Welcome to the Reducing Readmissions Preparation Program: Understanding Changes in Readmission Measures for Nursing Homes

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Director, Care Transitions, HSAG California

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Director, Nursing Homes, HSAG California

January 24, 2018
How to Submit a Question

1. To submit a question, click on the **Chat** option at the top right of the presentation.
2. The **Chat** panel will open.
3. Indicate that you want to send a question to **All Panelists**.
4. Type your question in the box at the bottom of the panel.
5. Click on **Send**.

To connect to the audio portion of the webinar, please have WebEx call you.
Presenters

Lindsay Holland, MHA
Director, Care Transitions
HSAG California

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Director, Nursing Homes
HSAG California
Welcome HSAG QIN-QIO

Arizona
Ohio
California
Welcome and Thank You
Objectives

- Explain readmission quality measures for nursing homes, including Skilled Nursing Facility Value-Based Purchasing (SNF-VBP), and hospital/nursing home penalty review.

- Review the reducing readmissions preparation program (RRPP) criteria and benefits of participation.

- Demonstrate how to enroll in the program.

- Learn about upcoming topics for webinar series.
Nursing Home All-Cause Readmission Rates by State

Data source: Medicare Fee-for-Service Part-A claims for index hospital discharges from July 1, 2016, through June 30, 2017.
RRPP Aligned with Quality Assurance and Performance Improvement (QAPI)

Reducing Readmissions Preparation Program (RRPP) = QAPI

Quality Assurance & Performance Improvement
Skilled Nursing Facility
Value-Based Purchasing (SNF-VBP)
Hospital Readmission Penalties

Section 3025 Affordable Care Act of 2010

- Fiscal years 2013–2018: hospitals are penalized for excess readmissions

- California (CA): 221, 74%
- Arizona (AZ): 50, 79%
- Ohio (OH): 106, 83%
Doing things the same way…

…will NOT reduce readmissions.

- October 2017
  - Readmission rates go public on Nursing Home Compare

- October 2018
  - VBP program for nursing homes begins
The SNF-VBP program offers Medicare incentive payments to SNFs based on their readmissions performance.

- Provides incentives for facilities to coordinate care

Builds on previous quality improvement efforts

- Nursing Home Compare
- SNF Quality Reporting Program
SNF-VBP Program

**Reduction amount: 2%**
- Lowest performers may lose 2% of Medicare funding

**Incentive payments**
- 50% to 70% of withheld funds will be available for distribution back to SNFs in top 60%

**SNFs will be ranked**
- Bottom 40% will be in the penalty-eligible range

**CMS* provides reports on the measure**
- SNFs can review and plan for action
- Began October 1, 2016

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*Centers for Medicare & Medicaid Services*
SNF Readmission Penalty Timeline

2014 Passed

2014
Jan.–Dec. 2015
Calendar Year (CY) Baseline time period

Confidential Feedback report with CY 2013 rates available in QIES system

Oct. 2017
Oct. 2017 Public reporting of SNF readmissions on Nursing Home Compare

Oct. 2018
Oct. 2018 Incentive/penalty goes live

Oct. 2018
Oct. 2018 2% withhold of SNF payments begin

$2B Savings/10 years

40% of SNFs nationally will receive less back than best 60%

60% of the withhold will go to incentive payments to SNFs

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html
The measure:
All-cause, risk-adjusted, unplanned hospital readmissions within 30 days of discharge

- Begins fiscal year (FY) 2019
- Payments on or after October 1, 2018
- Reduction amount is up to 2% of Medicare claims
What Counts as a Readmission

Hospital readmissions are identified through Medicare **hospital claims** (not SNF claims).

- Readmissions to a hospital within the 30-day window are counted if:
  - The beneficiary is readmitted directly from the SNF, or had been discharged from the SNF
- Excludes planned readmissions
- Is risk-adjusted based on:
  - Patient demographics
  - Principal diagnosis from the prior hospitalization
  - Comorbidities
  - Other health status variables that affect probability of readmission
# Definitions for SNF-VBP Program

<table>
<thead>
<tr>
<th>Term</th>
<th>Proposed Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement Threshold</td>
<td>The 25th percentile of national SNF performance on the quality measure during CY 2015</td>
</tr>
<tr>
<td>Benchmark</td>
<td>The mean of the best decile of national SNF performance on the quality measure during CY 2015</td>
</tr>
<tr>
<td>Improvement Threshold</td>
<td>The specific SNF’s performance on the measure</td>
</tr>
<tr>
<td>Performance Period</td>
<td>CY 2017</td>
</tr>
<tr>
<td>Baseline Period</td>
<td>CY 2015</td>
</tr>
</tbody>
</table>
### Measurement Time Periods

<table>
<thead>
<tr>
<th>Term</th>
<th>FY 2019 Program</th>
<th>FY 2020 Program</th>
</tr>
</thead>
</table>

**Diagram:****
- **Performance Period:** CY 2016 (Jan. 1–Dec. 31, 2016) and CY 2018 (Jan. 1–Dec. 31, 2018)

**FY 2019 Program:**
- Baseline Period
- Performance Period

**FY 2020 Program:**
- Baseline Period
- Performance Period
SNF-VBP amount is calculated using the “achievement/improvement” methodology used for hospital VBP.

- Rates will be compared to thresholds and benchmarks.
- SNFs will be awarded points for either achievement or improvement, whichever is higher.
CMS has adopted these scoring methodologies to measure SNF performance that include levels of achievement and improvement:

• **Achievement scoring**
  – Compares an individual SNF’s performance rate in a performance period against all SNFs’ performance during the baseline period

• **Improvement scoring**
  – Compares a SNF’s performance during the performance period against its own prior performance during the baseline period
Achievement Score: For FY 2019, points awarded by comparing the facility’s rate during the performance period (CY 2017) with the performance of all facilities nationally during the baseline period (CY 2015).
Improvement Score: Points awarded by comparing the facility’s rate during the performance period (CY 2017) with its previous performance during the baseline period (CY 2015).

1–89 points: Awarded according to the formula described in the final rule.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html
Performance Score Example: Nursing Home “Alpha”

National Achievement Rate (CY 2015) = 20.41%
National Benchmark Rate (CY 2015) = 16.39%

Readmission rate for Alpha:

- Alpha’s CY 2015 readmission rate (baseline) = 17.25%
- Alpha’s CY 2017 readmission rate (performance) = 15.74%
  - **Achievement** score = 100
    (because Alpha’s baseline score is better than the national Achievement Rate average)
  - No **Performance** score calculated
Calculating Performance Score: Inverted Rate

Performance scores are calculated by inverting SNF-RM rates

SNF-RM inverted rate = 1 – facility SNF-RM rate
Inverted Rate Example

SNF-RM inverted rate = 1 – facility SNF-RM rate

• SNF Readmissions Rate = 20.449%
  \( (SNF-RM \text{ Inverted Rate} = 1 - 0.20449) \)

• SNF-RM Inverted Rate = 0.79551

• Once the rate has been inverted, a higher score is better.
Inverted Score Example:
Nursing Home Alpha

National Achievement Rate (CY 2015) = .79590 (1 – .2041)
National Benchmark Rate (CY 2015) = .83601 (1 – .1639)

• Alpha CY 2015 Baseline Readmission Rate
  = .82750 (1 – .1725)

• Alpha CY 2017 Performance Readmission Rate
  = .84261 (1 – .1574)

  o Achievement score = 100
    (because Alpha’s inverted baseline score is better than the national inverted Achievement Rate Rate average)

  o No Performance score calculated
Accessing your SNF-VBP Report
Step 1. Quality Improvement and Evaluation System (QIES) for Providers

Access the CMS QIES for providers and click **CASPER Reporting** (on the left).
Step 2. Login

Use your **User ID** and **Password** to access the CASPER site.
Step 3. Folders

Click **Folders** at the top of your screen
Step 4. SNF Inbox

Click the first item under *Facility...SNF Inbox* and open the PDF file that appears.
Step 5. View Report

Your facility report will look similar to this sample

The Skilled Nursing Facility Value-Based Purchasing Program
Quarterly Confidential Feedback Report

March 2017 (Quarter 2, FY 2017)

Facility: YOUR SNF
CCN: 123456
City, State: WALTHAM, MASSACHUSETTS

Your SNF’s Performance on the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) in 2014

<table>
<thead>
<tr>
<th>Measure</th>
<th>Your SNF’s Number of Eligible Stays</th>
<th>Your SNF’s Number of Readmissions*</th>
<th>Your SNF’s Risk-Standardized Readmission Rate**</th>
<th>National Average Readmission Rate***</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNFRM</td>
<td>23</td>
<td>4</td>
<td>18.76%</td>
<td>19.09%</td>
</tr>
</tbody>
</table>

Source: Medicare claims and eligibility data from CY 2014.
More About SNF-VBP

CMS has more information online:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html

The Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

What's the Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)?

The SNF VBP Program rewards skilled nursing facilities with incentive payments for the quality of care they give to people with Medicare.

Email: SNFVBPInquiries@cms.hhs.gov
Next Steps

Determine what improvements can be made in your facility to positively impact your SNF-VBP performance period.

- Track and trend your readmission data to understand your performance.
- Review your confidential feedback report using the CMS QIES system.
- Compare your rates to regional, state, and national benchmarks.
- Improve your nursing home’s performance through implementing quality improvement programs such as HSAG’s RRPP program.
Join Us on a Nine-Month Journey!

Reducing Readmission Preparation Program

Starting the Journey
January–February

Well on the Way
March–April

Leading the Way
May–September
Question #1

Does your organization have reducing readmissions as a current priority?

• Respond via the chat box:
  ✓ Yes
  ✓ No

• Add your company or nursing home name
1. To submit your answer, click on the **Chat** option at the top right of the presentation.

2. The **Chat** panel will open.

3. Indicate that you want to send a response to **All Panelists**.

4. Type your answer in the box at the bottom of the panel.

5. Click on **Send**.

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*Is reducing readmissions a current priority? Respond via the chat box: Yes or No*  
Add your company or nursing home name
Your Commitment to Reduce Readmissions

1. Establish your reducing readmissions team with leadership involvement.
2. Track and trend Medicare Fee-for-Service 30-day readmissions data.
3. Improve staff members’ knowledge on strategies and clinical skills to prevent readmissions.
4. Use QAPI techniques to implement interventions.
5. Share successes and lessons learned with acute care partners.
Reducing Readmissions Preparation Program

Goals:

• Improve staff knowledge on readmission interventions
• Assist nursing homes to create and strengthen their readmission prevention programs
• Help facilities be a preferred provider to your local hospitals
• Improve readmission rates by October 2018
Reducing Readmissions Preparation Program (cont.)

Find it online

California
www.hsag.com/ca-rrpp

Arizona
www.hsag.com/az-rrpp

Ohio
www.hsag.com/oh-rrpp
Phase 1: Starting the Journey (Jan.–Feb. 2018)

- Sign Up! Submit commitment agreement to participate
- Submit Reducing Readmissions Committee Roster
- Submit Nursing Home Readmission Pre-Assessment
- Submit QAPI Self-Assessment Survey

Work with your Reducing Readmissions Committee to:

- Request and review available CMS readmissions data to establish your baseline readmission rate
- Begin QAPI project to implement a readmission intervention
Nursing Home Readmission Assessment

Work with your Reducing Readmissions Committee to complete the readmission assessment

- Focused on operational processes
- Pre-admission
- Admission/transfer from hospital

<table>
<thead>
<tr>
<th>Assessment Items</th>
<th>Yes, In Place With Consistent Use</th>
<th>Yes, In Place With Partial Use</th>
<th>Under Development</th>
<th>No, Not Doing at All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational Processes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Do you track and trend transfers using a readmission dashboard?</td>
<td>❌</td>
<td>✅</td>
<td>❌</td>
<td>❌</td>
</tr>
</tbody>
</table>

Rationale: “A dashboard is an ideal way to prioritize the most important indicators for a nursing home and encourage regular monitoring of the results. Nursing homes should include readmission as one of the measures in your dashboard.”

Submit completed form online or scan and email to your state contact:

Phase 2: Well on the Way (March–April 2018)

- Conduct and submit plan-do-study-act (PDSA) cycle(s) on readmission intervention(s)
- Participate in at least two learning opportunities, which can include:
  - 2018 Intervention Strategies and Clinical Skills Webinar Series
  - Coaching calls
  - Attendance to any CAHF readmission-related sessions

Work with your Reducing Readmissions Committee to:

- Track and trend Medicare Fee-for-Service 30-day readmissions data
  - Discuss in morning huddles
  - Review trends with executive leadership
  - Conduct monthly chart reviews for patients readmitted in past 30 days
### 2018 Webinar Series

<table>
<thead>
<tr>
<th>INTERVENTION STRATEGIES</th>
<th>CLINICAL SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome: Understanding Changes in Readmission Measures</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Principles from Evidence-based Care Coordination Programs</td>
<td>Heart Failure, Anticoagulants, Medication Reconciliation</td>
</tr>
<tr>
<td>Running a Readmission Review Committee</td>
<td>Diabetes and Hypoglycemia</td>
</tr>
<tr>
<td>Listening to Your Residents: Teach Back and Motivational Interviewing</td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
</tr>
<tr>
<td>Sharing Success Stories</td>
<td></td>
</tr>
</tbody>
</table>

**Up to 9 CEUs available:**
- Nursing (all states)
- Nursing Home Administrators (CA only)
### Phase 3: Leading the Way (May–Sept. 2018)

- Participate in three additional learning opportunities (total of five by end of program)
- Complete and submit Nursing Home Readmission Post-Assessment
- Achieve a 6% relative improvement rate from baseline to remeasurement period
- Submit story board of readmission program’s successes and lessons learned

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Work with your Reducing Readmissions Committee to:

- Continue QAPI project by using data monitoring and reporting results through QAPI committee
Next Steps: Let the Journey Begin!

- Sign Up! Submit commitment agreement to participate
- Submit Reducing Readmissions Committee Roster
- Submit Nursing Home Readmission Pre-Assessment
- Submit QAPI Self-Assessment Survey

Work with your Reducing Readmissions Committee to:

- Request and review available CMS readmissions data to establish your baseline readmission rates.
- Begin QAPI project to implement a readmission intervention
Sign up Today—Start the Journey

Complete commitment agreement:

Nursing Home Reducing Readmissions Preparation Program

Readmissions Penalties Are Coming. Are You Ready?
Did you know that Medicare is changing the reimbursement structure for nursing homes starting October 2018? A new factor that will contribute to your nursing home reimbursement includes hospital readmissions. Participating in this program will help improve knowledge on new readmission quality measures, identify strategies to prevent readmissions, and help facilities be a preferred provider to your local hospitals.

Program Activities
- Establish a Reducing Readmissions Committee to create a successful program in your facility.
- Track and trend Medicare Fee-for-Service 30-day readmissions data.
- Participate in monthly Intervention Strategies and Clinical Skills Webinar Series to reduce readmissions.
- Use Quality Assurance and Performance Improvement (QAPI) techniques to implement readmission interventions.
- To help keep you on track, participate in monthly coaching calls with HSAG to share best practices for implementing interventions, and share successes and challenges.

California nursing homes: sign up here today!

What's Involved? Steps in the Preparation Journey

Materials to Get You Started
- Program Overview: What is the Reducing Readmissions Preparation Program? Download the Program Overview.
- Commitment Agreement: Ready to join? Sign up online or download the Agreement PDF and fax it back.
- Program Criteria: What's involved? See our Program Criteria page for details, or download the Program Criteria flyer.
- Webinar Calendar: Webinars will help you along the way. To see upcoming events, download the Webinar Series Calendar.

California
www.hsag.com/ca-rrpp

Arizona
www.hsag.com/az-rrpp

Ohio
www.hsag.com/oh-rrpp
Reducing Readmissions Preparation Program
Commitment Agreement

Your pledge commits your organization to the following actions January 1—September 30, 2018:

1. Establish a Reducing Readmissions Committee and submit a roster of their contact information. Identify the lead champion for the committee.
2. Track and trend daily your Medicare Fee-for-Service 30-day readmissions data, either through electronic health record (EHR) or another tool. 30-day readmissions are defined as hospital stays readmitted within 30 days of hospital discharge.
3. Conduct at least one Performance Improvement Project (PIP) that is specific to reducing readmissions.
4. Participate in HSAG learning opportunities addressing readmission topics, including common clinical changes of conditions, intervention strategies, and coaching calls.
5. After this program, create a storyboard of your organization’s readmissions project. Templates will be provided.

I pledge to engage in the actions listed above and commit my organization to participate in the HSAG 2018 Reducing Readmissions Preparation Program.

* Facility Name

* CMS Certification Number (CCN) - 6 digits

* Administrator/Dir. of Nursing/Dir. of Social Services/Discharge Planner (name 1)

* Administrator Email Address

* Facility Phone

Facility Fax

* Signature (enter your name)
Question #2

If you work with a nursing home, when will you sign up for RRPP?

• Respond via the chat box:
  ✓ Today
  ✓ Tomorrow
  ✓ Next week

• Add your company or nursing home name
Next Steps: How to Get Your Readmission Data

• Request your baseline HSAG Nursing Home Readmission Report for Q3 2016–Q2 2017
  – CA: nhreadmissions@hsag.com
  – AZ: CAngotti2@hsag.com
  – OH: ohnursinghome@hsag.com
• Data will be available quarterly
• Remeasurement period: Q4 2017–Q3 2018
### Sample Nursing Home Readmission Data

#### Data source:
Medicare Fee-for-Service Part-A claims for index hospital discharges.

#### Table: Nursing Home Readmission Data

<table>
<thead>
<tr>
<th>Facility</th>
<th>Number of Discharges to SNF</th>
<th>Discharges to SNF with a 30-Day Readmit</th>
<th>Percentage of Discharges with a 30-Day Readmit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Facility</td>
<td>334</td>
<td>73</td>
<td>21.86%</td>
</tr>
<tr>
<td>Region 4</td>
<td>44,897</td>
<td>8,323</td>
<td>18.54%</td>
</tr>
<tr>
<td>California</td>
<td>158,193</td>
<td>25,993</td>
<td>16.43%</td>
</tr>
</tbody>
</table>

#### Table: Days to Readmission

<table>
<thead>
<tr>
<th>Days to Readmission</th>
<th>0–7 Days</th>
<th>8–14 Days</th>
<th>15–21 Days</th>
<th>22–30 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td></td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>N</td>
<td>29</td>
<td>28</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Percentage of 30-Day Readmits</td>
<td>39.73%</td>
<td>38.36%</td>
<td>5.48%</td>
<td>16.44%</td>
</tr>
<tr>
<td>N</td>
<td>3,058</td>
<td>2,307</td>
<td>1,606</td>
<td>1,352</td>
</tr>
<tr>
<td>Percentage of 30-Day Readmits</td>
<td>36.74%</td>
<td>27.72%</td>
<td>19.30%</td>
<td>16.24%</td>
</tr>
<tr>
<td>N</td>
<td>10,008</td>
<td>7,268</td>
<td>4,845</td>
<td>3,872</td>
</tr>
<tr>
<td>Percentage of 30-Day Readmits</td>
<td>38.50%</td>
<td>27.96%</td>
<td>18.64%</td>
<td>14.90%</td>
</tr>
</tbody>
</table>
Sample Nursing Home Readmission Data (Cont.)

30-Day All-Cause Readmission Rates

- **Your Facility**
- **Region 4**
- **California**

<table>
<thead>
<tr>
<th>Period</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 2014</td>
<td>10.0%</td>
</tr>
<tr>
<td>Q1 2015</td>
<td>15.0%</td>
</tr>
<tr>
<td>Q2 2015</td>
<td>25.0%</td>
</tr>
<tr>
<td>Q3 2015</td>
<td>20.0%</td>
</tr>
<tr>
<td>Q4 2015</td>
<td>18.0%</td>
</tr>
<tr>
<td>Q1 2016</td>
<td>15.0%</td>
</tr>
<tr>
<td>Q2 2016</td>
<td>20.0%</td>
</tr>
<tr>
<td>Q3 2016</td>
<td>18.0%</td>
</tr>
<tr>
<td>Q4 2016</td>
<td>22.0%</td>
</tr>
<tr>
<td>Q1 2017</td>
<td>15.0%</td>
</tr>
<tr>
<td>Q2 2017</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

Data source: Medicare Fee-for-Service Part-A claims for index hospital discharges.
Setting Goals (HSAG Report)

RIR* = (Baseline – Current) 
Baseline

Based on the HSAG Nursing Home Readmission Reports

6% Relative Improvement Rate

6.1% = (19.6% – 18.4%) 
19.6%

Stretch goals highly encouraged
Collaborative Effort to Promote Program

• Hospitals can encourage preferred nursing home providers to join.
• Nursing home chains can encourage facilities to join.
• Nursing homes can share with sister facilities.
• In CA, nursing homes likely to see program information through CALTCM and CAHF.
### CLINICAL SKILLS

**Sepsis**

Wednesday, February 28, 2018  
11 a.m.–12 noon PT  
Pre-register at:  
[https://goo.gl/zyF4dL](https://goo.gl/zyF4dL)

### INTERVENTION STRATEGIES

**Principles from Evidence-based Care Coordination Programs**

Wednesday, March 28, 2018  
11 a.m.–12 noon PT  
Pre-register at:  
[https://goo.gl/B8fdss](https://goo.gl/B8fdss)

Fourth Wednesday of every month. 11 a.m. PT  
[www.hsag.com/events](http://www.hsag.com/events)
Resources

For more information about the SNF-VBP Program, go to your state’s online RRPP page to find:

- SNF-VBP Rehospitalization Tip Sheet
- CASPER Report Instructions
- HSAG Nursing Home Reducing Readmissions Preparation Program

Find it online

California
www.hsag.com/ca-rrpp

Arizona
www.hsag.com/az-rrpp

Ohio
www.hsag.com/oh-rrpp
Questions?
More About SNF-VBP

CMS has more information online:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html

Email: SNFVBPInquiries@cms.hhs.gov
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Thank you!
It’s time for you to start your journey!
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