**CMS Health Equity Confidential Feedback Report Q&A**
**November 16, 2023**

**Ketchum:** Good afternoon. Thank you for joining today's Health Equity Confidential Feedback Reports for Post-Acute Care Q&A session. During today's webinar, CMS subject matter experts will provide answers to some of the most commonly-asked questions pertaining to the methodologies and interpretations of the Health Equity Confidential Feedback Reports that were released on October 16th. This webinar will include a live Q&A session where subject matter experts will respond to recent questions from the home health and patient rehabilitation facility long-term care hospital and skilled nursing facility quality reporting program helpdesks. If you have questions, we encourage you to submit them through the Q&A box. While not all questions may receive an answer today, CMS will incorporate any unaddressed questions into an FAQs document that will be published on its website in January 2024.

Before we begin, we have just a few quick housekeeping items to address. If you experience audio issues on your computer at any point throughout the webinar, you can connect to the webinar audio using a phone by clicking “Audio Settings” in the bottom-left corner of your screen, and then switching to "Join by Phone.” If you experience any other technical issues with the webinar platform today, please try closing out of the webinar and then rejoining through the link you received in your registration confirmation email. If you continue to experience any technical issues, please let us know by submitting a comment or a question through the Q&A box so we can assist you. Finally, a recording, a transcript, and the slides from today's webinar will all be available on CMS' website in the coming weeks.

So, with that said, I will now turn it over to Cindy Massuda from the Division of Chronic and Post-Acute Care at CMS to begin. Cindy?

**Cindy Massuda, CMS:** Thank you. Welcome. I'm Cindy Massuda, the CMS Health Equity Lead for the Post-Acute Care Quality Reporting Program. I'm joined by my colleague, Alex Laberge, who leads Post-Acute Care Value-Based Purchasing Quality Reporting Program. I'm

also joined by Yuki, the Acumen Health Equity Project Manager. We appreciate you joining us for today's webinar. We start today's webinar with the frequently asked questions.

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We start today's webinar with the frequently asked questions sent to us since we published the Health Equity Confidential Feedback Report on October 16th, 2023. We divided the questions into four topic areas. These topic areas are “Report Basics;” “Measuring Health Equity;” “Methodology;” and “Using the Reports.” After we answer these questions under these topic areas, we will answer as many more questions as time allows, including some questions you write to us in the Q&A tab provided with this webinar. With that, we will start the frequently asked questions with the topic area “Report Basics.” I will now turn to Alex to address Report Basics.

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**Alex Laberge, CMS:** Thank you, Cindy. Yes, thank you, Cindy. And I'd like to thank everyone who is attending this webinar today for joining us, and we hope that you find the information provided helpful. As Cindy mentioned, we will start with answering the frequently asked questions on Report Basics.

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The first question is “What are the Post-Acute Care Health Equity Confidential Feedback Reports?”

The Post-Acute Care Health Equity Confidential Feedback Reports contain confidential information that is being made available by CMS to providers for their reference. Currently, CMS releases two separate reports that show provider performance on the Discharge to

Community (DTC-PAC) and the Medicare Spending Per Beneficiary (MSPB-PAC) Measures, stratified by beneficiary Medicare/Medicaid dual-enrollment status, and separately by beneficiary race/ethnicity.

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"Which PAC providers are able to access the reports?"

The PAC Health Equity Confidential Feedback Reports will be available for Home Health Agencies, Inpatient Rehab Facilities, Long-Term Care Hospitals, and Skilled Nursing Facilities. It is important to note that different types of PAC providers are not compared to one another. Additionally, a facility agency must meet an across-provider comparison reportability threshold for at least one race/ethnicity or dual-status population. This requirement ensures that all providers that receive Health Equity Confidential Feedback Reports have at least one comparison result populated in their report. If a Confidential Feedback Report – if a Confidential Feedback Report – so further details about the reportability requirements will be available in the upcoming methodology report.

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"How do I access my report," you may ask?

To locate your Health Equity Confidential Feedback Report in iQIES, please follow the instructions listed in the next two slides. First, log in to iQIES at iQIES.cms.gov using your Health Care Quality Information System (HCQIS) Access Roles and Profile (HARP) user ID and password. If you do not have a HARP account, you may register for a HARP ID. From the "Reports" menu, select "My Reports."

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From “My Reports” page, locate and select the “Health Equity Confidential Feedback Reports.” Displayed for you is a list of reports available for download. Select the report name link to view the Health Equity Confidential Feedback Report data. If there are questions regarding accessing your Health Equity Confidential Feedback Report in iQIES, please contact the iQIES Service Desk by email at iQIES@cms.hhs.gov or by phone at 800-339-9313. For information, please review the iQIES Report User Manual or visit the Post-Acute Quality Initiative homepage.

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Our next topic is the Measuring Health Equity.

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We would like to begin reviewing Measuring Health Equity by defining what is stratification and why it is important. Stratification involves the calculation of certain outcomes separately for different populations. Stratified measure outcomes can provide valuable insight on how different patient populations perform on a given measure. This allows providers to see how the outcomes of their care may differ between certain patient populations in a way that would not be apparent from an overall score; that is, the average score of all beneficiaries.

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CMS chose to use dual enrollment status and race/ethnicity for the fall 2023 PAC Health Equity Confidential Feedback Reports. How is the dual enrollment status defined in the report?

Well, throughout the report, the term "dual eligible" or "duals" indicate beneficiaries who are dually enrolled in both Medicare/Medicaid at any point during their stay. Similarly, the two terms "non-dually enrolled" or "non-duals" indicate beneficiaries who are not dually enrolled in Medicare/Medicaid at any point during their stay. What is race/ethnicity group are shown in the report? What race/ethnicity group are shown in the report? The race/ethnicity category in the report are Asian American/Native Hawaiian/Pacific Islander, Black, Hispanic, White, and Non-

White. The "Non-White" groups are American Indian/Alaska Native, Asian American/Native Hawaiian/Pacific Islander, Black, and Hispanic populations. Results for American Indian/Alaska Native patients are not shown separately in the report because of limited sample size and the accuracy concern that was determined during the testing of the metric.

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Research suggests that certain social risk factors, such as having a low-income background or being of a particular race/ethnicity, may be associated with an increased risk of poor health outcomes. Dual enrollment status is used as a stratifier for Health Equity Confidential Feedback Reports because research has shown that beneficiaries who are dually enrolled in Medicare/Medicaid tend to have more complex needs compared to those who are eligible for only one program due to age, disability, or low-income status. The CMS stratified measure outcomes by race/ethnicity in the Health Equity Confidential Feedback Reports in order to better identify differences in the variations in the quality of care received by patients with different racial and ethnic backgrounds.

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Which measures did CMS choose to stratify in the Fall 2023 PAC Health Equity Confidential Feedback Reports?

First is the discharge-to-community measure which represents the rate of a successful discharge to the community with successful discharge to the community including no unplanned rehospitalizations or death in the 31 days following the discharge from the PAC setting. In the reports, the measure – it is measured with a percentage rate called the "Risk Standardized DTC Rate." The Medicare Spending Per Beneficiary measure is Medicare spending during the PAC treatment and 30 days after. In the report, this is measured as average dollars amounts called the "average MSPB Amount." The DTC-PAC and the MSPB PAC measures are important, valid, and reliable cross-setting PAC QRP measures. They capture important patient outcomes and efficiency of care. For more information of how these measure results are calculated for the

Health Equity Confidential Feedback Reports, please see the Methodology Report. I will now hand it off to Yuki for the next set of questions. Thank you.

**Yuki Hayashi, Acumen, LLC:** Thank you, Alex.

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This next question asks about the data sources that CMS used to calculate the results.

Speaking first about the measure data, the fall 2023 reports are based on data from calendar year 2021 to 2022 for the home health setting, and fiscal year 2021 to 2022 for the IRF, LTCH, and SNF settings.

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To speak a little bit more about the other data sources, CMS used data from a couple other sources to generate the Health Equity Confidential Feedback Reports. For example, CMS used Medicare Part A and B fee-for-service claims to calculate DTC and MSPB measure outcomes and conduct risk adjustment. Additionally, CMS used Medicare enrollment database data to determine beneficiaries' dual-enrollment status. Lastly, CMS used the Medicare Bayesian Improved Surname Geocoding (MBISG) method to identify beneficiaries' race and ethnicity. The MBISG is an imputation method that was designed for CMS by the RAND Corporation to indirectly estimate beneficiaries' race and ethnicity. This method is used in many CMS initiatives including the PAC Health Equity Confidential Feedback Reports due to its high validity.

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Now, we'll move on to talking about your questions related to the methodology of the report.

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This question asks about the across- and within- comparisons that CMS included in the reports.

The reports include two broad types of comparisons which provide a comprehensive summary of differences in care which are called the "across- and within-provider comparisons." I'll explain each of these comparisons at a high level today, but please feel free to refer to the educational webinar recording that was posted on CMS's PAC QRP Training websites to see a full walk-through of the comparison methods.

Now, on this slide we've included a few figures to help depict each of the comparisons. The building icon indicates your facility or agency, whereas the U.S. map icon indicates facilities and agencies nationwide in your care setting. We also have different-colored human-shaped icons indicating different patient populations included in a given comparison, such as duals and non-duals. So, to get started with the left-hand side of this slide, the across-provider comparisons compare a given provider to all other providers across their same care setting. So, for example, your LTCH would be compared to all LTCHs nationwide. And I'm using LTCHs in my example here, but the same concept applies to Home Health Agencies, IRFs, and SNFs as well. And in the reports, CMS provides two across-provider comparisons.

The first, on the left-top portion of this slide, compares your facility's patients to the national performance among all patients. So, for example, outcomes for duals at your LTCH are compared to outcomes across all LTCH patients nationwide.

And then the second, on the bottom-left of this slide here, compares your facility's patients to the national performance among the same population. So, using the same example, outcomes for duals at your LTCH are compared to outcomes among duals in LTCHs nationwide.

And now that we've touched on the across-provider comparisons, we can look at the last comparison on the right-hand side of the screen. The within-provider comparison examines differences in the quality of care by comparing outcomes for stratified patient populations

within the individual provider's care. Here, CMS calculates differences in outcomes between two populations at your facility such as between duals and non-duals.

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So, this next question asks about the set of results that CMS calculates for each of the comparisons I just spoke about.

To answer this question, CMS produces three results for each of the comparison types which are “the difference that is examined in the comparison,” “the confidence interval of the difference,” and “the category of the difference.” To speak a little bit more about each of these, the difference specifically refers to the difference in measure performance between the two groups examined by a given comparison. For example, one of the differences that CMS calculates for the within-provider comparison is the difference in measure outcomes between a given facility's dual and non-dual patients. For example, this might show that duals had a lower, or worse, discharge-to-community rate than non-duals at a given facility. Then, CMS also calculates a 95% confidence interval for each difference, because the difference alone may represent a result that is due to random chance. And a confidence interval is a range around the difference that conveys how precise the calculated outcome difference is. In this case, the confidence interval indicates that we are 95% confident that the true difference in measure performance falls within this range. Lastly, CMS then determines categories of the difference to describe whether a given facility's patient population is performing statistically significantly better than, worse than, or no different from the comparison group. To do this, CMS uses the upper and lower bounds of the 95% confidence interval to make those categorizations. For example, if your report included a result that indicated worse outcome for dual patients at your facility for a within-provider comparison difference, this means that the outcome among duals at your facility was statistically significantly worse than outcomes among non-duals at your facility.

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Next question is “How does CMS identify providers in similar geographic locations?”

To provide a little bit of context here, providers may have noticed that some of the tables in the reports show results for providers in similar geographic locations as you, such as the same rural or urban location, the same core-based statistical area, the same state, or the same region. CMS included this information on patient outcomes among facilities in similar geographic locations as you to give providers an idea of how providers located in similar areas performed. In terms of the data sources, CMS obtains facilities’ and agencies’ rurality and core-based statistical area information from the "Provider of Services File for Hospital and Non-Hospital Facilities.” This is a publicly available source that contains various pieces of provider characteristic information.

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This next question asks about how CMS identifies providers with similar patient composition.

Similar to the context for why CMS included results for providers in similar geographic locations, CMS included these results to give providers an idea of how facilities and agencies with similar patient composition as them performed on stratified measure outcomes. Here, CMS used three characteristics to determine the patient composition groups shown in the reports which are “patient risk brackets,” “proportion of duals,” and “proportion of Non-White patients.”

I'll briefly explain each of these three concepts. First, the patient risk brackets allow CMS to group providers based on average clinical complexity or risk of patients within the facilities and agencies. CMS groups each provider into 10 risk brackets based on the average clinical complexity of patients within the facilities and agencies. CMS uses expected outcomes from the measure risk adjustment model when calculating the patient risk brackets. Next, CMS calculates dual enrollment quintiles to determine facilities and agencies with similar proportions of dual patients. CMS does this by calculating the proportion of stays or episodes at each facility that are attributed to dually-enrolled patients. Then, CMS calculates dual enrollment quintiles so that quintile five includes providers with the highest proportion of duals, while

quintile one includes providers with the lowest proportion of duals. CMS also calculates Non-White patient quintiles following the same approach to determine the set of facilities and agencies with similar proportions of Non-White patients. As noted here, CMS will release a methodology report in January which will provide the step-by-step calculation details for each of these contexts.

Now, I'd like to hand it over to Cindy to cover the next few questions.

**Cindy Massuda, CMS:** Thank you.

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So now we're going to be talking about frequently asked questions related to using the reports.

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So, the first question is, in this category, is "How can the Post-Acute Care Providers use the Health Equity Confidential Feedback Reports?"

The Health Equity Confidential Feedback Reports are intended for providers to give them feedback about their performance for certain populations who may have been historically disadvantaged. These reports are meant to provide information to providers and identify opportunities for providers to focus their internal quality improvement initiatives so that all individuals have their best opportunity to achieve the best potential health outcomes.

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What are CMS's long-term plans for these reports?

CMS plans to release the Post-Acute Care Health Equity Confidential Feedback Reports to providers on an annual basis. We are continuing to explore the potential of expanding the

confidential feedback report approach to other measures and other social risk factors and/or demographic variables for future reporting. Additionally, we are also exploring the use of post-acute care assessment data as a source for social risk factors and demographic variables as such data become available.

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So, if you would like more information on the Post-Acute Care Health Equity Confidential Feedback Reports, people have asked where they could locate that and we have provided many resources. And these include resources that we posted in October of 2024 and those include the Health Equity Confidential Feedback Reports Fact Sheet and the Health Equity Confidential Feedback Reports for Post-Acute Care Education and Outreach Webinar. Today – we also today – today's webinar on Health Equity Confidential Feedback Reports for Post-Acute Care Questions and Answers Webinar, the recording for this webinar will also be posted on our Provider Education and Outreach website. And then in January of 2024, we will also be posting Frequently Asked Questions documents and the Methodology Report. Both of those reports, as I said, will be posted in January of 2024. You can find all of these materials on the – on the provider-specific training sites for Home Health, Inpatient – Inpatient Rehab Facilities, Long-Term Care Hospitals, and the Skilled Nursing Facility provider training websites.

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And so, where can I share feedback with CMS on the usefulness of the Post-Acute Care Health Equity Confidential Feedback Reports?

We really appreciate this question because we welcome your feedback to the Health Equity Confidential Feedback Reports. Please submit any feedback through your provider-specific helpdesk. So, for Home Health, it's the HomeHealthQualityQuestions @cms.hhs.gov. For IRF, it's the IRF.questions@cms.hhs.gov. For Long-Term Care Hospitals, it's the LTCHQualityQuestions @cms.hhs.gov. And for Skilled Nursing Facilities, it's the SNFQualityQuestions @cms.hhs.gov. And please make sure you include in the subject line

"Health Equity Feedback" in your email so we know that's the purpose of the email. And, with that, I will turn back to Yuki to open the webinar up to the written questions and answers.

Thank you very much.

**Yuki Hayashi, Acumen, LLC:** Great. Thank you, Cindy.

Thank you all for listening to the presentation portion of today's session. It looks like we've received some questions through our helpdesk inboxes as well as through the Zoom Q&A feature today. So, thank you all for submitting them. We'll go ahead and now start answering some of those questions. As noted earlier, please note that we may not be able to answer all of the questions today, but we will make sure to review all the questions after the webinar and incorporate them into the upcoming FAQ document, as needed. So, with that said, I'll start going through some of these questions.

Cindy, I'd like you to take this first question which asks, "Why didn't my facility receive a report or a certain result in the report?"

**Cindy Massuda, CMS:** Okay. That's a – I appreciate that question.

So, a facility has to meet specific reportability thresholds to receive certain comparison results in the report. For example, for a facility to receive a result for the within-provider comparison by dual status, they must have at least 10 Medicare Spending Per Beneficiary episodes for dual patients and 10 Medicare Spending Per Beneficiary episodes for non-dual patients. Additionally, in order to receive a Health Equity Confidential Feedback Report, a facility or agency must meet the across-provider comparison reportability threshold for at least one race/ethnicity, or dual-status population. This requirement ensures that all providers that receive the Health Equity Confidential Feedback Reports have at least one comparison result populated in the report. And, in addition to this explanation, the requirements will be – are described in further detail in the upcoming Methodology Report that's going to post in January of 2024. Thank you.

**Yuki Hayashi, Acumen, LLC:** Great, thank you, Cindy.

We have a couple questions actually, related to more specifics about the across-provider comparison, so I'll ask you, Cindy, for both, but one at a time. First, can you explain again the difference between the two across-provider comparisons in the report?

**Cindy Masuda, CMS:** Sure. So for this question, if we could look at slide 17 again as we talk through this question.

Thank you. So, the first across-provider comparison compares the measure outcome among a specific population at your facility. So, as Yuki was talking about before, as an example, your Long-Term Care Hospital duals compared to the national performance across all patients in your care setting such as all Long-Term Care Hospital patients, nationwide. That's the first one in that – in slide 17. In contrast, the second across-provider comparison compares the measure outcome among the specific population at your facility such as your Long-Term Care Hospital duals to the national performance among the same patient population in your care setting. So, that could be like all duals in the Long-Term Care Hospitals nationwide. Thank you.

**Yuki Hayashi, Acumen, LLC:** Thank you for that question and answer.

The next question is related. It's a follow-up to this. Could you please talk about why CMS chose to use the two across-provider comparison methods? Cindy, could you also answer this one?

**Cindy Massuda, CMS:** Sure. That's a great question.

So, CMS chose to use the two across-provider comparison methods because they serve different purposes. Like we mentioned previously, the first method allows providers to see how the specific population performed relative to the overall national average. And then, the second method further allows providers to see how their specific population performed relative to all

providers of the same population in their care setting. It's possible that a provider's patient performed well relative to one national comparison group but not the other. So that's the benefit of having both comparisons. CMS hopes – we hope that by providing both comparison results, we help equip providers with more information that they can use to better understand their population performance so that you can develop accepted internal quality improvement initiatives. Thank you.

**Yuki Hayashi, Acumen, LLC:** Great, thank you.

I'm also seeing a couple questions, too, about the within-provider comparison, so while we have the slide up, Alex, I'll have two questions for you. The first is "Can you explain again what the within-provider comparisons are?" Why is it important to see those results?

**Alex Laberge, CMS:** Thank you. That's a good question.

The within-provider comparison is important because it identified the differences in the quality of care by comparing the outcomes for stratified patient populations within the individual provider's care. The within-provider comparison calculates two sets of the measure performance differences between the following two combinations of patient populations: patients who are dually – dually enrolled and patients who are not dually enrolled, and patients who are Non-White and patients who are White.

**Yuki Hayashi, Acumen, LLC:** Great. Thank you, Alex.

A more detailed question, it looks like, for the within-provider comparison, Alex. Can you provide an example interpretation of the within-provider comparison results?

**Alex Laberge, CMS:** Sure.

A positive DTC rate difference for the within-provider comparison of the duals and non-duals signifies that the duals in the facility – in your facility or agency have a higher DTC rate which

would be a better performance than the non-duals at your facility/agency. A positive average MSPB amount difference for the within-provider comparison of duals and non-duals signifies that the duals at your facility or agency have a higher average MSPB amount or be, you know, a worse performance than the non-duals at your facility. As you can see, the different measures can have different directions based on the structure. The within-provider comparison provides your SNF, Home Health, IRF, or LTCH with insight on the care that you provide to the different populations to help your facility as you work to provide the highest quality care to all the patients you care for.

Thank you. I think that's it.

**Yuki Hayashi, Acumen, LLC:** Great. Great questions, and thank you for the answer, Alex.

Cindy, I'd like you to answer this next one. Can you clarify what race and ethnicity groups are shown in the report?

**Cindy Massuda, CMS:** Sure.

So, the race/ethnicity – ethnicity category shown in the reports are Asian American/Native Hawaiian/Pacific Islander, Black, Hispanic, White, and Non-White. The Non-White group consists of American Indian, Alaskan Natives, Asian American, Native Hawaiian, Pacific Islander, Black, and Hispanic populations. Results for the American Indian/Alaskan Native patients are not shown separately because of limited sample size and accuracy concerns during testing, so they're grouped in the Non-White category. Thank you.

**Yuki Hayashi, Acumen, LLC:** Great. Thank you, Cindy.

For this next question, if you could answer this again, Cindy. Why did my facility not receive a geographic location-related result within the report?

**Cindy Massuda, CMS:** Sure.

So, a given geographic location such as your core-based statistical area or CBSA, or your state or your region can show as “N/A”, not applicable values, if your geographic location didn't meet the reporting threshold. That's the minimum of 10 facilities or agencies with reportable comparison results. Or if there was no data available on your facility's geographic location. And then the other way is if your CBSA – your core-based statistical area column – is not populated with data, it's because your facility is located in an area outside a metropolitan statistical area, meaning it's a rural area. And, again, we have more details about this in the upcoming Methodology Report that we will post in January of 2024. Thank you.

**Yuki Hayashi, Acumen, LLC:** Thank you, Cindy.

This next question is for you, Alex. “How does CMS calculate those patient risk brackets for the comparisons to providers with similar patient composition?”

**Alex Laberge, CMS:** That's – that's another good question.

Patients risk brackets allow CMS to categorize providers based on the average clinical complexity or risk of the patient within the facility/agency. CMS calculates a risk bracket using the following steps. CMS calculates a risk score for each DTC stay, or MSPB episode that indicates the complexity of your patient. The risk scores are calculated as the expected DTC rate or the MSPB amount as predicted through the Measures Risk Adjustment Model. CMS then calculates the average risk score. This is the average of the risk scores for all the DTC stays and MSPB episodes. Finally, CMS creates a distribution of the average risk score across all providers in your care setting. CMS divides the distribution into deciles to create risk brackets with the equal number of providers in each bracket. A risk bracket of 10 includes providers with the highest average risk, while the risk bracket of one includes providers with the lowest average risk. Your risk bracket includes providers who have similar average risk score as you.

**Yuki Hayashi, Acumen, LLC:** Great. Thank you for walking us through that, Alex.

And just as a reminder, Cindy mentioned this earlier, but the upcoming Methodology Report in January will have this information and more detail as well.

We have the next question. Cindy, if you could please take this one. “Will CMS continue to produce these reports every year?”

**Cindy Massuda, CMS:** Thank you.

So, CMS plans to update the Post-Acute Care Health Equity Confidential Reports annually after this past fall 2023. And it's continuing to explore the potential of expanding the Confidential Feedback Report approach to other measures and other social risk factors for future reporting. And as we talked about, we really welcome your feedback on these Post-Acute Care Health Equity Confidential Feedback Reports so that we can take your comments into consideration for future reporting planning. If you have feedback – have any feedback, please submit it to your provider-specific helpdesk email which was listed on the last slide of our presentation. Thank you.

**Yuki Hayashi, Acumen, LLC:** Thank you. Okay, thanks Cindy.

I'm looking at the time here and it looks like we have time for just one more question before we wrap up today's webinar, so Cindy if you could please wrap us out by answering this final question.

“Will these reports be made publicly available?”

**Cindy Massuda, CMS:** So, the 2023 Post-Acute Care Health Equity Confidential Feedback Reports – they are strictly confidential and released to providers for their reference. It's a reference-only document. Our intention behind releasing these reports is for the providers, the SNFs, IRFs, LTCHs, and Home Health Agencies to use the results to develop strategies or quality improvement programs to reduce the negative impact of social risk factors on measure

outcomes for their patients. Results from the 2023 Post-Acute Care Health Equity Confidential Feedback Reports do not impact publicly-reported quality program scores or provider reimbursement. And I can't emphasize that enough. So, thank you for that question.

**Ketchum:** Great. Alright. Thanks so much, Cindy and Alex, for your answers, and thank you as well, Yuki, for moderating today. But, as Yuki has alluded to, you know, those are all the questions that we do have time for today, so we're going to go ahead and conclude the Q&A here.

Actually, Claire, would you mind going back to slide 25 please?

Great. Thank you so much.

Okay, so as Cindy mentioned earlier in the webinar, in January 2024 CMS is going to be publishing an FAQs document on its website. So, if your question wasn't answered during today's webinar, we do encourage you to submit your question to one of the four provider-specific helpdesk email addresses that we have listed here on this slide. And we are also going to post the email addresses in the chat box in case you'd like to copy them down. We're actually going to pause here for just a few seconds to give everyone an opportunity to copy the email addresses down if you'd like.

Great. Okay. Claire, would you mind going up to slide 27 please.

Alright, thank you.

So, the FAQs document I mentioned is going to be published on the Home Health, IRF, LTCH, and SNF provider training web pages on CMS's website. We did share the links to those four webpages in the chat box, so we do encourage you to copy those links if you haven't already done so, and then bookmark those pages. And then, in addition to the FAQs document, a recording, transcript, and the slides from today's webinar will also be published on those four pages within the next one to two weeks.

Alright, so that concludes today's webinar. Thank you, everyone, again for joining us today. And we hope you all have a great afternoon. Alright, bye, now.