

Centers for Medicare & Medicaid Services
Physicians, Nurses and Allied Health
Open Door Forum
Moderator: Jill Darling
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2:00 p.m. ET

OPERATOR: Good afternoon. My name is (Chris) and I'll be your conference facilitator today. At this time, I'd like to welcome everyone to the Centers for Medicare & Medicaid Services Physicians, Nurses and Allied Health Open Door Forum.

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

Operator: Jill Darling, you may begin your conference.

Jill Darling: Thanks, (Chris). Good morning and good afternoon. I'm Jill Darling in the CMS Office of Communications and welcome to today's Physicians Open Door Forum.

Before we dive into today's agenda, I have a brief announcement. 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 at press@cms.hhs.gov.

And now I will hand the call over to Marge Watchorn.

Marge Watchorn: Thank you, Jill. Hi, everybody, and thank you so much for joining us today for the Physician and Allied Health Open Door Forum. Today, we're very

pleased to be able to provide you some information about the provisions in the Calendar Year 2018 Physician Fee Schedule Proposed Rule, which went on display in the Federal Register July 13th. It was formally published last Friday, July 21st. And public comments will be due on the rule on Monday, September 11th. So we have a number of speakers today who are going to be going over some of the key provisions. We definitely look forward to your questions at that end of the presentation.

First, I'll give an overview of the PFS, Physician Fee Schedule Payment Update; first, regarding the target for misvalued codes as well as the overall update to the Physician Fee Schedule amount. The overall update for calendar 2018 would be an increase of 0.31 percent. This update reflects an increase of 0.0 – 0.5, excuse me, 0.5 percent, which was established under MACRA. And that update is reduced by 0.19 percent due to the misvalued code target recapture amount which is required under the ABLE Act.

In the proposed rule, we've proposed misvalued code changes that would achieve approximately 0.31 percent in that expenditure expense reductions. And if finalized, these changes would not meet the misvalued code target for calendar year 2018, which is 0.5 percent, which is why the increase that would otherwise be 0.5 percent would be reduced by 0.19 percent.

After applying these adjustments as well as the budget neutrality adjustment to account for changes and relative value units, all of which are required by law, the proposed PFS conversion factor for next year would be \$35.99, which is an increase to the 2017 PFS conversion factor of \$35.89. So that's a 10-cent increase.

Next, I wanted to give you a little update on what's happening with mammography services. We're not proposing any significant changes to the payment rates for diagnostic and screening mammography for next year. We are planning to adopt the CPT coding for screening mammography, bilateral diagnostic mammography, and unilateral diagnostic mammography. Currently, these services are reported to Medicare using HCPCS coding.

We previously adopted values that were recommended to us by the AMA's Relative Value Scale Update Committee for the professional component of those services in calendar year 2017. We have not proposed to adopt the values that were recommended to us for the technical component. We believe that those values, if adopted, would result in significant reductions for the technical component of mammography services. So, again, we are not proposing to adopt those values, which would have resulted in a decrease in payment for those services.

Next, little update on what's happening in the world of opioid addiction relative to the Physician Fee Schedule. This year, we're proposing to make payment for services describing the insertion and removal of buprenorphine hydrochloride drug implants for the treatment of opioid addiction. We're also proposing an improvement in the way rates are set that would positively impact office-based behavioral health services with the patient. The proposed change increase payment for these services by better recognizing overhead expenses for office-based face-to-face services with the patient.

Next, we have some updates regarding Medicare telehealth services and remote patient monitoring. For next year, we're proposing to add seven codes to the list of Medicare telehealth services. These services include a visit to determine low dose computed tomography eligibility, interactive complexity, health risk assessment, care planning for chronic care management, and psychotherapy for crisis.

Additionally, in the proposed rule, we are proposing to eliminate the required reporting of the telehealth modifier for professional claims as part of our overall effort to reduce the administrative burden for practitioners. We're also seeking comment on ways to further expand access to telehealth services within our current statutory authority. We're also seeking comment on whether or not we should make separate payments for several CPT codes that describe remote patient monitoring. We note that such services would not be considered Medicare telehealth services as defined by statute.

Next, a quick update on the global surgery claims-based data collection. We are not making any changes to the requirements pertaining to global surgery

data collection that we finalized for the current calendar year. I'm sure you're aware that the claims-based data collection went into effect July 1 of this year. And also I wanted to remind you that we are not proposing to implement any payment penalty for practitioners that do not submit the required claims-based information.

Next, an update for you on the payment rates under the Physician Fee Schedule for non-excepted items and services furnished by non-excepted off-campus provider-based departments of hospitals. This is also known as the provision Section 603 of the Bipartisan Budget Act of 2015. Section 603 requires that certain items and services furnished by off-campus hospital outpatient provider-based departments will no longer be paid under the Outpatient Prospective Payment System beginning January 1 of this year. And for this calendar year, we finalized the Physician Fee Schedule as the applicable payment system for most of these items and services.

For next year, we're proposing to reduce the current PFS payment rates for these items and services by 50 percent. Currently, we pay for these items and services under the PFS based on a percentage of the OPPS payment rate. The proposal for next year would change the PFS payment rates for these services from 50 percent of the OPPS payment rate to 25 percent of the OPPS rate. We believe that this adjustment would encourage fairer competition between hospitals and physician practices by promoting greater payment alignment.

Next, I want to talk about a couple of burden reduction initiatives that we have in the PFS this year. In addition to the payment and policy proposals, we released a request – for a request for information or RFI. The goal is to welcome feedback on positive solutions to better achieve transparency, flexibility, program simplification, and innovation. And we're hoping that the information we receive from this RFI will inform the discussion on future regulatory actions related to the PFS.

We want to start really a national conversation about improving the health care delivery system, about how Medicare can contribute to making the delivery system less bureaucratic and complex, and how we can reduce

burden for clinicians, providers, and patients in a way that increases the quality of care and decreases the cost.

I want to note that this RFI is one that we have included in all of our Medicare payment rules this year. So if you read it and the language seems familiar, it's because we really want to make this effort across all of our Medicare payment systems. And we definitely look forward to your comments and participation in that process.

Next, I want to talk a little bit about evaluation and management guidelines. Most physicians and other practitioners' bill patient visits as you know to the Physician Fee Schedule under a relatively generic set of codes that distinguish level of complexity, the site of care, and in some cases whether or not the patient is new or established. These are called Evaluation and Management codes or E&M visit codes.

Billing practitioners must maintain information in the medical record that documents that they have reported the appropriate level of an E&M visit code. Currently, there's five levels of E&M visit codes. CMS maintains guidelines that specify the kind of information that is required to support Medicare payment for each level. There are three key components to selecting the appropriate level, which are history of present illness, physical examination, and medical decision-making.

We've received feedback from stakeholders that the guidelines could be outdated and might need to be revised, especially the history and the exam components. So in this rule, we're seeking comment from stakeholders on specific changes that we should undertake to update the guidelines, to reduce the associated burden, and to better align E&M coding and documentation with the current practice of medicine.

And finally with regard to care management, we're continuing efforts to improve payment for chronic care management and similar care management services. We're proposing to adopt the CPT codes for next year for reporting several care management services that are currently reported to Medicare using HCPCS codes. We're also seeking public comment on ways that we

might further reduce burden on reporting practitioners for chronic care management and similar services, for example, through stronger alignment between CMS requirements and CPT's guidance for existing and potential new codes.

And now, I'll turn it over to Nina Brown-Ashford for some information about the Medicare Diabetes Prevention Program Model.

Nina Brown-Ashford: Great. Thank you. Hi, everyone. My name is Nina Brown-Ashford, and I'm the Deputy Group Director for the Prevention and Population Health Group here at the CMS Innovation Center. I'm going to provide you a brief overview of the Medicare Diabetes Prevention Program expansion, how we got here, and then talk at a high level about some of the proposals in the 2018 Physician Fee Schedule Proposed Rule.

So I'm sure many are aware, diabetes affects more than 25 percent of Americans aged 65 and older, and we anticipate that the prevalence is expected to double for all U.S. adults by 2050. In addition, we know that Americans, 65 and older with diabetes, account for roughly \$104 billion annually and these costs are growing. The good news is that type 2 diabetes is typically preventable with appropriate lifestyle changes.

In 2012, the Innovation Center awarded the Health Care Innovation Awards to the Young Men's Christian Association, also known as the YMCA, to test whether the Diabetes Prevention Program, or DPP services, could be successfully furnished by non-physician community-based organizations to Medicare beneficiaries that were diagnosed with prediabetes.

Between February of 2013 and June of 2015, the Y-USA in partnership with 17 local Ys and a number of other organizations actually delivered DPP and enrolled about 7,800 Medicare beneficiaries. And we saw outstanding results. About 83 percent of those beneficiaries attended at least four core sessions and 63 percent completed nine or more sessions. We also saw that beneficiaries who attended at least one core session lost an average of about 7.6 pounds and beneficiaries who attended four core sessions lost an average of 9 pounds.

When we looked at these health outcomes in terms of session attendance and weight loss, and the cost-savings achieved from those weight reductions, we saw that the program saved about \$2,600 per Medicare beneficiaries. Due to this success, the Y-USA award actually met the requirements under Section 1115AC of the Affordable Care Act and provided the secretary with the authority to expand the model to the rest of the Medicare program.

So, what is the MDPP benefit? It is a minimum of 16 core sessions that are delivered within the first six months followed by monthly maintenance sessions delivered in the second six months. We have added this or expanded this service as an additional preventive service, which means that Medicare beneficiaries will have access to the DPP benefit with no cost-sharing.

When we look at the eligibility of organizations who are able to provide the service, they must first obtain CDC recognition. That's the first step to be able to enroll in Medicare and provide the MDPP service. And so, once they have obtained that CDC recognition, they will actually then enroll in Medicare as MDPP suppliers.

Anybody that is an existing Medicare provider, so they already be enrolled for various types of services, will have to reenroll and adhere to the same requirement. They of course have to get CDC recognition and then they can reenroll as an MDPP supplier in order to provide this benefit.

When we look at who's eligible to receive the benefit from the beneficiary perspective, they have to be Part B Medicare beneficiaries. They have to have a BMI of greater than 25 or 23 for Asians. They have to have lab results that actually demonstrate high blood glucose levels, and no prior history of type 1 or type 2 diabetes. As I mentioned, this is being added as an additional preventive service benefit but it is a once for lifetime per beneficiary benefit. So once the beneficiary starts receiving the DPP services, that is – they have to complete the program in that period and that is the only time they will be eligible to receive reimbursement from Medicare for those services.

It is a 12-month benefit that includes, as I mentioned earlier, those core sessions and monthly maintenance sessions and then ongoing maintenance session if the beneficiary has achieved the necessary weight loss. There is no referral required to receive the benefit so beneficiaries can self-refer.

In the 2017 Physician Fee Schedule, we finalized a number of policies that really outlined the basic program structure including, eligibility for both beneficiaries and MDPP suppliers. We discussed the actual benefit and what that would include, and a number of policy areas that outlines the basic infrastructure of the benefit.

So in the 2018 Physician Fee Schedule Proposed Rule, we have further expanded to provide additional information on a number of additional program policies that we are now seeking public comment on.

I'll just touch at a very high level on what some of those are. The first is the effective date. We had originally set the effective date as of January 1 of 2018. We have now moved that effective date to April 1 of 2018, and suppliers can begin enrolling in Medicare beginning January 1 of 2018. We wanted to give folks enough time to make sure that they had the ability to enroll to be able to begin providing the service on the effective date.

We also added some proposed policies around the actual services, beneficiary eligibility, and payment. We proposed that beneficiaries who received a diabetes diagnosis during their participation in the program would not be prevented from continuing services. We've also proposed a two-year limit on maintenance sessions. So beneficiaries must attend three sessions and actually maintain a minimum of 5 percent weight loss at least once in the previous ongoing maintenance session interval in order to be eligible for additional maintenance sessions after that first interval.

We proposed a performance-based payment structure, which really links the payment to performance goals that are based on attendance and weight loss. The outcomes that were measured in the original Y-USA award at least are described in detail in the rule. Subsequently, we also proposed corresponding Healthcare Common Procedure Coding System G-codes or HCPCS G-codes

that the suppliers will use to submit claims for payment when all of the requirements for the billing codes have been met.

In addition, we also proposed to provide a bridge payment as a one time \$25 payment for an MDPP supplier furnishing its first session to a beneficiary who has previously received services from a different MDPP supplier. And really, this was intended to help account for any financial risk that a subsequent MDPP supplier might take on by furnishing a service to a beneficiary that changed suppliers in the middle of their service period.

We proposed a number of policies and provisions around supplier enrollment and compliance. I won't go into all of those in detail. But we did propose to establish a number of standards to mitigate fraud, waste, and abuse and ensure fidelity of the MDPP expanded model, and also provided some requirements around record keeping and as it relates to maintaining the beneficiary records of the – for participation.

We lastly provided some proposals around beneficiary engagement incentives and really proposed that supplies may choose to provide in kind patient engagement incentives to a beneficiary to assist the supplier in furnishing high quality services as well as engaging the beneficiary in health behavior change program. As we know, we want to keep them engaged in attending sessions as the more sessions you attend, the higher weight loss you achieve.

And lastly, we did consider including exclusively virtual service provision of the MDPP in the expanded model. However, because the original Y-USA test that met the statutory requirements did not include these virtual services, we do not propose to include DPP that is furnished exclusively through remote technologies with no in-person delivery in this proposed rule.

So we are very excited and look forward to receiving any comments you have on these proposals. And now, I will turn it over to Alesia Hovatter.

Alesia Hovatter: Thank you so much, Nina. This is Alesia Hovatter with the Center for Clinical Standards and Quality at CMS. Today, I'll briefly discuss the Physician Quality Reporting System and Value Modifier proposed policies.

In order to better align incentives and provide a smoother transition to the new Medicare Incentive Program under the Quality Payment Program, we are proposing changes for the final year of the Physician Quality Reporting System also known as PQRS, and the Value Modifier.

For the 2018 PQRS payment adjustments, which are based on reporting data for 2016, we are proposing to change the current PQRS program policy that requires reporting of nine measures across three National Quality Strategy domains to only require reporting of six measures. We are also proposing similar changes to the clinical quality measure reporting requirements under the Medicare Electronic Health Record Incentive Program for clinicians that electronically reported their quality measures through PQRS.

We are proposing that, for the 2018 Value Modifier: we would reduce the automatic downward payment adjustment for not meeting minimum quality reporting requirements from negative 4 percent to negative 2 percent for groups of 10 or more clinicians, and from negative 2 percent to negative 1 percent both physician and non-physician solo practitioners and those in groups of two to nine clinicians.

We would hold all groups and solo practitioners who met minimum quality reporting requirements harmless from downward payment adjustments for performance under quality-tiering for the last year of the program. And we would align the maximum upward adjustment amount for all physician groups and solo practices to two times the adjustment factor by reducing the maximum upward adjustment from four times the adjustment factor for groups of 10 or more.

For the last year of the Value Modifier program, because we are not using performance data to apply any downward adjustments, we would not post Value Modifier performance data on Physician Compare as we had previously finalized that we would do. In order to promote transparency in Value

Modifier performance data, we have made available and will continue to make available public use files and research identifiable files for each year of the program.

Thank you so much. And, Rasheeda, I'll pass it to you.

Rasheeda Johnson: Thank you, Alesia. This is Rasheeda Johnson from the Division of Ambulatory Services. The Clinical Laboratory Fee Schedule final rule entitled Medicare Program: Medicare Clinical Diagnostic Laboratory Tests Payment System implements Section 1834A of the Social Security Act, which requires extensive revisions to the Medicare payment, coding, and coverage for Clinical Diagnostic Laboratory Test paid under the CLFS.

Under the final rule, the payment amount for a test on the CLFS furnished on or after January 1, 2018 will be equal to the weighted median of the private payer rates determined for the test, based on the data of the applicable laboratories that is collected during a specified data collection period and reported to CMS during specified data reporting period.

The first data collection period was from January 1 through June 30th, 2016, and the first reporting period was from January 1, 2017 through March 31st, 2017. Laboratory industry feedback suggested that many reporting entities would not be able to submit a complete set of applicable information to CMS by the March 31st, 2017 deadline. As a result, on March 30th, 2017, we announced a 60-day period of enforcement discretion until May 30th, 2017, with respect to the data reporting period for reporting applicable information under the Medicare CLFS and the application of the Secretary's potential assessment of civil monetary penalties, CMPs, for failure to report applicable information.

CMS is seeking comments from applicable laboratories regarding their experience with the first data collection and reporting periods under the new private payer rate-based CLFS payment system. Comments received will be used to inform CMS for potential refinement of future data collection and reporting periods. In closing, all comments may be submitted following instructions found in the proposed rule.

And this concludes my portion of the agenda. Our next speaker Edmund Kasaitis who will discuss the comment solicitations for biosimilars.

Edmund Kasaitis: Thanks, Rasheeda. So biosimilar payment policy, as you probably know, for Part B, groups products with the same reference product. And the result is one HCPCS code and a weighted average ASP for these products. Now, although the United States biosimilar product marketplace is still in an early phase and we've only got about three products on the market right now, three Part B products on the market right now, we're interested in assessing the effects of our policy.

So we're seeking comments in this rule. We're particularly interested in data that's related to the U.S. marketplace, especially data that's based on experience here in the United States. We're also interested in market analyses or research articles on the economics of the U.S. biosimilar market, the role of individual HCPCS codes in payment, and also we're interested in hearing about other novel payment policies that would help increase competition, improve access, and result in cost-savings.

In summary, we're looking for evidence to help us make decisions and our goal remains a healthy, robust and competitive marketplace.

Finally, I just wanted to remind you this is a solicitation for comments. We're not making a proposal to change existing policy in this rule.

And up next, I want to turn this over to JoAnna Baldwin who will be talking about advanced diagnostic imaging. Thanks.

JoAnna Baldwin: Hi, everyone. This is JoAnna Baldwin. I'm going to talk about the proposal for the Appropriate Use Criteria Program for Advanced Diagnostic Imaging.

CMS is proposing to implement this program in a manner that allows practitioners more time to focus on and adjust to the Quality Payment Program among many other things. The Medicare AUC program is proposed to begin with an educational and operations testing year in 2019. What this

means is that physicians would be required to start using Appropriate Use Criteria, and they would be required to start reporting this information on their Medicare claims. But during this first year, CMS is proposing to pay claims for these services regardless of whether they contain information on the AUC consultation. This way both clinicians and the agency can prepare to begin this new program.

In conjunction with the proposed rule, we posted a list of newly qualified provider-led entities and clinical decision support mechanisms. So the qualified provider-led entities, these are the entities that are permitted to develop Appropriate Use Criteria, and then the qualified clinical decision support mechanisms are the tools through which the physicians can access the Appropriate Use Criteria.

So physicians can begin exploring these mechanisms. They are posted on our website, and they can start doing this well in advance of when the Medicare AUC program is to begin. In addition, by having these qualified clinical decision support mechanisms available and there are some of which that are free of charge, clinicians can use one of the mechanisms to earn credit under the Merit-Based Incentive Payment System as an improvement activity. The improvement activity was included in the Quality Payment Program proposed rule, and that rule was separately released on June 20th of this year. We are seeking and interested in getting comments from our stakeholders and from the public that help us to better understand the current readiness of the physicians of our hospitals, of all the outpatient centers, all of those that are involved in advanced imaging.

So in particular, we are seeking comments related to whether the program should begin as proposed, January 2019, with this educational and testing year, or if the public believe this should be delayed beyond that proposed start date. And for stakeholders that would like to comment on those lines, we're very interested in hearing how long, for example if longer than just one extra year should such a period the educational and operations testing period be available. We're interested to know if 12 months is enough time to allow our folks to prepare.

And that's all I have on the AUC program.

Jill Darling: All right. Thank you, JoAnna. And last but not the least, we have Felicia Lane who has some updates on Open Payments.

Felicia Lane: OK, great. Thank you so much. I'm from the Center for Program Integrity Data Sharing and Partnership Group in the Division of Data and Informatics. As a reminder, the Open Payments Program is a national program that promotes transparency by publishing data on financial relationships between the health care industry (applicable manufacturers and group purchasing organizations (GPOs) and health care providers (physicians and teaching hospitals).

The data includes payments and other transfers of value made to the physicians and teaching hospitals along with the ownership and investment interests held by physicians or their immediate family members in the reporting organizations. This data is required to be published on our public website and on Friday, June the 30th, CMS published its third full year of Open Payments data, with Program Year 2013 being a partial year. This publication consists of Program Year 2016 data as well as any newly submitted and updated payment records for Program Years 2013 through 2015.

In Program Year 2016, applicable manufacturers and group purchasing organizations reported 11.96 million records consisting of \$8.18 billion in payments and ownership and investment interests to the physicians and teaching hospitals. Payments in three major categories are: General payments (which are non-research related payments), Research payments, and Ownership and Investment interests.

In Program Year 2016, payments in these three major categories were: \$2.80 billion in General payments, \$4.36 billion in Research payments, and \$1.02 billion in Ownership and Investment interest held by physicians or their immediate family members. A summary of Program Year 2016 data and the Program Years 2013 through 2015 is available at openpaymentsdata.cms.gov

Over the course of Open Payments Program, CMS has published 40.77 million records accounting for \$24.94 billion in payments and ownership and investment interests. As a reminder, physicians and teaching hospitals are able to review the data attribute to them and may initiate disputes on any data they believe to be incomplete or inaccurate prior to the data being published. In addition, disputes may be initiated through the end of the calendar year in which the record is first published.

Next in January 2018, Open Payments will have a data refresh publication which includes a refresh of all the records published on June the 30th, data published will be the latest attested-to data as of the end of December 31st of this year, and updates to records between June the 30th publication date up until the end of the calendar year.

That's all that I had. Thank you for allowing me the opportunity to share this information. So I'll turn it back over to Jill.

Jill Darling: Thank you, Felicia and to all of our speakers today. And I will hand it over to (Chris) to open up our Q&A, please.

Operator: Thank you. And as a reminder, ladies and gentlemen, if you'd like to ask a question, please press star then one on your telephone keypad. And if you'd like to withdraw your question, press the pound key.

Please limit your questions to one question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may press star one again to rejoin the queue.

And the first question comes from the line of Jan Towers with AANP. Your line is open.

Jan Towers: OK. I wanted some more information related to where we can find the things related to – the information related to the advanced diagnostic imaging and the PQRS modifier policies.

Hello?

JoAnna Baldwin: Hi, this is JoAnna Baldwin. I can address the first question about the information for Appropriate Use Criteria for advanced diagnostic imaging.

We have on our website, which I understand where you are able to send a follow-up to this call, and we can include the link on exactly where to go to get this information. On the cms.gov homepage and then clicking the Medicare button, we have a link towards the bottom of that page that says Appropriate Use Criteria Program. And at that link is where you will find the list of qualified provider-led entities that develop Appropriate Use Criteria as well as the clinical decision support mechanisms. You'll see that some have been fully qualified and some are not quite fully qualified yet. They are working towards full qualification. We have those listed there as well.

We also then within that page have additional links. We've been setting up this program over the last three years using rulemaking, and we have links to all of the information that we put out each year related to the program.

And then I think your second question was about ...

Jan Towers: I tried to form it into one question since we have a limit to one question, but it was about PQRS. Where can we find those – that information?

Alesia Hovatter: Thanks. And this is Alesia for PQRS. What was the question? Where you could find the information on the Physicians Fee Schedule?

Jan Towers: The PQRS information.

Alesia Hovatter: All of the proposed policies that we have for PQRS this year are in the Physician Fee Schedule rule.

Jan Towers: OK, OK.

Alesia Hovatter: That is available for public comment right now.

Jan Towers: OK. And this is still – the PQRS will not be in existence after next year, is that still correct?

Alesia Hovatter: That is still correct. Yes, the Quality Payment Program will be the new program.

Jan Towers: The new what?

Alesia Hovatter: That will be the new incentive program.

Jan Towers: OK. It's very hard to hear you for some reason. Thank you.

Operator: And again, that is star one on your telephone keypad if you'd like to ask a question.

And I'm showing no further questions at this time.

Jill Darling: All right. Well, thank you everyone for joining today's Physician Open Door Forum. We will send out that e-mail blurb announcement from JoAnna Baldwin. So, thank you, again. And the date for the next one is scheduled for August 30th, but please note that that date is subject to change as well as the agenda item. So, have a great day everyone.

Operator: Thank you for participating in today's Physicians, Nurses and Allied Health Open Door Forum Conference Call. This call will be available for replay beginning today at 5:00 p.m. Eastern Time through midnight on July 28th. The conference ID number for the replay is 60388319. And the number to dial for the replay is 855-859-2056.

This concludes today's conference call and you may now disconnect. Thank you.

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