Overview of the FY 2021 Hospital Readmissions Reduction Program

Hosted by: Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor (Inpatient VIQR SC)

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Speakers

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Division of Values, Incentives, and Quality Reporting Program Support (DPS) Contract

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DPS Contract

Moderated by:
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Program Lead
Inpatient VIQR Outreach and Education SC
Purpose

This event will provide an overview of the fiscal year (FY) 2021 HRRP, including:

• Program updates
• Methodology
• Hospital-Specific Reports (HSRs)
• Review and Correction period
Objectives

Participants will be able to:

• Interpret the methodology used in the program.

• Understand your hospital’s program results in your HSR.

• Understand how to submit questions about your hospital’s calculations during the HRRP Review and Correction period.
Webinar Chat Questions

Please email any questions that are pertinent to the webinar topic to WebinarQuestions@hsag.com with the following information:

• Subject Line: Overview of the FY 2021 Hospital Readmissions Reduction Program
• Email Body: If your question pertains to a specific slide, please include the slide number

If you have a question unrelated to the current webinar topic, we recommend that you first search for it in the QualityNet Inpatient Questions and Answers tool, at https://cmsqualitysupport.servicenowservices.com/qnet_qa. If you do not find an answer, then submit your question to us via the same tool.
Overview of the FY 2021 Hospital Readmissions Reduction Program

Program Background and Methodology
Hospital Readmissions Reduction Program (HRRP) Background

• HRRP is a Medicare value-based purchasing program established under Section 3025 of the Affordable Care Act.

• HRRP encourages hospitals to improve communication and care coordination efforts to better engage patients and caregivers in post-discharge planning.

• CMS reduces payments to subsection (d) hospitals with excess readmissions.
Eligible Hospitals

• All subsection (d) hospitals, as defined under the Social Security Act, with eligible discharges are included in HRRP.

• CMS exempts Maryland hospitals from HRRP payment reductions because of an agreement between CMS and Maryland.
HRRP Measures and Performance Period

• The FY 2021 three-year performance period includes hospital discharges from July 1, 2016 through June 30, 2019.

• The following six condition/procedure-specific 30-day risk standardized unplanned readmission measures are included in HRRP:
  • Acute Myocardial Infarction
  • Chronic Obstructive Pulmonary Disease
  • Heart Failure
  • Pneumonia
  • Coronary Artery Bypass Graft surgery
  • Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty
21st Century Cures Act Provisions for HRRP

- Prior to the 21st Century Cures Act, CMS used a non-stratified methodology (FY 2013 to FY 2018) to assess hospital performance under HRRP.

- Beginning in FY 2019, the 21st Century Cures Act directs CMS to use a stratified methodology to evaluate a hospital’s performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full Medicaid benefits.

- The 21st Century Cures Act also requires that the stratified methodology produce the same amount of Medicare savings generated under the non-stratified methodology to maintain budget neutrality.
Payment Reduction Methodology

- The payment reduction is the percentage a hospital’s payments will be reduced based on its performance in the program.
- The payment reduction is a weighted average of a hospital’s performance across the 6 HRRP measures during the 3-year performance period.
- The payment adjustment factor is the form of the payment reduction CMS uses to reduce hospitals’ payments.
- The next slides will describe the steps involved in calculating the payment reduction.
Payment Reduction Methodology: ERR and Dual Proportion

**Step 1:** For every hospital, CMS calculates an excess readmission ratio (ERR) for each of the six HRRP conditions/procedures and a dual proportion.

**ERR:** a measure of a hospital’s relative performance, calculated using Medicare fee-for-service (FFS) claims.

**Dual proportion:** the proportion of Medicare FFS and managed care stays in a hospital where the patient was dually eligible for Medicare and full Medicaid benefits.
Dual Eligibility Definition

- As finalized in the FY 2020 IPPS rule, for FY 2021 CMS updated the definition of dual-eligibility used in the dual proportion calculations as such:
  - **Previous definition**: dual-eligible stays are defined as stays for Medicare beneficiaries with full Medicaid benefits for the month the beneficiary was discharged from the hospital.
  - **New definition**: dual-eligible stays are defined as stays for Medicare beneficiaries with full Medicaid benefits for the month the beneficiary was discharged from the hospital. *The exception are for those patient beneficiaries who die in the month of discharge who are identified using the previous month’s dual eligibility status.*
Payment Reduction Methodology: Peer Groups and Peer Group Median ERR

- **Step 2**: CMS stratifies hospitals into 1 of 5 peer groups (i.e., quintiles) based on hospitals’ dual proportions.

- **Step 3**: CMS calculates a median ERR for each peer group and each measure.

### Example peer groups:

<table>
<thead>
<tr>
<th>Peer group</th>
<th>Minimum dual proportion</th>
<th>Maximum dual proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.1347</td>
</tr>
<tr>
<td>2</td>
<td>0.1348</td>
<td>0.1832</td>
</tr>
<tr>
<td>3</td>
<td>0.1833</td>
<td>0.2316</td>
</tr>
<tr>
<td>4</td>
<td><strong>0.2317</strong></td>
<td><strong>0.3083</strong></td>
</tr>
<tr>
<td>5</td>
<td>0.3084</td>
<td>1</td>
</tr>
</tbody>
</table>

**Hospital A’s dual proportion = 0.2638**
**Hospital A is in peer group 4**

### Example peer group median ERRs:

<table>
<thead>
<tr>
<th>Peer group</th>
<th>AMI</th>
<th>COPD</th>
<th>HF</th>
<th>Pneumonia</th>
<th>CABG</th>
<th>THA/TKA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.9941</td>
<td>0.9943</td>
<td>0.9848</td>
<td>0.9876</td>
<td>0.9804</td>
<td>0.9841</td>
</tr>
<tr>
<td>2</td>
<td>0.9961</td>
<td>0.9944</td>
<td>0.9865</td>
<td>0.9844</td>
<td>0.9961</td>
<td>0.9969</td>
</tr>
<tr>
<td>3</td>
<td>0.9964</td>
<td>0.9956</td>
<td>0.9894</td>
<td>0.9866</td>
<td>0.9979</td>
<td>0.9901</td>
</tr>
<tr>
<td>4</td>
<td><strong>0.9970</strong></td>
<td><strong>0.9954</strong></td>
<td><strong>1.0077</strong></td>
<td><strong>0.9971</strong></td>
<td><strong>1.0093</strong></td>
<td><strong>1.0073</strong></td>
</tr>
<tr>
<td>5</td>
<td>1.0093</td>
<td>1.0104</td>
<td>1.0258</td>
<td>1.0253</td>
<td>1.0157</td>
<td>0.9989</td>
</tr>
</tbody>
</table>
Payment Reduction Methodology: Measure Contributions

Step 4: CMS determines which ERRs will contribute to the payment reduction. For an ERR to contribute to the payment reduction, it must meet two criteria:

- ERR > peer group median ERR
- Eligible discharges ≥ 25

Example payment reduction measure contribution determination for Hospital A:

<table>
<thead>
<tr>
<th>Measure</th>
<th>ERR</th>
<th>Peer group 4 median ERR</th>
<th>Eligible discharges</th>
<th>ERR &gt; peer group 4 median ERR</th>
<th>Eligible discharges ≥ 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI</td>
<td>0.9722</td>
<td>0.9970</td>
<td>42</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>COPD</td>
<td>1.0474</td>
<td>0.9954</td>
<td>38</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>HF</td>
<td>0.9983</td>
<td>1.0077</td>
<td>22</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1.1369</td>
<td>0.9971</td>
<td>25</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>CABG</td>
<td>0.9438</td>
<td>1.0093</td>
<td>25</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>THA/TKA</td>
<td>NQ</td>
<td>1.0073</td>
<td>0</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

The COPD and pneumonia ERRs will contribute to Hospital A’s payment reduction.
Payment Reduction Methodology: Measure Contributions

- **Step 5**: CMS calculates each measure’s contribution to the payment reduction.

Example calculations for Hospital A’s payment reduction:

\[
\text{Neutrality modifier} \times \text{DRG ratio} \times \left( \frac{\text{ERR}}{\text{Peer group median ERR}} \right) = \text{Contribution}
\]

- COPD
  - Neutrality modifier: 0.9458
  - DRG ratio: 0.0331
  - ERR: 1.0474
  - Contribution: 0.0016
- Pneumonia
  - Neutrality modifier: 0.9458
  - DRG ratio: 0.0648
  - ERR: 1.1369
  - Contribution: 0.0086

Only the COPD and pneumonia measures are shown in this step because these are the only two measures that will contribute to Hospital A’s payment reduction (see Step 4).
Payment Reduction Methodology: Payment Reduction

**Step 6:** CMS sums the measure contributions to the payment reduction.

- If the sum of the measure contributions to the payment reduction is >0.03, CMS applies the 3% cap.
Payment Reduction Methodology: Payment Adjustment Factor

Step 7: CMS calculates the payment adjustment factor (PAF).

\[ \text{Payment adjustment factor} = 1 - \text{payment reduction} \]

Step 8: CMS applies the payment adjustment factor to payments for Medicare FFS claims submitted starting October 1 each year.

\[ \text{PAF} \times \text{Base operating DRG payment amounts} \]

*Example application of the payment adjustment factor for Hospital A:*

Hospital A's total base operating DRG payment amount is: $9,842,675.00
Hospital A's payment adjustment factor is: 0.9898
Hospital A's total payment for Medicare FFS claims* = $9,842,675.00 \times 0.9898 = $9,742,279.72

*In general, base operating DRG payment amounts are the Medicare FFS base operating DRG payments without any add-on payments (e.g., Disproportionate Share Hospital and Indirect Medical Education payments).
Overview of the FY 2021 Hospital Readmissions Reduction Program

Hospital-Specific Report (HSR) Overview
HRRP HSR Content

The HRRP HSRs contains tabs that provide hospitals the following information:

• Payment Adjustment Factor
• Measure results/ERRs
• Neutrality Modifier
• Stratification information
  ▪ Dual stays
  ▪ Dual proportion
  ▪ Peer group assignment
• Discharge-level information for readmission measures
• Contact information for the program and links to additional resources
Table 1: Your Hospital’s Payment Adjustment Factor Information

HOSPITAL NAME  
Hospital Discharge Period: July 1, 2016 through June 30, 2019

<table>
<thead>
<tr>
<th>Number of Dual Eligible Stays (Numerator) [a]</th>
<th>Total Number of Stays (Denominator) [b]</th>
<th>Dual Proportion [c]</th>
<th>Peer Group Assignment [d]</th>
<th>Neutrality Modifier [e]</th>
<th>Payment Adjustment Factor [f]</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,932</td>
<td>27,178</td>
<td>0.1079</td>
<td>1</td>
<td>0.9613</td>
<td>0.9998</td>
</tr>
</tbody>
</table>

Mock HSR (illustrative data)
Table 2: Hospital Results

Table 2: Your Hospital’s Measure Results on 30-Day All-Cause Unplanned Risk-Standardized Readmission for AMI, COPD, HF, Pneumonia, CABG, and THA/TKA
HOSPITAL NAME
Hospital Discharge Period: July 1, 2016 through June 30, 2019

<table>
<thead>
<tr>
<th>Measure</th>
<th>Number of Eligible Discharges [b]</th>
<th>Number of Readmissions Among Eligible Discharges [c]</th>
<th>Predicted Readmission Rate [d]</th>
<th>Expected Readmission Rate [e]</th>
<th>Excess Readmission Ratio (ERR) [f]</th>
<th>Peer Group Median ERR [g]</th>
<th>Penalty Indicator (Yes/No) [h]</th>
<th>Ratio of DRG Payments Per Measure to Total Payments [i]</th>
<th>National Observed Readmission Rate [%]</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI</td>
<td>16</td>
<td>2</td>
<td>12.4378%</td>
<td>12.4355%</td>
<td>1.0002</td>
<td>0.9936</td>
<td>No</td>
<td>0.0077</td>
<td>15.7%</td>
</tr>
<tr>
<td>COPD</td>
<td>11</td>
<td>4</td>
<td>17.8431%</td>
<td>17.4282%</td>
<td>1.0238</td>
<td>0.9946</td>
<td>No</td>
<td>0.0031</td>
<td>19.6%</td>
</tr>
<tr>
<td>HF</td>
<td>27</td>
<td>6</td>
<td>19.9962%</td>
<td>19.7043%</td>
<td>1.0099</td>
<td>0.9974</td>
<td>Yes</td>
<td>0.0074</td>
<td>21.7%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>17</td>
<td>2</td>
<td>15.1148%</td>
<td>15.2421%</td>
<td>0.8916</td>
<td>0.9903</td>
<td>No</td>
<td>0.0080</td>
<td>16.6%</td>
</tr>
<tr>
<td>CABG</td>
<td>NQ</td>
<td>NQ</td>
<td>NQ</td>
<td>NQ</td>
<td>NQ</td>
<td>0.9758</td>
<td>No</td>
<td>NQ</td>
<td>12.6%</td>
</tr>
<tr>
<td>THA/TKA</td>
<td>12</td>
<td>0</td>
<td>3.3885%</td>
<td>3.4652%</td>
<td>0.9779</td>
<td>0.9892</td>
<td>No</td>
<td>0.0054</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

Mock HSR (illustrative data)
Tables 3 – 8: Discharges

Table 3: Discharge-Level Information for the AMI 30-Day All-Cause Unplanned Risk-Standardized Readmission Measure

HOSPITAL NAME

Hospital Discharge Period: July 1, 2016 through June 30, 2019

Note: This Microsoft® Excel® file contains MOCK data except for national results. Your hospital's HSR workbook contains discharge-level data protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any disclosure of protected health information (PHI) should be in accordance with, and only to the extent permitted by, the HIPAA Privacy and Security Rules and other applicable law. When referring to the contents of your hospital's HSR workbook, use the ID [Please note row 8 contains risk factor coefficients beginning in column S. Beginning in row 9 of the HSR, the file contains a 1 if the patient was identified as having that risk factor (and equals the years above 65 for the "Age minus 65" risk factor); 0 otherwise. The risk factor flags (1 or 0) will be in cells beginning in column T]

<table>
<thead>
<tr>
<th>ID Number</th>
<th>HICNO</th>
<th>MBI</th>
<th>Medical Record Number</th>
<th>Beneficiary DOB</th>
<th>Admission Date of Index Stay</th>
<th>Discharge Date of Index Stay</th>
<th>Cohort Inclusion/Exclusion Indicator</th>
</tr>
</thead>
</table>

Mock HSR (illustrative data)
Tables 3 – 8: Discharges (Continued)

<table>
<thead>
<tr>
<th>Index Stay (Yes/No)</th>
<th>Principal Discharge Diagnosis of Index Stay</th>
<th>Discharge Destination</th>
<th>Unplanned Readmission within 30 Days (Yes/No)</th>
<th>Planned Readmission (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>I2119</td>
<td>06</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>I214</td>
<td>03</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>I2119</td>
<td>01</td>
<td>No</td>
<td>No</td>
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<td>I214</td>
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<tr>
<td>Yes</td>
<td>I214</td>
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<td>No</td>
</tr>
</tbody>
</table>

Mock HSR (illustrative data)
## Tables 3 – 8: Discharges (Continued)

<table>
<thead>
<tr>
<th>Readmission Date</th>
<th>Discharge Date of Readmission</th>
<th>Principal Discharge Diagnosis of Readmission</th>
<th>Readmission to Same Hospital (Yes/No)</th>
<th>Provider ID of Readmitting Hospital [c]</th>
<th>HOSP_EFFECT</th>
<th>AVG_EFFECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>--</td>
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<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>99/99/9999</td>
<td>99/99/9999</td>
<td>I214</td>
<td>No</td>
<td>888888</td>
<td>N/A</td>
<td>N/A</td>
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<td>N/A</td>
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<td>N/A</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Mock HSR (illustrative data)
Table 9: Dual Stays

Table 9: Stay-Level Information for Dual Eligibles (Dual Proportion Numerator)

HOSPITAL NAME
Hospital Discharge Period: July 1, 2016 through June 30, 2019

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<table>
<thead>
<tr>
<th>ID Number</th>
<th>HICNO</th>
<th>MBI [a]</th>
<th>Beneficiary DOB</th>
<th>Admission Date</th>
<th>Discharge Date</th>
<th>Claim Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>999999999A</td>
<td>9999999999M</td>
<td>9/9/9999</td>
<td>9/9/9999</td>
<td>9/9/9999</td>
<td>Managed Care</td>
</tr>
<tr>
<td>2</td>
<td>999999999A</td>
<td>9999999999M</td>
<td>9/9/9999</td>
<td>9/9/9999</td>
<td>9/9/9999</td>
<td>Fee for Service</td>
</tr>
<tr>
<td>3</td>
<td>999999999A</td>
<td>9999999999M</td>
<td>9/9/9999</td>
<td>9/9/9999</td>
<td>9/9/9999</td>
<td>Managed Care</td>
</tr>
<tr>
<td>4</td>
<td>999999999A</td>
<td>9999999999M</td>
<td>9/9/9999</td>
<td>9/9/9999</td>
<td>9/9/9999</td>
<td>Managed Care</td>
</tr>
<tr>
<td>5</td>
<td>999999999A</td>
<td>9999999999M</td>
<td>9/9/9999</td>
<td>9/9/9999</td>
<td>9/9/9999</td>
<td>Managed Care</td>
</tr>
<tr>
<td>6</td>
<td>999999999A</td>
<td>9999999999M</td>
<td>9/9/9999</td>
<td>9/9/9999</td>
<td>9/9/9999</td>
<td>Managed Care</td>
</tr>
</tbody>
</table>

Mock HSR (illustrative data)
The Review and Correction period begins when CMS distributes HSRs via QualityNet Secure Portal accounts. For FY 2021, the Review and Correction period extends from August 10, 2020 through September 9, 2021.

CMS grants hospitals 30 days to review their HRRP data, submit questions about their result, and request a correction if a calculation error is identified.

If a hospital identifies a potential discrepancy in the payment adjustment factor and component results, the hospital should submit an inquiry to the Quality Q&A Tool no later than 11:59 pm PT on the final day of the Review and Correction period.
What can hospitals correct?

Hospitals CAN:

• Submit questions about the calculation of their:
  ▪ Payment Adjustment
  ▪ Dual Stays
  ▪ Dual Proportion
  ▪ Peer Group Assignment
  ▪ Neutrality Modifier
  ▪ ERR(s)
  ▪ Peer Group Median ERR(s)

Hospitals CANNOT:

• Submit additional corrections related to the underlying claims data.
• Add new claims to the data used for the calculations.
Public Reporting

• For hospitals with at least 25 discharges, CMS reports the following data elements for each of the 30-day risk-standardized unplanned readmission measures on Hospital Compare or the successor website:
  • Number of eligible discharges
  • Number of readmissions for hospitals with 11 or more readmissions
  • Predicted readmission rates (i.e., adjusted actual readmissions)
  • Expected readmission rates
  • ERR
After the Review and Correction period, CMS releases the IPPS/LTCH PPS final rule Supplemental Data File which includes the following components:

- Hospital payment adjustment factor
- Hospital dual proportion
- Hospital peer group assignment
- Neutrality modifier
- ERR for each measure
- Number of eligible discharges for each measure
- Peer Group Median ERR for each measure
- Penalty Indicator for each measure
- DRG payment ratio for each measure
Updates for FY 2021 HRRP

CMS will publicly report FY 2021 HRRP data on Hospital Compare or the successor website in early 2021.
HRRP Resources

Program information:  
https://qualitynet.org/inpatient/hrrp

HSR User Guide, Mock HSR, and Replication Example:  
https://qualitynet.org/inpatient/hrrp/reports

30-day risk-standardized unplanned readmission measure information:  
https://www.qualitynet.org/inpatient/measures/readmission
Submit questions about HRRP to the Quality Q&A Tool by selecting “Ask a Question” and then use the table below to determine which Program, Topic, and Subtopic to select.

<table>
<thead>
<tr>
<th>Question Subject</th>
<th>Program</th>
<th>Topic and Subtopic (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your hospital’s results, issues accessing the HSR, or patient-level data</td>
<td>HRRP – Hospital Readmissions Reduction Program</td>
<td>Hospital-specific reports &amp; requests</td>
</tr>
<tr>
<td>Request for Excel replication example</td>
<td>HRRP – Hospital Readmissions Reduction Program</td>
<td>HSR replication example</td>
</tr>
<tr>
<td>PAF or payment reduction methodology</td>
<td>HRRP – Hospital Readmissions Reduction Program</td>
<td>PAF Methodology</td>
</tr>
<tr>
<td>Readmission measure methodology</td>
<td>Inpatient Claims-Based Measures</td>
<td>Topic: Readmissions Subtopic: Understanding measure methodology</td>
</tr>
</tbody>
</table>
Questions
Webinar Chat Questions

Please email any questions that are pertinent to the webinar topic to WebinarQuestions@hsag.com with the following information:

- Subject Line: Overview of the FY 2021 Hospital Readmissions Reduction Program
- Email Body: If your question pertains to a specific slide, please include the slide number

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