Centers for Medicare & Medicaid Services

Rural Health Open Door Forum

Wednesday, August 4, 2021

2:00 pm ET

Coordinator: Welcome and thank you for standing by. Today's call is being recorded. If you have any objections you may disconnect at this time.

All participants are in a listen-only mode until the question and answer session of today's presentation. To ask a question at that time, you may press Star 1 and record your name clearly for question introduction. I would now like to turn over your call to your host, Jill Darling. Thank you.

Jill Darling: Great, thank you (Michelle). Good morning and good afternoon, everyone. I'm Jill Darling in CMS Office of Communications and welcome to today's Rural Health Open Door Forum.

As always, we greatly appreciate your patience in waiting for more folks to get in and especially since we set the agenda later than normal. So, we really appreciate you joining us today on the short notice.

Before we get into today's agenda. I have one brief announcement. This Open-Door Forum is open to everyone, but 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 do have any inquiries, please contact CMS at press@cms.hhs.gov. And I would now like to hand the call off to our co-chair, John Hammarlund.

John Hammarlund: Great, thanks so much Jill. And hi everybody. On behalf of Ing-Jye Cheng, the co-chair and myself, thank you so much for joining today's call. We're delighted to have so many people on. Again, apologies for getting you the agenda a bit late this time around.

Thank you to all my CMS colleagues who have joined the call today to talk to you. As you can see we have a very robust agenda, a lot of important information we want to share with you. In fact, we had so much we couldn't even fit it all into one call.

And so you will soon hear notice of a second Rural Health Open Door Forum call that's going to take place next week, Tuesday, August 10, at the same time 2:00 pm Eastern, for us to carry on the conversation and address some other topics. So you'll be hearing more about that as well.

And speaking of agenda topics, a reminder to all that we look forward to getting your input on what you would like to hear from CMS on future Rural Health Open Door Forum calls. At the end of today's call, our facilitator, Jill Darling will provide an email address you can use to submit proposed agenda items for the future.

So again, welcome to today's call. Thank you to all for joining. Thank you to my CMS colleagues who are going to be presenting and we'll get right into the agenda. Jill, I'll hand it back to you. Thank you.

Jill Darling: Great, thanks John. First up, we have Alpha Wilson who will talk about the health equity in the conditions of participation conditions for coverage.

Alpha Wilson: Thanks, so much Jill and good afternoon or good morning everybody. My name is Alpha Wilson and I am a Technical Adviser here in the Clinical

Standards Group within the Center for Clinical Standards and Quality here at CMS. And I'm going to be talking about advancing health equity and the conditions of participation.

So, CMS periodically conducts a comprehensive review of the current health and safety standards. Those are the Conditions of Participation, otherwise known as the COP and the Conditions For Coverage known as the CFC, with the goal of evaluating the efficacy of the current standards and identifying opportunities for regulatory improvements. The COPs and the CFCs are the health and safety standards that providers and suppliers must meet in order to receive Medicare and Medicaid payment. They apply to all individuals that receive care in a health care organization regardless of the payor type. They vary by provider but generally cover issues such as care planning, governance, quality assessment and performance improvement, emergency preparedness and patient, resident or client rights.

In accordance with President Biden's three executive orders addressing issues of health equity, we are now evaluating how we can address health equity and improve health disparities through the COPs and the CFCs. We are committed to advancing equality for all including racial and ethnic minorities, members of the LGBTQ community, people with limited English proficiency, people with disabilities, rural populations and people otherwise adversely affected by persistent poverty or inequality,

In order to achieve these goals, we are asking for information, input and ideas from the public on ways that we can address health equity within the COPs and the CFCs. We are asking for data, research, studies and any other information that can help inform any potential changes to the COPs and the CFCs that we might make in the future.

In particular we are looking for input on ways to reduce health disparities amongst rural populations and increase access to care in rural areas, how health equity can be improved during the care planning process, and how providers can partner with community based organizations to improve a person's care and outcomes after discharge, ways to hold a facility's governing body and leadership responsible and accountable for reducing disparities within our facility and advancing health equity policies and efforts, how the COPs can ensure that health equity is embedded into a provider strategic planning and quality improvement effort.

What types of staff, training or other efforts are necessary to ensure that people receive culturally competent care, ways to combat implicit and explicit bias in healthcare, how the COPs can be improved to ensure that providers are not discriminating against individuals in underserved populations, particularly racial and ethnic minorities, those with disabilities, sexual and gender minorities, people with limited English proficiency and rural populations.

How the COPs can ensure that providers offer fully accessible services for their patients in terms of physical communication and language access and any other data or additional information on ways to ensure that a provider is addressing and reducing health disparities within their facility.

We encourage you to submit information and your input to the following mailbox H-E for Health Equity dot outreach at cms dot hhs dot gov. Again that's he.outreach@cms.hhs.gov. We will review the information that we receive and use it to inform potential future policy making.

And now I'll turn it over to David Rice, who will give an update, an OPPS ASC rate update.

David Rice: Thanks Alpha. In the CY 2022 OPPS ASC proposed rule, CMS is in accordance with statute, proposing to update the OPPS payment rate by 2.3%. This update is based on the proposed hospital market basket increase of 2.5% minus a .2 percentage point adjustment for productivity.

CMS is also proposing to apply this same hospital market basket update of 2.3% to update payment rates for ambulatory surgical centers in calendar year 2022. At this point I'll pass it over to you Kianna Banks who will discuss the rural emergency hospital's request for information.

(Kianna Banks): Thank you David. I'll be providing information on a request for information that was included in the OPPS rules that David just talked about, and I'll begin with giving you some background information.

There's been a growing concern over closures of rural hospitals and critical access hospitals that is leading to a lack of services for people living in rural areas. One of these key services is access to emergency care. Following these concerns, Congress enacted Section125 of the Consolidated Appropriations Act of 2021 which establishes a new provider type called Rural and Emergency Hospitals.

The Consolidated Appropriations Act defines Rural Emergency Hospitals a facilities that convert from either a critical access hospital or a rural hospital with less than 50 beds that do not provide acute care inpatient services. Rural emergency hospitals are permitted to provide skilled nursing facility services furnished in a distinct part unit. Furthermore, rural emergency hospitals will be required to furnish emergency department services and observation care and may provide other outpatient medical and health services as specified by the secretary through rulemaking.

The Consolidated Appropriations Act provides that the statutory provisions governing Medicare payment for rural emergency hospital shall apply to items and services furnished on or after January 1, 2023. We have published a request for information in the OPPS ASC proposed rule to obtain feedback and comments from the public that we will use to inform our policymaking as we developed health and safety standards, quality measures and reporting requirements and payment policy for rural emergency hospitals.

Some of the targeted areas we are seeking input on are the extent to which the existing health and safety standards for hospitals, critical access hospitals and skilled nursing facilities should also apply to rural emergency hospitals; additional health and safety standards that should apply to all emergency hospitals; quality measurement and reporting; payment policies; addressing health equity; and data sources, additional considerations, considerations and unintended consequences that we should consider in the development of policy for local emergency hospitals.

We encourage you to provide your comments on the request for information for rural emergency hospitals via the standard process of commenting on notices of proposed rulemaking by visiting www.regulations.gov. And now I'll turn it over to Kelly for the discussion on the Home Hospice Proposed Policy Update.

Kelly Vontran: Hi, good afternoon and good morning everyone. As introduced, I'm Kelly Vontran and I'm the Deputy Director in the Division of Home Health and Hospice here in the Center for Medicare. So, I will be discussing the proposed home health payments policies in the calendar year 2022 Home Health Perspective Payment System Proposed Rule.

The comment period for this proposed rule continues until August 27. Comments on the calendar year 2022 Home Health Proposed Rule can be submitted online via regulations.gov. As a reminder because this proposal is still in the comment period, CMS is limited in answering questions on this proposed rule.

So beginning on January 1 of 2020, Medicare implemented the Patient Driven Grouping's Model, or what we call the PDGM and a 30 day unit of payment as required by law for the Home Health Prospective Payment System. This was done to better align the patient care needs and safeguard that clinically complex beneficiaries have adequate access to home health care.

The law also requires CMS to make assumptions about behavior changes that could occur because of the implementation of the 30 day (unit) of the payment and the PGDM and in the calendar year 2019 Home Health PPS final rule and comment CMS finalized three behavior assumptions. The clinical group coding, the comorbidity coding and a Low Utilization Payment Amount or LUPA threshold assumption.

These assumptions resulted in a 4.36% reduction to the calendar year 2020 national standardized 30-day payment rate to help achieve overall budget neutrality. The law also requires CMS to annually determine the impact of the differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures beginning with calendar year 2020 and ending with calendar year 2026 and to make temporary and permanent increases or decreases as needed to the 30-day payment amount to offset such increases or decreases.

So, this proposed bill provides preliminary analysis of the first year of the PDGM including data on admission source, timing, clinical grouping,

functional impairment level, comorbidity adjustment, and the provision of therapy visits, including physical, occupational and speech.

Additionally, in this proposed rule, CMS provided a detailed method on how it analyzed the difference between assumed and actual behavior changes. However, CMS did not propose any specific method or behavior assumption payment adjustments for calendar year 2022 in this proposed rule. Rather CMS solicited comments on the described method and other possible methods to determine the impact of the behavioral changes on estimated aggregate expenditures.

This proposed rule also includes a proposal to recalibrate the PDGM case mix weights. Each of the 432 payment groups under the PDGM has an associated case mix weight and LUPA threshold. CMS's policy is to annually recalibrate the case mix weights using the most complete utilization data available at the time of rulemaking.

In this proposed rule, CMS proposed to recalibrate the case mix weights, the functional impairment levels and the comorbidity adjustment subgroups using calendar year 2020 data to more accurately pay for the types the patients home health agencies are serving. Additionally, CMS is proposing to maintain the calendar year 2021 LUPA threshold for calendar year 2022.

Also, in this proposed rule, in accordance with the provision in the Consolidated Appropriations Act of 2021 CMS proposed conforming regulations text changes to permit the occupational therapists to complete the initial and comprehensive assessments for Medicare patients or in order with another rehabilitation therapy services such as speech or physical therapy. These disciplines establish program eligibility and, in the case, where skilled nursing services are also not ordered.

Finally, this bill proposes routine statutorily required upgrades to the home health payment rates for calendar year 2022. Of note, calendar year 2022 is the last year of the rural add on payments as mandated by the Bipartisan Budget Act of 2018. These rural add on payments are made for 60-day episodes, 30-day periods or visits ending during calendar years 2019 to 2022. The BBA of 2018 also mandated implementation of a new methodology for applying this payment.

So unlike previous rural add on model methods which will applied to all rural areas uniformly, these rural add on payments provide varying amounts depending on the rural classification by classifying each rural county or equivalent area into one of three distinct categories -- high utilization, low population density and all others.

For calendar year 2022 the rural add on payment is made for low population density areas only. Low population density areas are rural counties, and equivalent areas with a population density of six individuals or fewer per square mile of land area and are not included in the high utilization category.

CMS estimates that Medicare payments to home health agencies in calendar year 2022 would increase in the aggregate by 1.7% or $310 million based on the proposed policy. This increase reflects the effects of the proposed 1.8% home health payment update percentage or a $330 million increase and a 0.1% increase in payments due to the reductions made in the rural add on percentages mandated by the BBA of 2018 for calendar year 2022 which equates to a $20 million decrease.

Rural home health agencies would recognize a 1.4% increase in the aggregate in home health payments in calendar year 2022. Next is Jennifer Donovan who will discuss the home health value based purchasing program.

Jennifer Donovan: Thank you Kelly. Hello. My name is Jennifer Donovan. I work with the CMS Innovation Center and I'll be providing an overview of policies proposed in support of the Home Health Value-Based Purchasing, or HHVBP model for our current or original model and for on policies that are proposed to expand the HHVBP model nationwide.

The CMS Innovation Center operates the current HHVBP model, which began January 1, 2016 in nine states Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington. The last year of data collection was calendar year 2020.

The model test whether payment incentives can significantly change health care provider's behavior to improve quality of care through payment adjustments based on quality performance during a given performance year. Under the model, CMS adjusts fee for service payments to HHA's based on their performance on a set of quality measures relative to their peers.

In the calendar year 2022 Home Health Prospective Payment System proposed rule, we are proposing to end the current model one year early and not use calendar year 2020 performance data to impact payments to the HHAs in the nine model states. Given the potentially destabilizing effects of the COVID-19 Public Health Emergency on quality measure data in calendar year 2020 as well as the patterns that we have observed in utilization and reporting, we believe it would be most prudent to avoid using the 2020 data to apply calendar year 2022 payment adjustments under the original model to ensure that all Medicare certified HHAs nationwide begin participation in the

expanded model first performance year in calendar year 2022. Under the original model, we also proposed not to publicly report performance data from the calendar year 2020 performance year.

Based on the original model third annual Evaluation Report which shows average 4.6% improvement in quality scores as well as average annual savings of 141 million, the CMS chief actuary certified and the HHS secretary subsequently determined that the model met statutory requirements for expansion.

In January 2021 we announced our intent to expand the model no earlier than January 1, 2022 through notice and comment rulemaking. The proposed model expansion presents an opportunity to improve the quality of care furnished to Medicare beneficiaries nationwide through payment incentives to home health agencies.

We propose that all HHAs certified for participation in Medicare before January 1, 2021 would have their calendar year 2022 performance assessed and would be eligible for a calendar year 2024 payment adjustment. If finalized, all Medicare certified HHAs in the fifty states, District of Columbia and the territories would be required to participate in the expanded HHVBP model beginning January 1, 2022.

All eligible HHAs would compete on value based on an array of quality measures. Calendar year 2022 would be the first performance year and calendar year 2024 would be the first payment year with payment adjustments in 2024 based on the HHAs performance from 2022.

The proposed payment adjustment for the 2024 payment year is upward or downward of 5% and would be applied to each fee for service claim submitted with a date of service January 1, 2024 through December 31, 2024.

Proposals in support of model expansion largely mirror the original model design and incorporate changes to operationalize the model on a national scale including moving from within state smaller and larger volume HHA cohort competition to national smaller and larger volume HHA cohort competition to allow for a sufficient number of HHAs in each volume based cohort for like comparisons, for setting benchmarks and achievement thresholds, and for determining payment adjustments. HHAs would compete for payment adjustments within their national size level cohort.

Beginning with the calendar year 2022 performance year and for subsequent years, we propose a quality measure set that includes OASIS claims and HH CAHPS survey-based measures. We propose other policies related to quality measures including measure removal, measure suspension and measure modification policies. Many of the proposed measures overlap with those in the Home Health Quality Reporting Program.

Home health agencies that meet the minimum number of episodes of care on OASIS and claims quality measures or, if applicable, the minimum number of home health CAHPS surveys on five or more quality measures would receive a total performance score and a payment adjustment based on that performance year.

We propose that claims-based measures would be weighted at 35%, OASIS based measures 35% and the HH CAHPS survey-based measure at 30% when the HHA has applicable measures in all three categories and otherwise meets

the minimum threshold to receive a Total Performance Score or TPS. Together, all three categories would account for 100% of the TPS.

We propose to use the linear exchange function or LEF as we did for the original model because it was the most straightforward option to provide the same marginal incentives to all HHAs. And we believe the same to be true for the HHVBP model expansion. The LEF is used to translate an HHA's total performance score into a percentage of the value-based payment adjustment earned by each competing home health agency.

We propose to use two types of model specific reports that would provide information on performance and payment adjustments. These two reports are called the Interim Performance Report and the Annual Report. We propose to issue the Interim Performance Report or IPR on a quarterly basis, with the first performance report anticipated to be issued in July 2022 with subsequent IPRs in October, January and April.

The first Annual Total Performance Score and Payment Adjustment Report or Annual Report based on calendar year 2022 performance and the calendar year 2024 payment adjustment year is anticipated to be issued in August 2023. We propose an appeals process where if an HHA believes their IPR reflects an error in a data calculation, the HHA may submit a recalculation request. The appeals process for the annual report includes the recalculation request appeal level, along with a second and final level of appeal, the reconsideration request process.

We are proposing to publicly report certain performance data for the expanded model beginning with the 2022 performance and 2024 payment years and for subsequent years. Finally, we are, in general, proposing to adopt an extraordinary circumstance exceptions policy for the expanded HHVBP

model that aligns, to the extent possible, with the existing Home Health Quality Reporting Program exceptions and extension requirements. Thank you. That's all I have. I'll turn things over to (Gift).

(Gift Tee): Thanks Jennifer and good afternoon and good morning if you're on the West Coast. I want to cover a number of topics and the physician fee schedule rule for CY 2022. As most of you are aware, we issued the rule on July 13 last month and we are currently in the comment period. So please, please, please plan on submitting formal comments systems by September 13 and we will review them.

So, I will quickly cover our PFS rate setting conversion factor proposals, proposals on the evaluation, management services or implementation of CAA, Consolidated Appropriations Act for 2021 requirements, telehealth and other services involving communications technology, therapy services and a common solicitation on vaccine administration.

So, for CY 2022 in our rule we're proposing a series of standard technical proposals involving practice expense including the implementation of the fourth year of our market-based supply and equipment pricing update, changes to our practice expense for many services associated with the proposed update to our clinical labor pricing and standard rate setting requirements.

With our proposed budget neutrality adjustments or account for changes in RVUs as required by our statutory authority and the expiration of the 3.75% payment increase provided for 2021 in the Consolidated Appropriations Act our proposed 2022 PFS conversion factor is $33.58 -- a decrease of $1.31 cents from the CY 2021 PFS conversion factor of $34.89. And this conversion factor of course reflects our statutory update of 0% and the adjustments

necessary to account for changes in our RVUs and expenditures that would result from our proposed policies.

Under our E&M, Evaluation Management Services proposals, we are proposing a definition of split or shared visits as EMM visits provided in the facility setting physician and a nonphysician practitioner in the same group. We're also clarifying that the practitioner who provides a substantive portion of the visit more than half of the total time spent, would be the practitioner billing for the visit.

We are also clarifying and proposing that split or shared visits could be reported for new as well as established patients and initial and subsequent visits as well as prolonged services. We are also proposing to require the reporting of a modifier on the claim to ensure program integrity around furnishing OB services. We're also proposing that documentation should include two individuals who perform the visit with the individual providing the substantive portion to sign and date the medical record.

We are also proposing changes to our critical care services and the rule we are proposing to use the AMA's current procedural terminology preparatory language as the definition of critical care visits. We're proposing to allow critical care services to be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty.

We're also proposing to allow critical care services to be furnished as split or shared visits and that no other EMM visits can be billed for the same patient on the same day as a critical care service by the same practitioner or by practitioners in the same specialty and same groups to overcount - to account for overlapping resource costs. We're also proposing that critical care visits

can not be recorded during the same time period as a procedure with a global surgical period.

We are also proposing clarifying under our teaching physician payment policies that as part of our AMA CPT office outpatient EMM visit coding framework changes for 2021 practitioners can use either time or medical decision making to select the visit level. But specifically, we're proposing that following updates that the time when the physician, teaching physician is present can be included when determining EMM visit levels. And also, that under the primary care exception only MDM, Medical Decision-Making would be used to select the visit level to guard against the possibility of inappropriate coding that reflects the resident's experience rather than a measure of time required to furnish the services.

Okay quickly touching on our implementation of some of the consolidated Appropriations Act provisions, we are proposing to implement Section 122 of the CAA which amends the statute by providing a special coinsurance rule for procedures that are planned as colorectal cancer screening tests but become diagnostic tests when the practitioner identifies the need for additional services, for example, the removal of polyps.

We are also proposing to implement Section 403 of the division CC of the CAA that authorizes Medicare to make direct payments to physician assistants or professional services that they furnish under Part B beginning January 1, 2022. So beginning in 2022, PAs would be able to bill Medicare directly for their services and reassign payment for their services as well.

We are also implementing Section 123 of the CAA which removes the geographic restrictions and adds the home of the beneficiary as a permissible originating site for telehealth services when used for the purposes of

diagnosis, evaluation, diagnostic evaluation and/or treatment of a mental health disorder, and requires that there be an in-person non-telehealth service with a physician or practitioner within six months prior to the initial telehealth service and therefore at intervals as specified by the secretary.

We are proposing to require an in-person non-telehealth service be provided by the physician or practitioner furnishing the mental health telehealth service within six months prior to the telehealth service and at least once every six months thereafter and are seeking comment on those intervals.

Along those lines, we are proposing a number of refinements to our telehealth and other services involving communications technology policies. Specifically we are proposing to limit the use of audio-only interactive telecommunication system to mental health services furnished by practitioners who have the capability to furnished two-way audio-video communications, but where the beneficiary is not capable of using or does not consent to the use of two-way audio-video technology.

We're also proposing to require the use of a new service level modifier for services furnished using the audio-only communications technology modality, which would serve to certify that the practitioner had the capability to provide two-way audio-video technology, but instead use audio-only technology due to beneficiary choice or limitation.

We're also soliciting comment on whether additional documentation should be required in the patient's medical record to support the clinical appropriateness of audio only telehealth and whether or not we should preclude audio-only telehealth for some high level services such as Level 4 or Level 5 evaluation management visit codes or psychotherapy or crisis services and also if there

should be any additional guardrails we should consider putting in place in order to minimize program integrity and patient safety concerns.

We are also continuing to evaluate the temporary expansion of telehealth services that were added to telehealth lists during the COVID-19 public health emergency. We are specifically proposing to allow certain services be added to the Medicare telehealth list to remain on the list to the end of December 31, 2023 to allow more time to evaluate whether the services should be permanently added to the telehealth list following the TAT for COVID-19.

Under our communication technology-based services policies, we are proposing to permanently adopt and make payment for HCPC Code G2252 which subscribe describes our extended virtual check-in. We first talked about this proposal in our CY 2021 PFS final rule and received a number of comments in support of this action.

Along those same lines as a number of you might recall, through our March 31 COVID-19 interim final rule process we change the definition of direct supervision doing a PHE for COVID-19 to allow the supervising professional to be immediately available through virtual presence using real-time audiovisual video technology.

We finalized the continuation of this policy through the later of the end of the calendar year in which the PHE for COVID-19 ends or December 31, 2021. We also noted that the temporary exception to allow availability for direct supervision through virtual presence facilitates the provision of telehealth services by clinical staff of physicians or other practitioners incident to their own professional services. This is, of course, especially relevant for services such as physical therapy, occupational therapy, speech-language pathology services since those practitioners can only bill Medicare directly for telehealth

services under the waivers that are effective only during the PHE for COVID-19.

Under our therapy services policy, we are implementing the final part of Section 53107 of the Bipartisan Budget Act of 2013 which required us through the use of new modifiers to identify and make payment at 85% of the otherwise applicable Part B payment amount for therapy and occupational therapy services furnished in whole or in part by therapy assistance for dates of service beginning January 1, 2022.

We are proposing to revise a de minimis standard established to determine whether services are provided in whole or in part by therapy assistance. and specifically, in cases where there is one unit remaining to be billed CMS is proposing to allow time service to be built without the modifiers we created in cases when an assistant and a therapist provide care to a patient but the therapist meets the Medicare billing requirements for the time of service by providing more than a 15-minute midpoints or at least eight minutes. Under this proposal any minutes furnished by the therapy assistant would not matter for billing purposes.

We also in our research to establish these proposals, identified a limited number of cases in which there are two units remaining to be billed where the therapist and assistant each provide between nine and 14 minutes of a service with a total combined time of 23 through 28 minutes. In these cases we are proposing to allow one 15 minute unit to be billed without the modifiers the CQ and CO modifies.

And finally, we also are seeking comments on vaccine administration services. Specifically we are looking to obtain information on the cost involved in furnishing preventive vaccines with the goal to inform the

development of a more - of more accurate rates for these services or specifically seeking information on the different types of healthcare providers who furnish vaccines and how these providers have changed since the start of the COVID -19 pandemic and also how the cost of furnishing through meningococcal and Hepatitis B vaccines compares to the costs of furnishing the COVID -19 vaccine and how those costs may vary for the different types of health care providers.

We're also looking to understand how the COVID-19 TTA may have impacted costs and whether healthcare providers envision these costs to continue. We're also seeking input on our preliminary policy to pay $35 addon for certain new vulnerable beneficiaries when they receive a COVID-19 vaccine at home. We are interested in stakeholder input and what qualifies as the home and how we can balance ensuring program integrity with beneficiary access.

And finally, as the market for COVID-19 monoclonal antibody products mature, we're also seeking comment on whether we should treat these products the same way we treat other physician administered drugs and biologicals under Medicare Part D. And with that I will turn it back over to Jill Darling or John Hammarlund. Thank you.

Jill Darling: Great thanks (Gift) and thank you to all of our speakers today. (Michelle) will you please open the lines for Q&A?

Coordinator: Sure, if you'd like to ask a question at this time, you may press Star 1 and clearly record your name for question introduction. Again, to ask a question, please, press Star 1 and clearly record your name. One moment please to see if we gather questions.

And our first question will come from (Elizabeth Gorgansky). Your line is now open.

(Elizabeth Gorgansky): Yes hi. I just had a quick question on the number of units that can be billed that you were just discussing on the therapy side. Does that then increase the number of units that can be billed to two 15 units, one with the modifier and one without? Or is it the same?

(Gift Tee): Thanks for that question. So, we've identified a small number of cases where there are two units remaining to be billed. So, in those cases specifically, we'd be allowing one 15 minute unit to be built with the CQ CO modifier to get back to the one minute issue that I talked about before that and at that point...

(Elizabeth Gorgansky): Right.

(Gift Tee): ...considering what the therapist billed versus what the therapist's assistant was doing, would allow for that for that unit to be bill without the CQ, the CO modifier.

(Elizabeth Gorgansky): Okay thank you.

(Gift Tee): Thank you.

Coordinator: And currently I show no additional questions at this time.

Jill Darling: All right well great. Thank you everyone, for joining us. Thank you to our speakers. Again, John Hammarlund had to step away to go into another call. But to close out our call just another reminder we as John mentioned at the beginning of the call, we have a second Rural Health Open Door Forum

scheduled for August 10 at 2:00 pm. Eastern. So be on the lookout for the agenda for that.

And as always, if you have any suggested agenda items for future rural health calls, please email us at the Rural Health Open Door Forum email. It is listed on the agenda and is ruralhealthodf@cms.hhs.gov. And if you have any other questions or comments you may use that email.

So we thank you for joining us and hope to hear from you next week. Thanks, everyone. Have a great day.

Coordinator: This will conclude today's conference. Thank you for joining and thank you for your participation on today's call. You may now disconnect.

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