

Centers for Medicare & Medicaid Services
Rural Health Open Door Forum
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Jill Darling: Good morning and good afternoon. Thank you so much, and again, welcome, everybody. We do apologize for the very short notice of the re-registration technical difficulties that we sometimes stumble upon, but as always, we appreciate your patience for that. Again, welcome to today's Rural Health Open Door Forum. My name is Jill Darling, and I'm in the Office of Communications here at CMS. Before we begin, I have a few announcements.

This webinar is being recorded. The recording and transcript will be available in about two weeks or so after today's webinar on the CMS Open Door Forum Podcast and Transcript webpage. That link is on the agenda. If you are a member of the press, you may listen in, but please refrain from asking questions during today's webinar. If you do have any questions, please email press@cms.hhs.gov. All participants are muted. For those who need closed captioning, a link will be provided and located in the chat function of the webinar. We will be taking questions at the end of the agenda today, and for today's webinar, there are no slides except for the agenda slide that you see right now. When it is time for questions, you may use the raise hand feature at the bottom of your screen, and we will call on you to ask your question and one follow-up question, and we will do our best to get to your questions today. And now I will turn over to our co-chair, John Hammarlund.

John Hammarlund: Hello everyone. I am John Hammarlund, I'm Deputy Director of CMS's Office of Program Operations and Local Engagement, and I'm joining you from my home office in Seattle, Washington. Thank you so much for joining this month's Open Door Forum call. As you can see from the slide, we have a very robust agenda. This is what I call payment rule season. So, we wanted to make sure that we brought on all of the experts to talk with you about some key provisions and some of these major payment rules. So, we appreciate all who joined us today to be part of this informative session.

I will let you know that while we have not yet scheduled a November Open Door Forum call, we do have the intention of scheduling one next month as well. That's because we have some more payment rules coming up, and we want to make sure that we bring those issues to your attention. So somewhere, I don't know, we don't have a date yet, but somewhere, maybe around the second week of November or something like that, we will have another ODF with some other important provisions for you. So, stay tuned for that, and it will also give you a chance to celebrate National World Health Day with you all on November 16.

I also want to let you know that these agendas are built primarily from the topics that we believe at CMS are important for you to hear. We do our very best to distill down the firehose of information that comes out of our agency into those things that we think are particularly

pertinent for rural providers in rural communities, and we do so because we want to make sure that you have good information that is digestible and that you can use. But these agendas should also be built from your input, and as always, we will be inviting you at the end of this meeting to help us build the agendas of future meetings. We really would like to get your input on what you would like to hear from, so Jill will offer the email box that you can write us on in the chat, and I do encourage you to help us build the agendas in the future. Once again, welcome on behalf of Ing-Jye Cheng and myself. We are delighted to have you; it looks like we have a big audience today, and we are going to launch right into the agenda. We will turn it over now to Amanda Gardner, who will talk about the 2024 Hospice Final Rule, so Amanda, take it away.

Amanda Gardner: Thank you so much, John. On July 28, 2023, CMS issued the Fiscal Year 2024 Hospice Final Rule that updates Medicare hospice payments and the aggregate cap amount for the Fiscal Year 2024 in accordance with the existing statutory and regulatory requirements. The Fiscal Year 2024 final rule has a payment update percentage of 3.1%, which is an estimated increase of 780 million in payments for fiscal year 2023. This is the result of the 3.3% inpatient hospital market basket percentage increase reduced by a 0.2 percentage point productivity adjustment.

The Consolidated Appropriations Act of 2021 changed the payment reduction for hospices who failed to meet the hospice quality reporting requirements from 2 to 4 percentage points. Therefore, beginning in Fiscal Year 2024 and for each subsequent year, hospices that fail to meet quality reporting payment requirements will receive a four-percentage-point reduction to the annual hospice payment update percentage for that year. The Fiscal Year 2024 rates for hospices that do not submit the required quality data is updated by the final fiscal year hospice payment update percentage of 3.1% minus four percentage points, which results in a negative 0.9% update. The fiscal year 2024 Hospice Final Rule also updates and includes its statutory aggregate cap amount that limits the overall payments per patient that is made to a hospice annually. The hospice cap amount for Fiscal Year 2024 is 33,494, which is equal to the Fiscal Year 2023 cap amount updated by the market basket percentage increase of 3.1%. And finally, this rule finalizes conforming regulations steps changes related to the expiration of the COVID-19 Public Health Emergency. Now, I will hand it over to Renate.

Renate Dombrowski: Thank you. I will give a summary regarding the Rural Emergency Hospital (REH) Medical Graduate Education (GME) Provision, which was included in the Fiscal Year of 2024, IPPS final rule. This provision finalizes CMS's proposal to support residency training in rural areas by considering REHs as allowable training sites for Medicare Graduate Medical Education payments. The provision provides similar flexibilities to REHs that are provided to critical access hospitals when it comes to residency training. Effective October 1, an REH can be considered a non-provider site, which means another hospital can send residents to train at the REH and be paid for that training if the other hospital pays the residents' salaries and benefits, or the REH can choose to be paid directly at 100% of reasonable costs for the cost that it incurs in training residents. Now, I will turn over to Dan to discuss the wage index.

Dan Schroder: Good afternoon! This is Dan Schroder. I have two brief updates on new proposals for FY 2024. First off is the continuation of the low-wage hospital policy. CMS finalized a policy to continue the temporary policy finalized in FY 2020 to address wage index

disparities affecting low-wage index hospitals, which includes many rural hospitals. At this time, we only have one year of relevant data from FY20 that we could use to evaluate any potential impacts of the policy. Since CMS does not have sufficient data from the time period that this policy has been in effect, we believe it was appropriate to continue this policy while we obtain additional data.

Second issue of note is a change to the calculation of the rural wage index methodology. It also affects the rural floor policy. CMS has taken into consideration recent public comments that have urged it to change its wage index policies involving the treatment of hospitals that have reclassified from urban to rural under Section 1886(d)(8)(E) of the Social Security Act. We also refer to these as 412.103 hospitals for regulation. CMS is proposing to interpret that Section 1886(d)(8)(E) of the Social Security Act is intended to treat all rural reclassified hospitals the same as geographically rural hospitals for the purpose of calculating the wage index. Specifically, we will include all hospitals with 412.103 reclassifications where applicable in the rural wage index calculations as described in the preamble of the rule for FY 2024.

Under Section 44 10a of the Balanced Budget Act of 1997, the area wage index applicable for any hospital located in an urban area of the state may not be less than the area wage index for hospitals located in rural areas of that state. This provision is referred to as the Rural Floor. We will include data for all 412.103 reclassified hospitals in the calculation of the wage index for the rural area of the state and the calculation of the Rural Floor for the urban hospitals in that state, effective for FY 2024. I will throw it back to you for the SNF update.

Tammy Luo: Thank you, Dan. Good afternoon, everyone. For the Fiscal Year 2024 updates, the SNF payment rates, on July 31, 2023, the Centers for Medicare and Medicaid Services issued a final rule that updates Medicare payment policies and rates for Skilled Nursing Facilities under the SNF Prospective Payments for Fiscal Year 2024. CMS estimates that the aggregate impact of the payment policies in this rule would result in a net increase of 4% or approximately 1.4 billion in Medicare Part A payments to SNFs. This estimate reflects a 2.2 billion increase resulting from the 6.4% net market basket update to the payment rates, which is based on a 3% SNF market basket market increase plus a 3.6% market basket forecast error adjustment and a 0.2% productivity percentage adjustment as well as a negative 2.3% or approximately 789 million decrease in the Fiscal Year 2024 SNF PPS rates as a result of the second phase of the Patient-Driven Payment Model (PDPM) parity adjustment recalibration.

Note that on September 29, CMS released a correction notice that corrects a technical error in the calculation of the final Fiscal Year 2024 SNF PPS wage indexes. Which also required provisions to the wage index budget neutrality factor, the unadjusted SNF PPS federal per diem rates, and the case mix adjusted SNF PPS rates.

Next, the technical changes in the PDPM ICD 10 code mappings. The PDPM utilizes ICD 10 diagnosis codes in several ways, including using the person's primary diagnosis to assign patients to clinical categories. In response to stakeholder feedback and to improve consistency between the ICD 10 code mappings and the current ICD 10 coding guidelines, CMS is finalizing several technical changes to the PDPM ICD code mappings. Note that on September 29, CMS released a correction notice that corrected some errors in the PDPM's ICD 10 code mappings. Finally, for

the exclusion of marriage and family mental health counselor services from SNF consolidated billing, the Consolidated Appropriations Act of 2023 requires Medicare to exclude MFT and NET services from SNF consolidated billing. Exclusion from consolidated billing allows these services to be billed separately by the performing clinician rather than be included in the Medicare Part A SNF payment. We finalized regulatory text changes required to codify this new legislative] requirement to exclude MFT and MHT services from the SNF consolidated billing for services furnished on or after January 1, 2024. And with that will turn over to Chris Palmer.

Chris Palmer: Thank you, Tammy. [Inaudible]

Karen Mohr: Excuse me, this is the Zoom moderator—we are not able to hear you clearly.

Jill Darling: Okay, I think we might have lost Chris. If you can hear us, try logging out and back in, please?

Chris Palmer: Okay, can you hear me now?

Jill Darling: Much better.

Chris Palmer: Sorry, I was having issues with my headset.

Jill Darling: Okay, do you mind starting from the top again?

Chris Palmer: Yes, no problem. The Skilled Nursing Value-Based Purchasing Program rewards SNFs with incentive payments based on the quality of care they provide. In this year's final rule, CMS adopted four new quality measures, replaced one quality measure, and finalized several policy changes in the SNF VBP program. This brings the total amount of SNF VBP measures to eight. This includes adopting three new measures in the program beginning in the FY 2025 performance year and FY 2027 program year and one new measure beginning with the FY 2024 performance year and the FY 2026 program year. The new quality measures are as follows: We are adopting the nursing staff turnover measure for the SNF VBP program beginning with the FY 2024 performance year and FY 2026 program years. This is a structural measure that has been collected and publicly reported on Care Compare and assesses the stability of the staffing within a SNF using the nursing staff turnover data. We are adopting the discharge function scoring measure beginning with the FY 2025 performance year and FY 2027 program year. This measure assesses the functional status by assessing the percentage of SNF residents who meet or exceed an expected discharge function score and uses mobility and self-care items already collected on the MDS.

We are adopting the long-stay hospitalization measure per 1,000 resident days beginning with the FY 2025 performance year and the FY 2027 program year. This measure assesses the hospitalization rates of long-stay residents. CMS is also adopting the percentage of residents experiencing one or more falls with major injury long-stay measure beginning with the FY 2025 performance year and FY 2027 program year. This measure assesses the falls with major injury rates of long-stay residents. We will be replacing the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) with the Skilled Nursing Facility Within-Stay Potentially

Preventable Readmission Measure (SNF WS PPR) beginning with the FY 2025 performance year and the FY 2028 program year. This will fulfill the requirement in the original SNF VBP legislation in PAMA (Protecting Access to Medicare Act). We will also be adopting the audit portion of the validation process for our MDS-based (Minimum Data Set-based) program measures beginning with the FY 2025 performance year and FY 2027 program year. We intend to establish the pass/fail scoring methodology and how the results will be incorporated into the SNF VBP program as a part of next year's final rule.

To prioritize the achievement of health equity, improve care that all beneficiaries receive, and reduce the disparities in health outcomes and SNFs, CMS is adopting a health equity adjustment in the SNF VBP program. This adjustment rewards SNFs that perform well and whose resident population during the applicable program year includes at least 20% of residents with dual eligibility status. This adjustment will begin with the FY 2025 performance year and the FY 2027 program year. In addition, CMS is increasing the payback percentage policy under the SNF VBP program from the current 60% to a level such that the bonuses provided to the high-performing high dual SNFs do not come at the expense of other SNFs. For the first year of the health equity adjustment, it is expected that the payback percentage will be 66.5%. And now here is, let's see, Susanne, with updates on the IRF PPS final rule.

Susanne Seagrave: Thank you so much. So, on July 27, 2023, the Centers for Medicaid and Medicare Services issued a final rule to update the Medicare payment policies and rates under the Inpatient Rehabilitation Facility Prospective Payment System, or IRF PPS, and the IRF Quality Reporting Program (IRF QRP) for Fiscal Year 2024. CMS has updated the IRF PPS payment rates by 3.4% for FY 2024 based on an IRF market basket update of 3.6% reduced by 0.2 percentage point productivity adjustment.

In addition, the final rule contains an adjustment to the outlier threshold to maintain outlier payments at 3% of total payments. We estimate that this adjustment results in a 0.6 percentage point increase in outlier payments. CMS estimates that overall IRF payments for Fiscal Year 2024 will increase by 4.0%, or \$355 million, relative to payments in fiscal year 2023. Note that on September 29, CMS issued a correction notice that corrects technical errors and typographical errors in the market basket, the calculation of the final Fiscal Year 2024 IRF PPS wage index, and the Quality Reporting Program. CMS also finalized in the FY 2024 final rule modifications to the regulations governing excluded hospital units to allow hospitals to open a new IRF unit and begin being paid under the IRF Prospective Payment System at any time during the cost reporting period. To make this change, hospitals must notify the CMS regional office and the Medicare administrative contractor in writing at least 30 days before the date of the change and maintain the information needed to accurately determine the cost attributable to the IRF unit. Such a change would also remain in effect for the rest of the cost reporting period.

An identical proposal to modify the excluded hospital unit regulation, which pertains to both IRF and inpatient psychiatric facility units, was also proposed in the Fiscal Year 2024 Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) proposed rule. The consolidated change to the regulation is being finalized in the Inpatient Psychiatric Facility Prospective Payment System final rule. CMS believes that this will alleviate unnecessary burden and administrative complexity placed upon hospitals and increase access to care.

Lastly, approximately every four years, CMS rebases and revises the IRF market basket used to update IRF PPS payments to reflect more recent data on the IRF cost structures. CMS last rebased and revised the IRF market basket in the Fiscal Year 2020 IRF PPS rule where CMS adopted a 2016-based IRF market basket. For the Fiscal Year 2024, CMS has adopted a 2021-based IRF market basket and included changes to a market basket cost week, price proxies, and labor related share. At this point, I think I'll turn it back to Jill.

Jill Darling: Thank you, Susanne. We do have Ariel.

Ariel Cress: Hello, I'm sorry, hi, this is Ariel Cress. I'm going to give you some updates for the IRF QRP. For this year's rule, the QRP finalized the addition of two new measures, one measure update, three measure removals, and one public reporting policy. The first measure is the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure, which is calculated using a raw rate for the number of patients who are up to date with the COVID-19 vaccination within a facility. The second measure that we added is the Discharge Function measure, which is a cross-setting functional outcome measure that assesses functional status by looking at the percentage of IRF patients who meet or exceed an expected discharge function score. Our measure update is the modification to the COVID-19 Vaccination Coverage Among Healthcare Personnel measure. This update would report the cumulative number of health care personnel who are up to date with the recommended COVID-19 vaccinations per the latest guidance of the CDC.

The three measures that we removed include the application of the percent of LTCH (long-term care hospital) patients with an admission and discharge functional assessment and a care plan that addresses function and the IRF function outcome measures: the Change in Self-Care measure and the Change in Mobility measure. Lastly, we are finalizing the public reporting of the Transfer of Health Information to the Provider measure and the Patient measure. These two measures report the percentage of patient stays with a discharge assessment indicating that a current reconciled medication list was provided to the subsequent provider and/or the patient, or family or caregiver at discharge or transfer and was finalized with the FY 2020 PPS final rule with collections beginning October 21st of 2022. With that, I will hand it over to Jill. I apologize, actually I will hand it over to Heidi.

Heidi Magladry: Okay, hi everybody, this is Heidi Magladry, and I am the Skilled Nursing Facility Quality Reporting Program Coordinator, and I will provide you with some updates about our finalized policies for the SNF QRP. This year, CMS has adopted, finalized in the rules, CMS is adopting two measures in the SNF QRP, removing three measures from the QRP, and modifying one measure. In addition, this rule makes policy changes to the SNF QRP and begins public reporting of four measures. First, CMS is adopting the Discharge Function Score measure beginning with the Fiscal Year 2025 SNF QRP. As Ariel mentioned when presenting for the IRF QRP, this measure assesses functional status by assessing the percentage of SNF residents who meet or exceed an expected discharge function score and uses mobility and self-care items already collected on the minimum data set. This measure will replace the topped-out Process measure, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and Care Plan that Addresses Function.

CMS is also adopting the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure beginning with the Fiscal Year 2026 SNF QRP. This measure reports the percentage of stays in which residents in SNF are up to date with recommended COVID-19 vaccinations in accordance with the CDC's most recent guidance. Data will be collected using a new standardized item on the MDS. CMS is modifying the COVID-19 Vaccination Coverage Among Healthcare Personnel measure. This measure tracks the percentage of health care personnel working in SNFs who are considered up to date with the recommended COVID-19 vaccination in accordance with the CDC's most recent guidance. The prior version of the measure reported only on whether health care personnel had received the primary vaccination series for COVID-19, while this modified measure requires us to report the cumulative number of health care personnel who are up to date with recommended COVID-19 vaccinations in accordance with the CDC's most recent guidance.

Moving on to measure removals. We are removing three measures, as I spoke of before: the Application of the Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function measure. We are removing this measure because the measure performance on this measure among SNFs is so high and unvarying that meaningful distinctions in performance improvements can no longer be made. And secondly, this measure meets the condition for measure removal factor 6 that there is an available measure, which is the new DC Function measure discussed earlier that is more strongly associated with the desired resident functional outcomes. We are also removing the application of the IRF Functional Outcome measures Change in Self-Care Score and the Change in the Mobility Score, beginning with the Fiscal Year 2025 SNF QRP. We are removing these two measures because they meet the removal factor 8—the cost associated with these measures outweighs the benefits of their use in the program. Additionally, these measures are similar to or duplicative of other measures within the SNF QRP, namely the Discharge of Self-Care Score and the Discharge Mobility Score measures.

Moving on to policy proposals, we are increasing the SNF QRP data completion threshold for the minimum data set data items beginning with the Fiscal Year 2026 SNF QRP. SNFs must report 100% of the required quality measure data and standardized patient assessment data elements collected using the MDS on at least 90% of the assessments they submit to CMS. Any SNF that does not meet the requirements will be subject to a reduction of two percentage points to the applicable fiscal year annual payment update beginning with the Fiscal Year 2026.

And finally, we are beginning the public reporting of the Transfer of Health Information to the Provider and Transfer of Health Information to the Patient measures with the October 2025 Care Compare refresh. These measures report the percentage of patient stays with the discharge assessment, indicating that a current reconciled medication list was provided to the subsequent provider or the patient family caregiver at discharge or transfer. In response to COVID-19, we initially delayed the compliance date for collection and reporting of these two measures in the SNF QRP, but the data collection has now begun on these measures with patients discharged on or after October 1. And finally, just to note, after consideration of public comments received, CMS did not adopt the CoreQ Short-Stay Discharge measure for inclusion in the SNF QRP. And that is all the updates I have for the SNF QRP and will pass it back to Jill.

Jill Darling: Great, thank you, Heidi, and thank you to all of our speakers today. And now we will go into our Q and A, so again a reminder, the raise hand feature at the bottom of your screen, please click on that, and you will be brought into a queue, and you will be called on, and please have one question and one follow-up. We will give it one moment. James Gallant, unmute yourself and ask a question.

James Gallant: Can you hear me now?

Karen Mohr: Yes, we hear you.

James Gallant: Okay, thank you very much for this opportunity. My name is James Gallant, and I am with the Marquette County Suicide Prevention Coalition in Marquette, Michigan. My question to you folks is—I guess my question, and will you look into it—what is the CMS doing to ensure that the mental health assessments in the states are consistent with the state laws in those states? In Michigan, we have the Michigan Mental Health Code, and I'm with our local independent or intermediate school district; we have a Community Wellness Task Force, and the Director of Health and Human Services, Elizabeth Hertel from Michigan, the Department of Human Health Services, stated we reach out to her and ask the definition of a comprehensive mental health services and because the Governor Whitmer was talking about that is what they are providing in Michigan now, and we have like hundreds of millions of dollars of extra funding, and what the response was that it's the Michigan Mental Health Code is now required in all mental health services in Michigan and that Medicaid is being charged for these assessments, and in our school-based health programs, and the problem is that what they have approved is the Behavioral Health Works Program, an assessment program from Drexel University, and is a nationally validated assessment tool. But it does not comply with Michigan state law. It is nationally validated because it doesn't address any state laws. Well in Michigan it is MCL 330.1712. Is an individualized written plan of services in the Michigan Mental Health Code and it says that there will be nine tenants of a person's life addressed in an individualized written plan of services, you know food, shelter, clothing, medical care, but the needs for legal services and that is missing from the assessments in Michigan, and Medicaid is being charged for these assessments and they are not addressing their needs for legal services for the children, and 63% of children from fatherless homes, the suicides are 63% of the youth suicides are from children from fatherless homes. So, the custody and parenting rights and the visitation violations that are happening and alienating the children from the family that they don't live with, that's part of the problem. And these are needs for legal services, and in Michigan, every circuit court has a make-up parenting time policy by law, it's a statutory requirement that every judge will have a make-up time policy. All you have to do is say, "Hey, please review and enforce, if necessary," and the judge will do it. And the schools won't do it because is not on that assessment. So, I would ask you to review the Drexel University's behavioral health works program and ensure that it is adjusted according to every state that it is used in. They say you can use it in any state—well they can, but our requirements in Michigan are different than the ones in Washington, and Ohio, and California, so when they use it in Michigan, and I think is a skewing all of the research also. Because the standards for the national research, like the child traumatic stress network, they are using different standards. They are not the same because they are all the Michigan Mental Health Code in Michigan at, you know, the University of Michigan is big on that, and so I ask you to

please ensure that, like you said, the mental health assessments are complete according to that state's laws. Michigan, it is MCL 330.1712. So, if you can bring this up on your agenda and just figure it out, that would be great. And you know, we could maybe start preventing some of the suicidal behavior. Thank you very much.

Jill Darling: Okay, thank you, James. So that sounds like a Medicaid State Plan question, so if you can, please send that into the Rural Health ODF email that I sent in the chat, and I will resend it out—we will get that to the correct folks. Thank you.

James Gallant: Okay, thank you very much, I appreciate it.

Karen Mohr: Okay, Tee Faircloth, you may unmute yourself and ask your question.

Tee Faircloth: Awesome, thank you so much. I'm just wondering if y'all can comment on St. Mark's, the rural emergency hospital that managed to fail within six months. Didn't know if that was the kind of thing that would be covered on the call today, but I guess not. Is there anybody who can talk on the rural emergency hospital failing within six months? Thank you.

John Hammerlund: I don't think we have anyone on the call today who can address your question. I'm sorry.

Tee Faircloth: Maybe next time, thanks.

John Hammerlund: Yes, okay, thank you. We will make a note.

Tee Faircloth: Thank you, John.

Karen Mohr: Mary Ellen DeBardeleben, you can unmute and ask your question.

Mary Ellen DeBardeleben: Thank you for the presentation today, really appreciate it. I was asking for IRF QRP, when hospitals are going to get notified regarding the noncompliance reconsideration request—we were originally told mid-to-late September, and I was wondering if there is an update on when hospitals would get notified.

Ariel Cress: I can somewhat answer that, Mary Ellen. So, I don't have the exact date, but those notifications should be coming in the next week or so, hopefully, next week or two weeks, but they should be coming very soon.

Mary Ellen DeBardeleben: Okay, thank you.

Karen Mohr: Jan Plummer, you may unmute and ask your question.

Jan Plummer: Hi, good afternoon. I wondered if you would be able to clarify for me for the purposes of data, accountability, and reporting. I am in a county; I serve with projects as part of the MSA for Buncombe County. But we are still very, very rural. So, I want to know if there is any difference in what counties that are in an MSA receive in terms of benefits or grant

opportunities versus totally rural, 100% rural counties. I hope that's a fair question. If not, I can get a link and look it up myself. Thank you.

Dan Schroder: Sorry, this is Dan Schroder. I can probably answer part of this. If you are an urban area, an urban MSA, you can apply under 412103 to be treated as if you are in a rural area. That does open up a lot of opportunities, and I think 340B and different things I don't deal with and also has different wage index implications. But just from that level, there is a way to reclassify as rural, if you are an urban hospital.

Jan Plummer: Okay thank you.

Jill Darling: Okay, at this time I don't see any more hands raised but we will give it a couple more seconds in case anybody decides to raise their hand. Okay, everyone. I will hand it back to John or Ing-Jye Cheng for any closing remarks.

John Hammerlund: I want to thank everybody for joining us today—again we had a good crowd and I want to say thank you to the panelists who are subject matter experts who spoke on these. Again, you know we strive to try to get you information that is timely and that is digestible that you can use. We always appreciate your feedback on that. Jill just put our email address in the chat box again, and that is also where you can send proposed agenda items for the next call. And again, we will be back in touch with you soon about a scheduled call, sometime in the first couple of weeks of November. And we will have more important topics to cover then and then will be able to celebrate National Rural Health Day with you all as well. So, thank you again for joining today's call; we really appreciate it.

Jill Darling: Thank you, everyone, for joining us, and that will conclude today's call. Have a great day.