

Centers for Medicare and Medicaid Services
Home Health, Hospice and DME Quality
Open Door Forum
Moderator: Jill Darling
Wednesday, April 3, 2019
2:00 p.m. EST

Operator: Good afternoon. My name is (Mariana) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Home Health, Hospice and DME Quality Open Door Forum.

All lines have been placed on mute to prevent any background noise. After, the speakers' remarks, there will be a question and answer session.

If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you. Jill Darling, you may begin your conference.

Jill Darling: Thank you (Mariana) and good morning and good afternoon everyone, welcome to today's Home Health, Hospice and DME Open Door Forum. Before we get into our agenda, as always I have my announcements.

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 have any inquiries, please contact CMS at press@cms.hhs.gov. And I'll hand the call up to our chair, Hillary Loeffler.

Hillary Loeffler: Thanks, Jill. Good afternoon everyone and good morning to those joining from the West Coast. We have a last minute addition to the agenda today. We are joined by Jennifer McMullen.

She's going to talk a little bit about the review choice demonstration so I'm going to go ahead and hand it over to her before we jump in to the more formal part of today's call. Jennifer?

Jennifer McMullen: Thank you. We wanted to give you an update on the review choice demonstration for home health services. We have received a Paperwork Reduction Act, or PRA approval for the demonstration.

The Office of Management and Budget has reviewed the demonstration documents and CMS's responses to the public comments and has approved the collection of information.

In response to public comments, the demonstration incorporates more flexibility and choice for providers as well as a risk based change to reduce burden on providers demonstrating compliance with Medicare Home Health Policies.

Home Health Agencies will select from three initial choices, pre-claim review, post-payment review or minimal post-payment review with a 25-percent payment reduction.

After a six-month period, home health agencies demonstrating compliance with Medicare rules through pre-claim review or post-payment review will have additional choices including release from most reviews except for a review of a small sample claim.

Home Health Agencies in Illinois that previously participated in the pre-claim review demonstration for home health services and met a 90-percent target full provisional affirmation rate based on a minimum of 10 requests being submitted can begin the demonstration by selecting from the additional choices.

Full demonstration details are available in the operational guide, which is published on the demonstration website at <https://go.cms.gov/homehealthrcd>. The choice selection period for Home Health Agencies located in Illinois will begin on April 17, 2019 and it will end on May 16, 2019.

Home Health Agencies in Illinois who bill to Palmetto GBA can visit the Palmetto GBA Provider Portal for more information and instructions on the collection process. Beginning on April 17, 2019, Home Health Agencies will be able to view their available choices and make their selection through the portal.

Palmetto GBA will also send letters to all Illinois Home Health Agencies detailing this information. However, Home Health Agencies do not need to wait to receive their letter and may go to the provider portal starting on April 17, 2019. Those who do not make a choice selection by May 16, 2019 will automatically be placed in choice 2, post-payment review.

Following the close of the choice selection period, the demonstration will begin in Illinois on June 1, 2019 and all episodes of care starting on or after this date will be subject to the requirements of the choice selected.

We will continue to post updated information on the demonstration website and Palmetto GBA will also be posting information on their website and providing educational opportunity.

In addition, we'll provide notice before these – the demonstration is (phased) into the other states of Ohio, Texas, North Carolina and Florida. And questions can be sent to homehealthrcd@cms.hhs.gov. Thank you. I'll now turn it back over to Hillary.

Jill Darling: All right. Thank you Jennifer. Up next, we have Gina Longus who will – who has an update on the Round 2021 DMEPOS Competitive Bidding Program.

Gina Longus: Thank you. On March 7, 2019, CMS announced plans for Round 2021 of the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program.

CMS is consolidating the competitive bidding areas, or CBAs, that are included in round one 2017 and round 2 re-compete by conducting Round 2021 in those same geographical areas for a total of 130 CBAs.

Round 2021 contracts are scheduled to be effective beginning on January 1, 2021 and extended through December 31, 2023. CMS is implementing important regulatory reforms included in the final rule published on November 14, 2018.

Round 2021 includes the lead item pricing methodology that uses maximum winning bid amounts for setting the single payment amounts, shifting from some items to different smaller product categories to accommodate the lead item pricing methodology and phasing in three new product categories, off-the-shelf back braces, off-the-shelf knee braces and noninvasive ventilators.

A complete list of the 16 product categories included in Round 2021 can be found on the Competitive Bidding Implementation Contractor or the CBIC's website, www.dmecompetitivebid.com.

As I mentioned in 2021, CMS is implementing the lead item pricing methodology for all items included in the product category. This means that rather than submitting individual bid amounts for each item within a product category, bidders will only submit one bid amount for the lead items in the product category.

The supplier's bid for the lead item represents the supplier's bid for furnishing the lead item and all other items, known as the non-lead items in the product category. Bid amounts for the lead item in the product category will be used to calculate the single payment amounts or SPA for all of the items within that product category.

The SPA for the lead item is the maximum amount – the maximum bid amount submitted for the item by bidders who bid amounts for the item (in) the winning range in that CBA and product category combination.

The SPA is for the non-lead items within a product category or determined by multiplying the lead item SPA by a (relative) ratio. The ratios are based on the historic differences in the (C schedule) amounts for the lead item and non-lead items.

To ensure that bidders have ample time to prepare for Round 2021, CMS has launched a pre-bidding awareness program followed by Bidder Education Programs in May, 2019; and bidder's registration in June, 2019. The bid window also will open in June, 2019.

We want to remind all suppliers interested in bidding in Round 2021 to ensure that their enrollment records at the National Supplier Clearinghouse (are taxed) including licensure and accreditation.

Another important reminder is that the bid surety bond requirements – which is new for Round 2021. All bidders must obtain a 50,000 bid surety bond to an autho – from an authorized surety on the Department of Treasury's list of certified companies for each CBA, which based under the bid.

As this is a new bidding requirement for 2021, we encourage suppliers to start obtaining their bid surety bonds as soon as possible. The CBIC is the official information source for bidders and focal point for all bidder education.

Again, the CBIC's website, www.dmecompetitivebid.com teaches important and helpful resources to ensure that suppliers have the information necessary to understand the new bidding rules and prepare for Round 2021.

To sign up and receive important competitive bidding announcements and reminders, suppliers are encouraged to subscribe to e-mail updates on the CBIC website. Thank you.

Jill Darling: Great. Thank you, Gina. Next is (Will Gehne) who has an update on the home health PDGM claims processing instructions?

(Will Gehne): Thanks Jill. On our last call, I described the instructions that we issued in change request 1181 as a down payment on all of the manual revisions that we

need to make to fully reflect the Patient-Driven Groupings Model, and said that there will be additional transmittals coming out later in the year.

And I'd hoped that the first of those transmittals would have been available by the time of this call, but those instructions are still in the CMS clearance process and – but they should be out before the end of this month.

I just wanted to provide a brief preview of some of the things that will be in it. So, a lot of it will be updates to additional sections that refer to a 60-day episodes as the unit of payment, (no) to also reflect 30-day periods of care, but more notably there will be new instructions that describe in detail the (pricer) logic that will be applied under the PDGM.

The original transmittal just included the record layout for our pricer and so this transmittal will describe the way the data will be processed and it will all – the transmittal will also include some diagnosis coding instructions that answer questions that were raised in our National Provider Call, back in February. So stay tuned and additional instructions should be published between this call and the next. Thank you.

Jill Darling: Thank you (Will). Next is Lori Teichman who has some HHCAHPS survey update.

Lori Teichman: Thank you Jill. On today's agenda, there are several large links referencing Home Health CAHPS or HHCAHPS materials.

This is an easy way to find the Home Health CAHPS website and updated materials that are needed for the Calendar Year 2021 Annual Payment Update, and links to new materials such as the home health CAHPS new quarterly newsletter, which we posted on April 1st.

Also on April 1st, we began the survey participation period for the Calendar Year 2021 Annual Payment Updates, which runs from April 1, 2019 through March 31, 2020.

We require Home Health Agencies to do monthly survey participation in HHCAHPS to receive the full annual payment update and if they are a very small agency and qualified for a Home Health CAHPS exemption then they should complete the Home Health CAHPS exemption form for the Calendar Year 2021 Annual Payment Update. And this form is also noted on the link to Home Health CAHPS website that's in the agenda.

And a reminder about the next Home Health CAHPS data submission date is two weeks from tomorrow on April 18th. And if you are a Home Health Agency, you are advised to check with your vendor if your data has been submitted.

And you can also verify if you would like to not contact them directly, you could also check the data submission reports by going into the portal on the Home Health CAHPS website and entering your ID and use a password and you were – you will be able to be taken to your particular Home Health Agency and see the history of your data submission and of course the most recent data submission history. And if your current data have not been submitted, you might want to then contact your vendor.

As always, I do say this all the time, but you can always participate in Home Health CAHPS even if you have stopped it some time in the past. And it happens to be an excellent time to register for Home Health CAHPS and find a vendor, because you can start now and not miss the first month of participation.

First month of participation for the Calendar Year 2021 period is April 2019, but data collection does not begin until after May 21, 2019.

So now is a great time to contact (RTIV), our federal contractor for the National Implementation of Home Health CAHPS and the phone number and the e-mail address are on the agenda and they always welcome new Home Health Agencies and they would love to help you get started.

And also if you have any – if you are a current participant in the survey, you can always contact (RTI). We encourage you to always contact them even if

your question seems minor to you, because you'll get it addressed right away and it will help you in the future as well.

So if – in case you have an issue now that may reoccur. And I think that's all I have to cover today. And now it's my privilege to introduce the next speaker, (Heidi Magladry) and – for updates on both the Home Health and the Hospice Quality Reporting Programs.

(Heidi Magladry): Good afternoon. We have two groups of updates for the home health community today. The first set of updates are about the OASIS Instrument and Guidance and the second set are related to public reporting for the Home Health Quality Reporting Program or the QRP.

We'll start with the update from the OASIS Guidance and Instrument Development. We would like to inform Home Health Agencies that we have released a fact sheet on coding the M and GG function items in OASIS D.

The fact sheet clarifies that the response options for the OASIS M1800 series function items and the Section GG function items are not intended to be duplicative. Instead there are differences between items that have the same or similar names so responses may be different.

To download this fact sheet, please navigate to the Home Health Quality Reporting Training web page on the Home Health QRP website. For other common questions on OASIS D, we also released an updated OASIS D Q&A document. You will find it in the same location on the Home Health QRP website.

We also want to update you on the release of an updated OASIS instrument. This updated instrument, which we will call OASIS D1 will be implemented on January 1, 2020.

All changes that will be reflected in the OASIS D1 are based on proposals finalized in the Calendar Year 2019 Home Health Final Rule. The changes are to add two existing items to the follow-up time point for data collection

and to make data collection at certain time points for 23 existing OASIS items optional.

CMS intends to release the OASIS D1 instrument and related guidance changes in the early summer of 2019. Secondly, we'll share some updates on the public reporting for the Home Health QRP.

As of March 22nd, you can download the latest provider preview reports and the quality of patient care star rating preview reports from CASPER. These reports preview data that will be displayed in the Home Health Compare website beginning July 24, 2019.

The provider preview reports are available to providers in CASPER for 60 days only. The star ratings provider preview reports are available to providers in CASPER for 90 days only. Providers are encouraged to save a copy of their preview reports for later reference.

You can also find the sample of the July 2019 star rating provider preview report in the download section of the Star Ratings Page of the Home Health QRP website. In addition, we released three updated quality of patients care star rating artifacts for the April 2019 Home Health Compare Refresh.

One document details the star ratings methodology. The fact sheet provides a short reference for the most commonly asked questions related to star ratings, and finally the frequently asked questions document provides more comprehensive information on the development and purpose of the home health star ratings.

You can find all three documents in the download section of the Star Ratings Page of the Home Health Quality Reporting website.

Finally, we'd like to remind Home Health Agencies that you can always go to the Spotlight Announcement Page of our Home Health QRP web page to learn about all the latest Home Health QRP Announcements. And with that, I'll hand it off to Charlie Padgett for the Hospice Quality Reporting Program.

Charles Padgett: Thank you (Heidi). Good afternoon. We have multiple updates today for the Hospice Quality Reporting Program or HQRP, including updates on the hospice visits when death is imminent measure pair, the newly available review on (correct) reports and a preview of changes you'll see on Hospice Compare for the upcoming May 2019 refresh.

Let's begin with the update on the hospice visits when death is imminent measure pair. As a reminder, this is the measure pair that assesses hospice staff visits to patients at the end of life over a three- and seven-day period, respectively.

The three-day measure, which we also call Measure 1 assesses the percentage of patients receiving at least one visit from the registered nurse, a physician, a nurse practitioner or a physician assistant in the last three days of life.

The seven-day measure or Measure 2 assesses the percentage of patients receiving at least two visits from social workers, chaplains or spiritual counsels, licensed practical nurses or aides in the last seven days of life.

The announcement we have is that only the three-day measure or Measure 1 will be publicly reported as scheduled on Hospice Compare starting this summer. The seven-day measure or Measure 2 will not be published at this time to allow for additional testing.

Our decision to only publicly report the three-day measure is based on the result of scientific acceptability testing for the measure pair. Specifically the testing results for reliability, validity and reportability indicate that the seven-day measure does not meet the readiness standards for public reporting at this time.

As a next step, we'll continue additional testing to determine if there are modifications needed either for the (measure) specifications or to the method for displaying the measure.

The results of our additional testing will inform our next steps regarding the public reporting of the measure and help ensure that any measure that is publicly reported in the future is thoroughly evaluated.

We'll keep providers informed regarding our plans to publicly report the seven-day measure through sub-regulatory channels and regular HQRP communication strategies such as future open door forums via the Medicare Learning Network, CMS.gov website announcements and various Listserv messaging.

In the meantime, hospices will have continued data collection requirements for the seven-day measure through Fiscal Year 2020. I'd like to note that the items collected for both measures are the same.

As I mentioned, the three-day measure or Measure 1 will be publicly reported on Hospice Compare this summer. So the requirement to continue to report data for the seven-day measure or Measure 2, we just want to make note does not create any additional burden whatsoever on hospice organizations.

The seven-day measure will be included, I'd like to note on Hospice CASPER Quality Measure Reports, even though it will not be publicly reported on Hospice Compare at this time.

The CASPER QM reports are intended for providers' internal use and to aid hospices in quality improvement efforts, and we believe it's important for providers to internally review and be informed by these data.

And of course, we recommend reviewing these data to ensure that hospices are providing the patients and caregivers the support they need in their patients' last days of life.

We want to assure hospice providers that although data collection will continue, CMS has decided not to publicly release any of the data related to the seven-day measure at this time.

Thus, Measure 2 will not be reported on your provider preview reports. And the reason for this is because the provider preview reports are intended to – for providers to preview their data immediately prior to being publicly reported on Hospice Compare.

Please note that we recently posted communication materials on this update on the public reporting background and announcements page of the Hospice Quality Reporting Program website.

The second announcement I'd like to go over is that we'd like to remind providers that as of April 1st, you can now access the review and correct reports – the hospice review and correct reports through the CASPER System.

These confidential provider reports contain hospice level quality measure data and the associated patient level data for all measures based on Hospice Item Set or HIS data. Each report covers 12 months of data. They're designed to give hospices feedback on the quality of care they're providing and the opportunity to correct their HIS-based QM data if needed.

CMS will host a training event in June, 2019, specific to using these new reports and details on the training will be posted on the Hospice Quality Reporting Program website and sent via Listserv notifications as soon as we have the dates confirmed.

Finally, we want to preview some changes you will see during the May, 2019, refresh of Hospice Compare. First, beginning in May, Hospice Compare will post new provider demographic data from Medicare Public Use Files or PUF under new – under a new general information section on the website.

The PUF data contain information on services provided to Medicare beneficiaries by hospice providers. This data in the – in the (file) are based on claims that providers themselves have already adjudicated and that have been made publicly available.

From this file, Hospice Compare will report the following data in May – the number of patients cared for by a hospice on average each day, or the average

daily census; levels of hospice care provided; medical conditions treated and location of care provided.

Second, CMS will update zip codes in the search function of Hospice Compare to improve and enhance the search functionality. When the website was launched in 2017, the search function drew solely from zip codes associated with the physical location of hospice organizations in addition to hospice's self-reported zip codes for service locations using the Hospice Item Set.

This, however, caused some gaps in zip code coverage, so we're adding supplemental database on the National Core Based Statistical Areas or CBSA file to address these gaps.

Our analysis indicates that the CBSA data are a helpful supplement to the zip code data from HIS and claims data and improve the comprehensiveness of the Hospice Compare Search Function to be more representative of hospice's (catchment) areas.

CMS will continue to monitor the search function for remaining gaps in its coverage and in May, the zip code data in the Hospice Compare will be updated to include 2017 claims along with the enhanced CBSA data just described. And that's all I have.

Jill Darling: All right, thank you Charles. Next and last, we have Debra Dean-Whittaker who will go over the CAHPS Hospice Survey.

Debra Dean-Whittaker: Hello, everyone. The CAHPS Hospice Survey data submission deadlines are the second Wednesday of the month for the months of February, May, August and November.

The next data submission deadline for the CAHPS Survey is May 8, 2019. We suggest you put that date on your calendars so that you can check your data submission reports in the CAHPS Hospice Survey Data Warehouse. I recommend that you start checking well before the deadline.

If you have questions about how to access your reports, please contact our Technical Assistance Team. They will be glad to help you. Their contact information is on the agenda.

We also want to encourage hospices to make the CAHPS Hospice Survey available in languages that your patients (and families) use.

We currently offer to mail a version of the survey in the following languages – English, Spanish, traditional and simplified Chinese, Russian, Portuguese, Vietnamese, Polish and Korean. We offer the phone version of the survey in English, Spanish and Russian.

Please let us know if your hospice needs the questionnaire translated into another language. And, we also would like to point out that (we have issued) technical corrections and clarifications to the CAHPS Hospice Survey Quality Assurance Guidelines Manual Version 5.

The document is posted by the CAHPS Hospice Survey website, which is at [www H-O-S-P-I-C-E-C-A-H-P-S-S-U-R-V-E-Y dot org](http://www.H-O-S-P-I-C-E-C-A-H-P-S-S-U-R-V-E-Y.org). That's www.hospicecahpssurvey.org. We also want to let everyone know that we have updated the podcast on the survey website.

We have added new concepts to the following podcasts – selecting and authorizing a survey vendor; data hospices must provide you their survey vendor; changing survey vendors, and public reporting.

These podcasts are specifically intended for hospices. To view them, go to the survey website, click on the left-hand "Information for Hospices" navigation button and then select the "Podcasts for Hospices" navigation button at the top of the page. If you have a suggestion for a podcast topic, please e-mail us. Thank you.

Jill Darling: Great, thank you Debra and thank you to all of our speakers today. (Mariana), we'll please go into our Q&A, please.

Operator: Certainly. As a reminder, ladies and gentlemen if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

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

Your first question comes from the line of (Cheryl Patella) with New Milford Visiting Nurse Association and Hospice. Your line is open.

(Cheryl Patella): Thank you. Good afternoon everyone and thank you so much for the call today. I wanted to clarify something.

We were asking if Medicare payment will be connected to having the patients advanced directives on the plan of care. A recent (cert) audit had denied payment due to no AD on the plan of care yet the (max say) they would not deny based on this reason.

My understanding from the Medicare Payment Policy Manual is that only those services necessary to establish the need for services can be subject to denial if not on the plan of care. And this is outlined in Section 30.2.1 regarding the content of the plan of care. Can you please comment on this?

Kelly Vontran: Hi, this is Kelly Vontran from the Division of Home Health and Hospice. While these are COP requirements to include all those items on the plan of care, we did recently put out a change request with the – with the and accompanying (MON) article in the course of changes in the Benefit Policy Manual and the Program Integrity Manual that, for payment purposes, the items that establish the need for such services would be listed on the plan of care. Does that help?

(Cheryl Patella): Yes, it does. Thank you. It looks like some of this content was just recently updated, so ...

Kelly Vontran: That is correct.

(Cheryl Patella): ... thank you.

Kelly Vontran: That's correct.

(Cheryl Patella): OK, great. Thank you.

Operator: Your next question comes from (Diane Siegel) with (AdoptHealth). Your line is open.

(Diane Siegel): Hi. My questions are in relation to the competitive bidding. And I wanted to find out for the credit reporting, is there an acceptable score number, such as (Dun's) – their scores go all the way up to 100. For each one of the credit reporting companies, is there a certain score that competitive bidding is looking for?

Female: (That's) a great question. Could you please submit that question to the mailbox, the open door forum mailbox and someone can appropriately answer that question for you?

(Diane Siegel): OK. Will do. And then my ...

Female: Thanks.

(Diane Siegel): ... second question – and my second question is with competitive bidding again. Are the end users – when the AO sets up the end users, are the end users able to actually submit the bids or the AO has to go in and actually submit?

Female: That's another great question that will be better answered by an expert.

(Diane Siegel): OK.

Female: Can you please submit those questions together at that address please?

(Diane Siegel): I will. Thank you so much.

Female: Thank you for your questions.

Operator: Your next question comes from (Cheryl Sweeten) with Crossroads Hospice. I apologize, your next question comes from Andrea Stark with MiraVista. Your line is open. Andrea Stark, your line is open.

Andrea Stark: Yes. I just had a question about the DME competitive bid timeline and when we can start seeing education? And how you expect to deploy that (edge) – those pre-bidding education efforts. I'm sorry. Did my question come through?

Female: (Yes, actually it did). The bidder education will be starting in June of this year. Does that answer your question?

Andrea Stark: I believe they said they would be starting the pre-bidder education in May. Correct? Will we get – when will we get more firm dates regarding the timeline?

Female: That should be when we get firmer dates in May. Regarding the timeline?

Andrea Stark: Yes.

Female: Yes.

Andrea Stark: And atypically in this – in this bidding timeline, it looks like the bidder registration is going to open in the same month as the bid window. Normally in prior rounds, we've had 60 days for bidder registration prior to the window opening. Is that going to be a shortened timeline this round? Or we don't know?

Female: Yes. I know in prior rounds we've had more time, but because of the gap period that we just experienced, it kind of like shortened things for us. So yes, the timeline is different. However, that – all of that information will be available in May.

Andrea Stark: OK, thank you.

Female: Yes.

Operator: Your next question comes from (Cheryl Sweeten) with Crossroads Hospice.
Your line is open.

(Cheryl Sweeten): Thank you. Good afternoon. I just have a quick question regarding when does CMS expect to update the notice of termination where you can place the zeros to remove a (revocation)?

It's become very burdensome out here in the provider world, because we not always have other hospices that won't do (precipitate) in removing their claims and removing their (revocations). So when you go to the contractor, I've got some that's been taken months.

So just kind of – and then they told me their hands are tied based off of this SC18007. So I just wanted to know if you can expand on that when you anticipate the updates in the system to be able to accommodate that please?

(Will Gehne): This is (Will Gehne). How – how recently did you have that experience? Because I (thought) that that correction had gone in April 1st.

(Cheryl Sweeten): Yes sir. We are still getting the (reason) code in regards to that when you're placing the zeros. In the update in August, it says that there would be a future change request or an update to this policy, but I talked to a provider today and she says I tried to remove your (revocation), but I got a (reason) code and a reject. It (RTP'd) out or return back to provider.

So – and I haven't seen anything since this last revision that was in August 20, 2018 in regards to that and I've even talked to (Armak) in regards to this and they indicated that they hadn't seen anything come across as far as the zeros working to remove that (revocation) indicator, so.

(Will Gehne): I'm sorry that I'm drawing the blank on the dates. I know that we have issued instructions to the (max) that may have been a confidential change request, but that – it's either April or – April 1st or July 1st.

I'm sorry I don't have the date, but I could confirm that for you offline, if you send us e-mail to the address on the agenda and it will get routed to me and I'll research that a little bit more for you.

(Cheryl Sweeten): Thank you for your time. I appreciate it.

Operator: There are no further questions at this time. I will now turn the call back over to the presenters.

Jill Darling: All right. Well thank you everyone for joining us today. You will get some time back and have a wonderful day. Thank you.

Female: Thanks all.

Operator: This concludes today's conference call. Thank you for participating in today's Home Health, Hospice and DME Quality Open Door Forum.

This call would be available for replay beginning today, Wednesday, April 3rd at approximately 5 o'clock pm Eastern Time until Friday, April 5th at midnight Eastern Time. The conference ID number for the replay is 7983386 and the number to dial for the replay is 855-859-2056.

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