

Centers for Medicare and Medicaid Services  
Hospital  
Open Door Forum  
Moderator: Jill Darling  
Tuesday, July 31, 2018  
1:00 pm CT

Coordinator: Welcome everyone to today's conference call. At this time your lines have been placed on listen-only for today's conference until the question and answer portion of our call at which time you will be prompted to press Star 1 on your touch-tone phone. Please be sure to unmute your phone line and record your name when prompted so that I may introduce you to ask your question. Our conference is also being recorded and if you have any objections you may disconnect at this time. I will now turn the conference over to our host, Ms. Jill Darling. Ma'am you may proceed.

Jill Darling: All right thank you (Jill) and welcome everyone to today's Hospital Open Door Forum. I'm Jill Darling in the CMS Office of Communication. And before we get into today's pretty long agenda, just 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 at [press@cms.hhs.gov](mailto:press@cms.hhs.gov). And I'll now hand the call off to our Chair Tiffany Swygert.

Tiffany Swygert: Thanks Jill. Hi everyone. I'm Tiffany Swygert the Director of the Division of Outpatient Care here at CMS and I want to welcome you all to this call today. We do have a rather long agenda as Jill mentioned. We will be covering some

of the highlights from the calendar year 2019 Outpatient Prospective Payment System in Ambulatory Surgical Center Payment System Proposed Rule.

Before we jump into that I just wanted to remind folks that we are now in the comment period which is a 60 day public comment period which is set to end on September 24. We know that there are a lot of proposals in the rule and we very much hope that folks will submit their public comments for our consideration for development for the final rule. In addition the hospital outpatient panel or payment panel will also be held to discuss OPPS issues. The agenda will be forthcoming. We hope that those who are in the area are able to join us in person for that. The first day will be on August 20. There will also be information for how to join by or how to join virtually as well.

So with that I'm going to start discussing just a couple of issues that were in the rule and then we have a number of other folks who will discuss the highlights of other issues as well. The first issue that I wanted to talk about is a drug payment related policy which for those of you who have or who are familiar with the Physician fee schedule rule may already be somewhat familiar with a similar proposal. With respect to the OPPS rule for 2019 we are proposing to pay separately payable drugs and biological products that do not have pass through payment status and are not acquired under the 340B drug program at wholesale acquisition cost that's WAC plus 3% instead of WAC plus 6%.

If WAC data are not available for a drug or biological product we're proposing to continue our policy to pay these drugs at 95% of the average wholesale price. Drugs and biologicals that are required under the 340 B program would continue to be paid at ASP minus 22-1/2%, WAC minus 22-1/2% or 69.46% of average wholesale price as applicable. Again this proposal is intended to apply under the OPPS wherever the WAC plus 6% payment

policy would otherwise apply rather than WAC plus 6% the proposal is to pay WAC plus 3%.

In addition there was a request for information in the proposed rule related to price transparency. This is a proposal that was included in several of the proposed rules the payment proposed rules under the Medicare Fee-for-Service program. With respect to the request for information or RFI in this proposed rule we're seeking your thoughts on how we can empower consumers through better transparency on prices for health services. CMS has already taken some steps to improve price transparency as well as patient empowerment. For example CMS is expanding the data we make available to researchers through public use files. CMS is taking an API approach to modernize how we exchange data with our partners. CMS also recently updated our hospital charge master guidelines to require hospitals to post their charges online in a machine readable format.

We know that these initial efforts don't fully address patient needs but we're just getting started and through RFIs such as this one we are asking the public for ideas about what additional information patients may need to make informed decisions about their care. We very much need and request your ideas and input and we need the benefit of your individual expertise and experience. We look forward to hearing from you on this important initiative. With that I will turn it over to David Rice.

David Rice: Hi everyone. I'm David Rice the Deputy Director of the Division of Outpatient Care. In accordance with statute CMS is proposing to update the Outpatient Prospective Payment System payment rates by 1.25% in 2019. This update is based on the projected hospital market basket increase of 2.8% minus both a .8% adjustment for multifactor productivity and a .75 percentage point adjustment required by law. Overall OPPS payments are expected to

increase in 2019 by about \$5 billion with aggregate payments that include beneficiary cost sharing expected to be around \$75 billion compared to \$70 billion in 2018. Know that this projected increase is primarily due to projected baseline growth in enrollment, case mix and utilization rather than changes proposed in this rule.

Moving on to the Ambulatory Surgical Center rate update previously CMS had updated ASC payment rates each year by the percentage increase in the Consumer Price Index for all urban consumers which is also known as CPIU. In the 2017 proposed rule CMS solicited recommendations and ideas on ASC payment system reform. For this 2019 OPPS/ASC proposed rule in response to the comments received CMS is proposing to update ASC payment rates using the hospital market basket rather than CPIU for 2019 through 2023.

We also seek comment on an alternative program proposal to maintain CPIU while collecting evidence to justify a different payment update or adopting a new proposed payment update based on the hospital Market basket continuing permanently. We also request comment on what type of evidence should be used to justify a different payment update and how CMS should go about collecting this information in the least burdensome way possible.

Using the hospital market basket update CMS proposes to update ASC rates for 2019 by 2% which is the projected hospital market basket increase of 2.8% minus a .8 percentage point adjustment for multifactor productivity. CMS believes this change will help to promote site neutrality between hospitals and ASCs by helping to address the disparity in payment between hospital outpatient rates and ASC rates for the same service.

Based on this proposed update we estimate the total payments to ASC including beneficiary cost sharing and estimated changes in enrollment,

utilization and case mix for 2019 will be approximately \$4.9 billion, an increase of approximately \$300 million compared to estimated 2018 Medicare payments. At this point I'd like to pass it over to (Lela Strong) who will discuss payment for non-opioid pain management therapy.

(Lela Strong): Thank you Dave. The Presidents Commission on combating drug addiction and the opioid crisis recommended that CMS review its payment policies for certain drugs that function as a supply specifically non-opioid pain management treatment. Currently drugs that function as a surgical supply are packaged under the OPPS and the ASC payment systems.

In response to this recommendation as well as stakeholder requests and our own internal data analysis for calendar year 2019 we're proposing to pay separately an average sales price or ASP plus 6% for non-opioid pain management drugs that function as a supply when used in a private surgical procedure when the procedure is performed in an Ambulatory Surgical Center or ASC. We are not proposing any changes to the OPPS packaging policy for drugs that function as a supply for 2019 however we are interested in comments on whether there may be evidence to suggest that separate payment under the OPPS may be appropriate.

Also we're seeking comments regarding whether there are other non-opioid treatments for acute or chronic pain including other drugs or devices that might be affected by OPPS and ASC packaging policies and warrant separate payment. And we are requesting evidence that such non-opioid alternatives leads to a reduction in opioid prescriptions and addiction. We are also interested in comments regarding whether we should provide separate payment for non-opioid pain management treatment using a mechanism such as an equitable payment adjustment under our authority at Section 1833P2E of

the act which allows for adjustment as determined to be necessary to ensure equitable payments.

Lastly we're interested in comments on whether a reorganization of the APC structure for procedures involving non-opioid pain management treatment or establishing more granular APC groupings for specific and device combinations would better achieve our goal of incentivizing increased use of non-opioid alternatives. Now I'll turn it over to my calling Elise Barringer.

Elise Barringer: Hi. We're going to be talking about the preferred one common solicitation on a method two control unnecessary increases in volume of outpatient services. CMS has been concerned that there has been an unnecessary increase in the volume of clinic visits furnished in Off-Campus Provider-Based Departments. We believe that payment incentives in the form of higher payment amounts under the OPPS may have driven services from the physician's office to Off-Campus Provider-Based Departments or PBDs. To address this concern we are proposing to pay for clinic visits furnished in and off campus PBD that is otherwise paid under the OPPS that is it is an accepted PBD at a Physician fee schedule or PFS equivalent rate.

Paying for clinic visits furnished in accepted off campus provider based department as the PFS equivalent rate removes this payment incentive. We believe that this change will allow for greater physician and beneficiary choice of a site of service selection and will control unnecessary increases in the volume for this covered outpatient department service. Additionally this proposed change would result in lower copayments for beneficiaries and savings for the Medicare program and taxpayers which are estimated to be \$760 million for 2019. For an individual Medicare beneficiary current Medicare payment for the clinic visit is approximately \$116 with \$23 being the average copayment amount. Our proposal to adjust this payment to the

PFS equivalent rate would bring the payment rates down to \$46 and the copayment to \$9 thus saving beneficiaries an average of \$14 per visit.

In addition to the proposal we are making for 2019 we are interested in public feedback on additional items or services that may be over utilized in hospital outpatient departments in subsequent years. We are also interested in comments on what other methods could be employed to control for unnecessary increases and hospital outpatient department utilization. And now I'll turn it over to my colleague Juan Cortes to talk about the expansion of services at PBDs paid under the OPSS.

Juan Cortes: Good afternoon everyone. This is Juan Cortes and I'll be talking about the expansion of services at PBDs paid under the OPSS. In the calendar year 2017 OPSS ASC proposed rule we proposed that if an accepted off campus provider based department furnished items or services from a clinical family of services but it did not furnish prior to November 2, 2015 and thus did not also bill for services from these new clinical families of services will not be considered covered outpatient services under the OPSS and instead will be paid under the MPSS.

Although it is not finalized for a proposal in the calendar year 2017 OPSS ASC final rule we express concern that if accepted Off-Campus Provider-Based Departments could expand pass-through services provided at their facilities and also be paid OPSS rate – rates for these new pass-through services hospitals may be able to purchase additional physician practices and expand services furnished by assisting accepted Off-Campus Provider-Based Departments as a result. We continue to be concerned that if accepted off-campus PBDs are allowed to furnish new pass-through services that are not provided such facilities prior to the date of enactment of the Bipartisan Budget Act of 2015 and can be paid OPSS rates for these new pass-through services

hospitals may be able to purchase additional physician practices and add those physician practices to assist in accepted off-campus PBDs.

Resulting in newly purchased physician practices furnishing services that are paid out OPPS rates which we believe Section 603 Amendment to Section 1833T of the Social Security Act are intended to prevent. Therefore for CY 2019 we're proposing that if accepted off-campus provider-based department furnishes a service from a clinical family of services for which it did not previously furnish the service and subsequently bill for that service prior to November 2, 2015 services from this new clinical family of services will not be considered covered outpatient services under the OPPS instead services in the new clinical family of services will be paid under MPSS.

Additionally if unaccepted off-campus provider-based department did not furnish services under the OPPS until after November 1, 2014 we're proposing that the one year baseline period begins on the first date off-campus PBD furnished covered outpatient services prior to November 2, 2015. For providers that met the mid-bill requirement we're proposing to establish a one year baseline period that begins on the first date at the off-campus provider-based department furnish of service billed under the OPPS. We're proposing changes to our regulations at 42 CFR 41948 to include these alternatives based on periods.

I will now talk about the proposal to apply 340B drug payment policy to non-accepted off-campus PBDs. In the calendar year 2017 OPPS ASC final rule we implemented Section 603 of the Bipartisan Budget Act of 2015. As a general matter applicable items and services furnished by certain off-campus outpatient departments of the provider on or after January 1, 2017 are not considered covered outpatient services for purposes of payment under the



OPPS and are paid under the applicable payment system which is generally the Physician fee schedule or PFS.

In 2018 OPPS ASC final rule we finalized the payment policy that separately payable covered outpatient drugs and biologicals acquired under the 340B program are paid ASP minus 22.5% rather than ASP plus 6% when billed by a hospital paid under the OPPS that is not accepted from the payment adjustment. These changes better reflect the resources and physician costs that 340B participating hospitals incur. For calendar year 2019 we are proposing to extend this policy to 340B acquired drugs furnished by non-accepted cross campus provider-based departments that's not accepted of departments at the hospital are still eligible for the 340B discount. Now I'll turn it over to my colleague Josh McFeeters.

Josh McFeeters: Thank you Juan. I'm Josh McFeeters. And I'm an analyst here in the Division of Outpatient Care. The next topic we will discuss is the payment for biosimilar products supplied under the 340B program. For calendar year 2019 we are proposing changes to our Medicare Part B drug payment methodology for biosimilars acquired under the 340B program specifically for calendar year 2019 and subsequent years we're proposing to pay non-pass-through biosimilars acquired under the 340B program at ASP minus 22.5% of the biosimilars ASP, and so the biosimilars ASP minus 22.5% of the reference products ASP.

The next topic we're going to discuss is Section 1301 of the Consolidated Appropriations Act of 2018. Section 1301A1 of the Consolidated Appropriations Act of 2018 provides that for drugs or biologicals whose period of pass-through payment status ended on December 31, 2017 and for which payment was packaged into a covered hospital outpatient service furnished beginning on January 1, 2018 such pass-through payment status

shall be extended for a two year period beginning in October 1, 2018 through September 30, 2020. For calendar year 2019 we are proposing to continue pass-through payment status for drugs and biologicals consistent with the statute.

In addition the law requires that payment amount for such drugs or biological does – drugs or biologicals that are furnished during the period beginning in October 1, 2018 and ending on March 31, 2019 shall be the greater of either the payment amount that would otherwise apply under Section 1833 Subsection T Subsection 6 Subsection B Subsection I of the act for such drug or biological during first period or option two the payment amount that applied under Section 1833 Subsection T subsection 6 Subsection B Subsection I of the act for such drug or biological on December 31, 2017. We intend to address pass-through payment for these drugs and biologicals for the last quarter of calendar year 2018 through similar regulatory guidance.

For January 1, 2019 through March 31, 2018 we are proposing that pass-through payment for these four drugs and biologicals would be the greater of one, ASP plus 6% based on current ASP data or two, the payment rate for the drug or biological on December 31, 2017. We are also proposing that for the period of April 1, 2019 through December 31, 2019 that the pass-through payment amount for these drugs and biologicals would be the amount that applies under Section 1833 Subsection T Subsection 6 Subsection B Subsection I of the act.

Now we're going to proceed to the next topic which is new technology APC payment for extremely low volume procedures. For calendar year 2019 we are proposing to apply a smoothing methodology based on multiple years of claims data to establish a more stable rate for services assigned to new technology APCs of fewer than 100 claims per year under the OPPS which we

classify as low volume procedures. We are concerned that the methodology we use to estimate the cost of a procedure under the OPPS by calculating the geometric mean for all separately paid claims for HCPCS procedure code on the most recent available year of claims data may not generate an accurate estimate of the accurate – of the actual cost of the procedure.

Under the smoothing methodology we would calculate the geometric mean cost, a median cost and the arithmetic mean cost for these procedures to promote payment stability. We believe that using the median or arithmetic mean rather the geometric mean may be more appropriate in some cases. We'll give an opportunity for the public to comment on the services price using an alternative statistical methodology and rule making. Finally we are proposing to exclude low volume services from bundling into comprehensive APC procedures. This proposal will generate more claims that will be available to certain rates for new technology services which helps achieve our objective to gather sufficient claims data to enable us to assign the new technology service through appropriate clinical APC.

The next topic I'll discuss is our skin substitute payment policy proposed. Skin substitute products are packaged into their associated surgical procedures as a part of a broader policy to package all drugs and biologicals that function as supplies when used as a surgical procedure. Under current policy skin substitute products are either placed into a high cost group or a low cost group in order to ensure adequate resource homogeneity among APC assignments for the skin substitute application procedures. This involves the comparison of both the Mean Unit Cost otherwise referred to as the MUC and the Per Day Cost referred to as the PDC of these products.

Some shareholders have raised concerns about significant fluctuation in both the MUC threshold in the PDC threshold from year to year. A fluctuation in

these thresholds may result in the reassignment of several skin substitutes from the high cost group to the low cost group which under current payment rates can result in a significant payment difference for the same procedure. In order to allow additional time to evaluate concerns and suggestions from stakeholders about the volatility of the MUC and PDC thresholds for calendar year 2019 we have proposed to continue our policy from 2018 that a skin substitute that was assigned to the high cost group for calendar year 2018 will be assigned to the high cost group for calendar 2019 even if it does not exceed the calendar year 2019 MUC or PDC thresholds.

In addition for consideration for calendar year 2020 and subsequent years we request that public comments on ideas to change the skin substitutes payment methodology. These ideas include and one establishing a lump sum episode based payment for a wound care episode or a single payment or multiple payments to be designated to improve the quality of care a beneficiary receives while reducing excessive application of skin substitute products. Two, eliminating the high cost low cost categories for skin substitutes and only having one payment category and one set of procedure codes for all skin substitute products this option would reduce the financial incentives to use expensive skin substitutes and will provide incentive to use less costly skin substitute products that have been shown to have similar efficacy treating wounds as more expensive skin substitute products.

Three, we could allow for the payment of current add-on codes or create additional procedure codes, pay for skin graft services between 26 square centimeters and 99 square centimeters and for services that are – include a substantial over 100 square centimeters of the skin substitute product. The final major proposal that was – idea that was proposed in this RFI was to keep the high and low cost skin substitute category but change the threshold used to assign the skin substitute in the high or low cost group. The thresholds will be

designed to limit the number of products that annually switch between a low cost and high cost category. Again we seek comments on the ideas described the rule and welcome other alternative ideas from stakeholders as well for consideration for the calendar year 2020 rule making cycle. Thank you and I will turn over the discussion to (Twi Jackson).

(Twi Jackson): Thank you Josh. Effective January 1, 2019 CMS is implementing a HCPCSs level modifier to be reported on all hospital outpatient claims submitted by provider-based off-campus emergency departments. The creation and implementation of this new modifier which was previously recommended by MedPAC will allow CMS to collect data on the volume of acuity level of the services provided in these EDs and allow us to observe any significant shifts in the volume or service mix or services furnished in off-campus provider-based emergency departments. Additionally while the modifier is not a proposal in the proposed rule we are recommending stakeholder feedback on the modifier as well as associated issues with off-campus provider-based emergency departments. We also note that critical access hospitals are not required to report this modifier.

Also in this proposed rule in efforts to more appropriately cover cost for procedures that involve certain high cost devices we are proposing to modify the criteria for device intensive procedures. Specifically we're proposing to grant – we are proposing to grant device intensive status to procedures with a device offset exceeding 30% of the procedures mean costs that involve implantable devices including single use devices that must be surgically inserted or implanted and are assigned a CPT or HCPCS code.

This – the proposed criteria would allow procedures that use costly implantable medical devices that do not remain in the patient's body after the conclusion of the procedures to be device intensive. Additionally the 30%

amount would be used as a default device offset amount for device intensive procedures for which there is no claims data. I will now turn it over to (Scott Talaga) who will talk about the proposed changes to the ASC risk of covered surgical procedures.

(Scott Talaga): Thank you Troy. Under the ASC payment system a surgical procedure is currently defined as any procedure described within the range of category one CPT codes that the CPT editorial panel of the AMA defined as surgery, those are CPT codes within the 10,000 through 69,999 range. We have also included as surgical procedures those procedures that are described by Level II HCPCS codes or by Category III CPT codes that directly crosswalk or are clinically similar to procedures in CPT surgical range that we had determined do not pose a significant safety risk, will not be expected to require an overnight stay were performed in an ASC and are separately paid under the OPPS.

For calendar year 2019 CMS is proposing to revise our definition of surgery to account for surgery like procedures that are described by Category I CPT codes that are not in the surgical range but directly crosswalk or are clinically similar to procedures in the Category I CPT surgical range. These codes will be limited to those that we have determined do not pose a significant safety risk, will not be expected to require an overnight stay when performed in an ASC and are separately paid under the OPPS.

For calendar year 2019 we are also proposing to add 12 cardiac catheterization procedures to the list for calendar year 2019. In addition for calendar year 2019 CMS is proposing to review all procedures that were added to the ASC covered procedures list within the last three calendar years to ascertain the ASC and patient experience with these recently added procedures. Under this proposal our reassessment will begin with procedures added to the covered

procedures list in calendar years 2015, 2016 and 2017. We will assess whether newly added procedures continue to meet our definition or criteria for addition to the list. We are also seeking comment from members of the public on whether these procedures continue to meet the criteria to remain on the ASC covered procedures list. And now I will turn it over to Anita Bhatia.

Anita Bhatia: Thank you Scott, good afternoon. I am Anita Bhatia, a program lead with the Center for Clinical Standards and Quality. And I am here today to outline the quality reporting proposals contained within this rule. The Hospital Outpatient and Ambulatory Physical Center Quality Reporting program proposal for this proposed rule are made within the framework of the Meaningful Measures and Patients Over Paperwork Initiative to achieve the goal of measures sets that focus on the most critical quality issues while minimizing burdens for clinicians and providers.

Proposals for measure removals as well as administrative updates to reduce paperwork burden and to simplify and clarify program requirements were made and include form removal, alignment of measure removal criteria between the two programs and increasing of reporting period timeframes to increase claims based measure reliability. If finalized these proposals will remove ten measures from the Hospital Outpatient Quality Reporting Program leaving 13 measures reducing total provider burden by an estimated 262,820 hours and approximately 9.6 million and would remove eight measures from the Ambulatory Surgical Center Quality Reporting program leaving three measures reducing total facility burden by an estimated 154,061 hours and approximately 5.6 million.

In addition, a proposal for the Hospital Inpatient Quality Reporting program is included in this rule. If finalized this proposal will modify the Hospital Consumer Assessment of Healthcare Providers and Systems also known as

HCAHPS, Patient Experience of Care survey measure by removing the three recently revised pain communication questions starting with January 1, 2022 discharges for this fiscal year 2024 payment determination and subsequent years.

Although we are not aware of any scientific studies that support an association between scores on the prior or current iterations of the communication of about pain questions and opioid prescribing practices out of an abundance of caution and to avoid any potential unintended consequences we are proposing this update to the HCAHPS survey by removing the communication about pain question. I am here to address any hospital outpatient or ASC quality reporting questions. Mr. Bill Lehrman is here for HCAHPS questions. Thank you and the session can now be returned back to Jill Darling. Jill?

Jill Darling: Thank you Anita. Up next we have Ellen Lukens.

Ellen Lukens: Hi there. This is Ellen Lukens. And I'm the Division Director for Ambulatory Payment Models within the Center for Medicare and Medicaid Innovation. As part of this rule we included a request for information to leverage the authority of the Competitive Acquisition Program where you may have referred it – heard it referred to as the CAP program to potentially develop an innovation center model. And the goal of this model consistent with other CMMI models would be to reduce Medicare expenditures while maintaining or improving the quality of care furnished to beneficiaries. In this RFI we seek feedback on ways to design such a model that would test private sector vendor administered payment arrangements for Part B drugs and biologicals. We've previously asked for input and comments on the potential CAP model including through President Trump's blueprint to lower drug prices and those comments have been very helpful to us.



This RFI goes a little bit further in asking for specific input on model parameters. And examples of those parameters would be the types of providers and suppliers that should be included in the model, the types of Medicare Part B drugs and biologicals that may be best suited to this kind of model and the role of the vendor including the role of the vendor in negotiating and administering value based arrangements with manufacturers. We also are soliciting input on beneficiary incentives and protections. We welcome comments from stakeholders on all of those parameters. This input is really invaluable to us as we develop models and we as we continue to work through the specifics of a potential CAP model. With that I will turn it back to Jill Darling.

Jill Darling: Thank you Ellen. And last we have Bill Lehrman who wants to share some information on the new podcast on the HCAHPS online Web site.

Bill Lehrman: Thank you Jill. This is Bill Lehrman. I work in the Center for Medicare at CMS on the HCAHPS survey. And I'd like to announce a series of three new podcasts about calculating HCAHPS scores. About a week ago we added a new podcast to the HCAHPS online Web site and I'll give that - throw that out to you for you in a minute. This podcast is about the calculating patient scores, from patient discharges to completed survey. It's the first of three podcasts that will cover the topic of HCAHPS score calculations and will review the steps needed to be followed in order to draw an HCAHPS sample and ultimately calculate completed surveys.

In the next week or two we will add two more podcasts to HCAHPS online: one is about how to calculate the patient adjustment that we use when we calculate HCAHPS scores before we publicly report them and a third one is about how we calculate the top box composite score which is publicly reported on Hospital Compare. So we report the top box, middle box and

bottom box scores. Most people are interested in top box scores and this podcast which will be available in early August walks you through the process of how we calculate the top box scores.

Finally I'd like to remind you that there is also a podcast on HCAHPS online about how to improve response rates. In this podcast hospitals can find a lot of practical information about how they can examine response rates and steps they might possibly take to improve their response rates. And all those podcasts are on HCAHPS online that is spelled H-C-A-H-P-S-O-N-L-I-N-E.org (HCAHPSonline.org) and you can find them under the podcast button on that Web site. Thank you Jill.

Jill Darling: All right thank you Bill and thank you to all of our speakers today. (Jill), please open the lines for Q&A please.

Tiffany Swygert: ...if there remains to be confusion. Thank you for that question and thank you everyone for all of your questions today and your participation on this call. We really value your input and we know that there are a lot of proposals in the rule. We just a reminder the public comment period does end on September 24. Obviously we welcome comments before that day but we'll certainly expect or accept them all the way through September 24. And we'll take all of them into consideration in the development of the final rule.

So again if there are any questions there is a number of folks who are listed in the proposed rule we obviously can't answer or provide information that's not already in the rule but if there are, you know, general questions or if you believe that there is a mistake or an error please don't hesitate to let us know and if it's something that we can address we will certainly do so. And again

the hospital outpatient panel on outpatient payment is coming up next month  
so we hope to see at least some of you there. Thank you.

Coordinator: That does conclude today's conference call. We thank you all for  
participating. You may now disconnect and have a great rest of your day.

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