific HCPCS or CPT codes, to hold the ACO accountable for that beneficiary's care for the performance year.

When we established the Shared Savings Program through rulemaking in 2011, RHC and FQHC stakeholders asked CMS to permit them to form an

ACO and to include their beneficiaries in the assignment methodology. However, FQHC and RHC claims contain very limited information concerning the individual practitioner, or even the type of health professional, who provided the service because this information wasn't necessary to determine payment for services in RHCs and FQHCs. So unlike Physician Fee Schedule claims, there was no direct way for us to determine if a claim was for a service furnished by a physician as the statute required.

Therefore in the absence of special rules under the Shared Saving Program, we wouldn't – we weren't able to establish an eligible pool of beneficiaries because remember the statute requires that a beneficiary be assigned to an ACO and the basis of primary care service furnished by a physician.

So, we established special rules for ACOs that include FQHCs and RHCs, so that their beneficiaries could be considered under the assignment methodology. Specifically, we currently require that at the time of application, as part of the ACO participant list, the ACO has to submit the NPIs (the National Provider Identifiers) of the physicians that provide direct patient care in FQHC and RHC settings and attest to that.

We also use revenue center codes as proxies for primary care services because the prior billing rules – because prior to billing rules that took effect in October 2014 and April 2016, FQHCs and RHCs respectively were not required to use HCPCS or CPT code for billing purposes.

So, that special process that I just described to you that's currently in place imposes an additional burden on ACOs that wish to include or be formed by RHCs and FQHCs. But in addition, due to operational complexities, the program integrity screening and other issues, we only permit submission of NPIs on an annual basis. Our stakeholders have also told us that tracking NPIs across sites of care and a sheer number of necessary submissions is prone to error and may result in fewer claims being considered for purposes of Shared Savings Program assignment than would otherwise occur.

So in part, to address these issues and as a result of your lobbying efforts, Congress passed an amendment to the statutory language governing the

Shares Savings Program assignment methodology in the 21st Century Cures Act in December. The Act amends the Shares Savings Program to require the secretary to assign beneficiaries to ACOs participating on a Shared Savings Program based not only on their utilization of primary care service furnished by a physician but also based on utilization of services furnished by RHCs and FQHCs effective for performance year beginning on or after January 1st, 2019.

The statute provides the Secretary with broad discretion to determine how to incorporate those services into the Shared Savings Program beneficiary assignment methodology. Therefore, because of this broadened flexibility, we're proposing in the Physician Fee Schedule starting with performance year 2019 to: First, remove the requirement for ACOs to identify and attest to physicians who directly provide primary care services in the RHC or FQHC. Second, to use all RHC and FQHC claims to establish beneficiary eligibility for assignment. And finally, consider all RHC and FQHC claims as primary care services without regards to the HCPCS codes that are included on the claims.

We believe that this proposal will drastically reduce the operational burdens for ACOs that include RHCs or FQHCs and bring greater consistency to our assignment methodology.

We're really looking forward to seeing your comments on this (as folks have already stated) through the formal comment process. And we hope that you will find these proposals welcome. Thanks.

Jill Darling: Thank you, Terri.

Now, we're going to move into some rural highlights for the Outpatient Perspective Payment System Proposal. And first up, we have Elisabeth Daniel.

Elisabeth Daniel: Thank you, Jill.

For the 2018 OPSS Proposed Rule, we are proposing to apply a different payment methodology for drugs purchased under the 340B drug pricing program beginning January 1, 2018. The proposed 340B drug payment policy would apply to hospitals paid under the OPSS. So critical access hospitals or CAHs are excluded from this proposal. To be clear, CMS' proposal effects OPSS payment for 340B drugs and does not otherwise change or alter the 340B program criteria rules for participation.

To give the payment proposal a bit of a context, under the OPSS, all hospitals except CAHs are paid the same rate for separately payable drugs regardless of whether the hospital purchased the drug at a discount through the 340B program. Likewise, Medicare beneficiaries are responsible for a copayment that is equal to 20 percent of the OPSS payment rate regardless of the 340B purchase price for the drugs.

For 2018, we are proposing to amend our OPSS drug payment methodology for 340B hospitals that we believe would better and more appropriately, reflect the resources and acquisition costs that these hospitals incur. These changes would allow Medicare beneficiaries and the Medicare program to pay less when hospitals participating in the 340B program furnish drugs to Medicare beneficiaries that are purchased under the 340B program.

Specifically, we are proposing to pay for separately payable drugs and biologicals that are obtained with the 340B discount other than drugs on pass-through status and vaccines at the average sales price or ASP minus 22.5 percent. Put another way, drugs with status indicator K, as in kitchen that are purchased through the 340B program are proposed to be paid at ASP minus 22.5 percent. Separate payable drugs that are not purchased with the 340B discount will continue to be paid at ASP plus 6 percent.

As mentioned in the proposed rule, while it's not a proposal, we intend to establish a claim level HCPCS modifier that would indicate that a separately payable was not purchased with the 340B discount. Details on the modifier and other technical guidance on billing for 340B purchased drugs will be communicated through either sub-regulatory guidance document after publication of the 2018 OPSS final rule or – and/or in the 2018 final rule.

Finally, as part of the 340B payment proposal, we invite comment on a view specific elements that include whether to apply a different payment rate to account for the average minimum discount of OPPS drugs purchased under the 340B program, whether to phase in the payment adjustment, whether 340B hospital should report their acquisition cost for OPPS drugs on the claim, whether certain groups of hospitals such as cancer or sole community hospitals should be except from this proposal, and whether other types of drugs such as blood clotting factor should be excluded from this proposal.

This concludes my review of the payment policy and I'll turn it over to Tiffany.

Tiffany Swygert: Sure. Hi. This is Tiffany Swygert. Good afternoon everyone.

For physician supervision, what's generally required for outpatient services is the direct supervision requirement. And this has been an item of great interest to rural providers. In 2009 and 2010, we clarified that the direct physician supervision requirement was required for outpatient – hospital outpatient therapeutic services that are furnished in hospitals as well as critical access hospitals and provider-based departments of hospitals.

For several years, as you are likely aware, there has been a moratorium on the enforcement of this direct supervision requirement for therapeutic services and small rural hospitals that those are hospitals located in rural areas with fewer than 100 beds or with 100 or a fewer beds, excuse me, as well as for all critical access hospitals. We continue to hear concerns about recruitment issues in these hospitals that are located in rural areas and that this policy in particular was problematic particularly for critical access hospitals in small rural hospitals.

Accordingly, in the 2018 rule, we are proposing to reinstate the moratorium on the direct supervision on the enforcement of the direct supervision requirement for two years. So that would be for 2018 and 2019. And we are soliciting comments on that proposal.

With that, I will turn it over to (Lela Strong) to talk about the inpatient only list.

(Lela Strong): Thanks, Tiffany.

The Medicare inpatient only list includes procedures that are typically provided only in an inpatient setting and are only paid under the hospital inpatient prospective payment system.

Each year, CMS establish criteria to review the inpatient only list and determine whether or not any procedure should be removed from the list. Most notably for 2018, CMS is proposing to remove total knee arthroplasty from the inpatient only list. The 2018 OPPS/ASC proposed rule seeks comment regarding whether partial and total hip arthroplasty should be removed from the inpatient only list.

In addition, CMS is soliciting comments on whether total knee arthroplasty, partial hip arthroplasty and total hip arthroplasty meet the criteria to be added to the ASC cover procedures' list.

And now, I'm going to turn it over to Sarah Shirey-Losso to talk about the laboratory date of service policy.

Sarah Shirey-Losso: Hello. We are inviting comments on potential revisions to the laboratory date of service policy.

Under the current date of service policy, if the test is ordered less than 14 days after the date of the patient's discharge from a hospital, the hospital bills Medicare for the test and then pays the laboratory that performs the test if the laboratory provided the test under arrangement.

CMS has received feedback from stakeholders that the date of service policy creates unintentional operational burden for hospitals and the laboratories that perform molecular pathology tests and certain advanced diagnostic laboratory tests. Therefore, we are considering potential modifications to the date of service policy that would allow laboratories to bill Medicare directly for

molecular pathology and advanced diagnostic laboratory tests which are excluded from the OPPTS packaging policy and ordered less than 14 days following the date of the patient's discharge from the hospital.

We are seeking information from stakeholders on whether these tests by their nature are appropriately separable from a hospital stay that preceded the test and therefore should have a date of service that is the date of performance rather than the date of the specimen collection.

We look forward to your comments. Thanks.

Jill Darling: All right. Well, thank you and to all of our speakers. And (Tiffany), we'll go into our Q&A please.

Operator: Thank you for participating in today's conference call. To ask a question, please press star followed by the number one on your telephone keypad. If you would like to withdraw your question, press pound key.

Please submit your questions to one question and one follow-up to allow other participants' time for question. If you require any further follow-up, you may press star one again to rejoin the queue. Again, that is star one on your telephone keypad to ask a question.

There are no questions in queue at this time.

Carol Blackford: All right. Well, this is Carol Blackford, co-chair of this Rural Health Open Door Forum Calls. And I want to extend my appreciation to all of the CMS folks who walked through some of these really important provisions and our proposed payments rules, and to extend our appreciation to all the folks on the call who – hopefully this information was helpful to you.

I do want to reiterate a comment that John made at the beginning of the call. Please take advantage of the comment periods for these rules and send us your comments on the provisions that we talked about today. There are also more detailed provisions included in each – both the PFS and the OPPTS Proposed Rules. We obviously didn't have time to go through each and every provision

today. But I do encourage you to take a look at those documents. They are available on – links to those documents are available on the CMS website, in addition to press releases and fact sheets on both of the rules

So please take advantage of the opportunity to submit those comments. As John, mentioned we do read each and every comment that comes in and your feedback does inform our decision-making for policies included in the final rule.

I also wanted to take a quick moment to mention that all of the proposed payment rules for the Medicare Fee-For-Service Program include request for information on flexibilities and efficiencies. We are looking for feedback on positive solutions to achieve – to better achieve transparency, flexibility, program simplification, and innovation. This will inform the discussion on future regulatory action related to outpatient services, physician services, all of our payment systems.

And we are looking for ideas for regulatory, sub-regulatory policy, practice, procedural changes, things that we can do to do better accomplish the goals as stated in, as I just mentioned, achieving transparency, flexibility, program simplification and innovation.

So, in addition to comments on the specific payment and policy proposals included in our rules, we do have this request for information and we encourage you to submit comments to that. And instructions for submitting comments to that request for information are included in the proposed rule documents.

So, I look forward to receiving your feedback and I look forward to your participation in future open door forum calls. Thank you.

Operator: Thank you for participating in today's Rural Health Open Door Forum Conference Call. This call will be available for replay beginning today at 6:30 Eastern through midnight on July 24th. The conference I.D. number for the replay is 60357503. The number to dial for the replay is 855-859-2056.

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

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