Slide 3:

- Thank you. I'd like to start us off on today's webinar with a few announcements. First, the PY6 Reconciliation Report is available on the CJR Data portal as of **November 7, 2023**. The previous PY5.2 Final Reconciliation report and summary files are available separately on the Data Portal.

- Second, performance year 6 episodes are no longer included in your monthly data feed in the CJR Data Portal because we have completed reconciliation. The reconciliation claims data folder contains your final PY6 episode data.

- Lastly, if you have any questions about today's webinar materials, please address them to the CJR Support email: CJRSupport@cms.hhs.gov

Slide 4:

- Before we get into the webinar content, we want to highlight a few high-level updates for PY6.

- This is the first reconciliation that incorporates methodology changes for the three-year extension of the CJR model. We will get into these changes later on in the webinar.

- For PY6, there will only be *one* reconciliation – previous years went through both an initial and final reconciliation. Because of this, we'll also be referring to reconciliations by the performance year being reconciled, rather than the calendar year in which it occurs.

- Payment or repayments for PY6 will occur separately from PY5.2 final, which concluded earlier this year. They will not be netted against each other unless a debt is outstanding. The same applies to appeals, as these are two distinct processes.

Slide 5:

- As a refresher, reconciliation amounts are calculated using the methodology described in 42 C.F.R. Sections 510 and 512. In this slide, we've included the links to the relevant CJR Final rules, the updates to the model due to the COVID-19 public health emergency, and the three-year extension final rule, which contains the updates to the model for PY6-8.

- Regulations and notices can also be found on innovation.cms.gov / initiatives / CJR

Slide 6:

- In the next few slides, we will be discussing payment and repayment. As a reminder on terminology, we will use "payment" to refer to your hospital receiving a payment as a result of reconciliation, and "repayment" to refer to your hospital receiving a demand letter for amounts owed to CMS.

Slide 7:

- For those not appealing their reconciliation reports, you can expect to receive payments around **February 2024**.
- For those appealing their reconciliation results, you should expect payments around **May 2024**. We'll discuss the appeals process later in the presentation.

Slide 8:

- Banking details and contact information must be up to date to ensure payments are received and repayments don't accrue interest.
- These need to be correct in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).
- Please note that payments are sent to the account where your Medicare payments typically arrive.

Slide 9:

- For hospitals expecting payment, National Government Services (not the regular Medicare Administrative Contractor) will be facilitating the reconciliation process via USBank.
- The first addenda line on the EFT remit is displayed on this slide under the second bullet point.
- There will be one payment with separate addenda lines showing which Medicare trust funds were drawn from.
- The total payment will reflect the sum of the part A and part B lines.

Slide 10:

- For those who owe a repayment amount, your hospital will receive a demand letter in the mail that will detail how to submit payment.
- However, if you want to submit payment sooner, you can refer to the instructions included either in the email that notified you of the availability of the reconciliation reports, or the notice section of the reconciliation report itself.

Slide 11:

- There are a few situations where you may receive a payment *less* than the amount in the reconciliation report. Several of these are due to the consolidation of payments and repayments in the event that there are multiple CJR participant hospitals associated with the same tax identification number. If you receive a lower-than-expected payment, it's due to one of three things:

- Either your CCN has an outstanding debt or unpaid interest from a previous reconciliation; or another CCN that shares your TIN has an outstanding CJR debt or unpaid interest from a previous reconciliation.

    - An example of this would be if your PY6 reconciliation report says you are set to receive a $30,000 payment, but earlier this year you did not submit payment in response to the demand letter for $5,000 from PY 5.2 final, you will receive a reduced total of $25,000.

    - Note that this is *only* if you have an outstanding debt due to non-payment. Unless that is the case, payment or repayments for PY6 are completely separate from PY5.2 final.

- ; or

- The third reason could be that another CCN that shares your TIN owes a repayment for this reconciliation. The outstanding amount or repayment will be netted against your reconciliation payment.

Slide 12:

- Now let's get into the performance year 6 reconciliation review and updates. We'll walk through the methodology for determining your hospital's payment or repayment, and highlight the major changes from previous performance years.

Slide 13:

- We'll review four topics in this section:

    - Reconciliation Parameters

    - Episode Definitions and Adjustments

    - Target Prices, and

    - Net Payment Reconciliation Amount Adjustments

Slide 14:

- Starting off with the parameters for PY6 – specifically, how we determine what episodes and target prices are used in reconciliation.

Slide 15:

- PY6 includes episodes that *ended* from October 1, 2021 – December 31, 2022. Note that this reconciliation includes 15 months, which is longer than most performance years.
- While performance years are based on episode end dates, target prices are based on episode *start* dates.
- PY6 episodes that start on or after July 4, 2021 will receive the same set of prospective PY6 target prices.
- The small set of episodes that begin *before* July 4, 2021 receive a target price from performance year subset 5.2. There are some special considerations for these PY6 episodes with PY5.2 target prices, as we'll mention throughout the webinar.
- In your reconciliation report, you may see that your episodes are split out into additional "episode periods". While there's only two sets of standardized target prices for PY6 episodes, we split these out further in the reports due to different applicable *wage factors*, which are applied by federal fiscal year.

Slide 16:

- As we mentioned earlier, episodes in PYs 6-8 only go through *one* reconciliation.
- PY6 reconciliation uses claims processed into the CMS Integrated Data Repository, or "IDR", as of **July 1, 2023.** This is six months after the close of the performance year**.**
- Unlike in PY1-5, there will not be a second reconciliation for the performance year with additional claims runout. The reconciliation payment or repayment in the report is final – the only reconciliation taking place next year will be PY7.

Slide 17:

- Moving on, we'll now go through updates to the methodology for defining episodes and making adjustments to episode spending.

Slide 18:

- Beginning with PY6, the CJR model includes hospital *outpatient department* lower extremity joint replacement procedures in addition to inpatient procedures. We use the term "outpatient" to refer to these HOPD procedures in this presentation.

- Outpatient anchor stays are identified using HCPCS codes 27447 for total knee arthroplasty or 27130 for total hip arthroplasty.

- Because outpatient episodes do not have an inpatient admission, the 90-day post-discharge period for outpatient episodes includes the day of the anchor procedure. As a result, all outpatient episodes are 90 days in length.

- There are not separate target prices for outpatient episodes. Rather, outpatient episodes and inpatient episodes with similar characteristics are assigned to the same prospective target prices.

Slide 19:

- So, how do we group the outpatient and inpatient episodes together?

- Outpatient episodes and inpatient episodes are assigned to an "episode type" based on the DRG of the procedure (for inpatient episodes) or HCPCS code and fracture status of the procedure (for outpatient episodes).

- Some episode types include both inpatient and outpatient episodes, while others include just inpatient episodes. In all cases, the episode type is referred to by the *inpatient DRG.* This might sound a bit confusing at first, but we'll show you how this works in the next slide.

- Episodes with the same episode type and period receive the same prospective regional target price. Prospective target prices are then adjusted at the episode level at reconciliation – which we'll get into in the next section.

Slide 20:

- Here we have a crosswalk of the four episode types. This table will also be included at the top of your reconciliation reports.

- Episode type DRG 469 includes inpatient episodes initiated with an inpatient stay for DRG 469, which represents total hip and knee replacements with major complications or comorbidities; or ankle replacements

- Episode type DRG 470 includes inpatient episodes initiated with an inpatient stay for DRG 470, which represents total hip and knee replacements without a major complication or comorbidity. It *also* includes outpatient episodes for total knee replacement (HCPCS 27447) and total hip replacement without fracture (27130)

- Episode type DRG 521 includes inpatient episodes initiated with an inpatient stay for DRG 521, which represents hip replacement with hip fracture with major complications or comorbidities.

- Episode type DRG 521 includes inpatient episodes initiated with an inpatient stay for DRG 522, which represents hip replacement with hip fracture without a major complication or comorbidity. It *also* includes outpatient hip replacements with fracture (HCPCS 27130).

- You can see how outpatient procedures are grouped with inpatient episodes without major complication or comorbidity – either with or without fracture.

Slide 21:

- As a reminder, not all episodes with these inpatient or outpatient procedures are included in the CJR model. Common reasons that episodes are excluded include:

    - A beneficiary is covered by non-traditional Medicare health plans, such as Medicare Advantage.

    - A beneficiary has a date of death during the episode.

    - Or a beneficiary is admitted for another anchor stay.

- For more information on episode exclusion criteria, you can look at:

    - The Episode Definition Specifications and the "DROP REASON" variables in the Data Dictionary. Both can be downloaded from the data portal in the ReadMe and Data Dictionary zip folder.

    - For details on why specific episodes were excluded, you can refer to the episode exclusion file in the Reconciliation claims data zip folder, which notes the applicable DROP REASON for a given potential episode. Note that the episode exclusion file doesn't necessarily include EVERY potential episode – for example, it does not include episodes where a managed care organization paid for the anchor procedure.

- Information on exclusions is also available in sections 205 and 210 of the final rule.

Slide 22:

- Moving now from episode definitions to episode adjustments. On this slide, we note some of the episode-level adjustments made at reconciliation. Episode cost can be modified in three different ways:

    - Capping of episode payments at the target price for episodes occurring during an emergency period or that include a claim with a COVID-19 diagnosis

    - Capping of episode payments at the high-cost threshold

    - And adjustments for the suspension of Medicare sequestration

- The inpatient payment already reflects the Medicare DRG payment adjustment for hospital–acquired conditions.

- All these episode spending adjustments are described in further detail in the Episode Definition Specifications, as well as in the reconciliation report.

Slide 23:

- There is one update to the capping of episode payments at the high-cost threshold for PY6.

- For PY6-8, high-cost episode spending is capped at the *99th percentile* of regional episode spending, rather than the previous method of capping high-cost episodes at two standard deviations above the regional mean.

- For the subset of episodes with PY5.2 target prices, we will apply the prior methodology, which caps episode spending at two standard deviations.

- This cap is still calculated separately for each region and episode type combination.

Slide 24:

- We also have an update on Medicare sequestration adjustments made for PY6.

- As we've mentioned during PY5 reconciliations, Medicare sequestration was suspended or partially suspended from May 2020 to July 2022. Medicare sequestration is the automatic 2% payment reduction in Medicare payments

- During reconciliation, episode spending and target prices have been adjusted based on episode start date to reflect the full or partial suspension of sequestration.

- This table shows the three different sequestration adjustments that are applied to episodes at different points during PY6.

    - For episodes with start dates from May 1, 2020 – March 31, 2022, episode spending and target prices for episodes have been adjusted to remove the standard 2% sequestration decrease. *Essentially,* this looks like is a 2% increase in standardized payment amounts and target prices.

    - For episodes with start dates from April 1, 2022 – June 30, 2022, episode spending and target prices have been adjusted to remove 1% of the standard 2% sequestration decrease. This would be close to a 1% increase.

    - Finally, for episodes with start dates on or after July 1, 2022, no adjustment is made. Sequestration returns to its standard 2% reduction.

Slide 25:

- With that, let's get into target prices. We'll provide an update where the methodology has changed along with a few reminders.

Slide 26:

- We'll start with a review of prospective target prices. CMS establishes episode target prices for participant hospitals each performance year.
    - Prospective target prices are applied based on an episode's start date, and assumes a 3% discount for quality (which is equivalent to the acceptable quality category)
- Standardized prospective target prices are posted publicly on the CMS website prior to reconciliation. For PY1-5, these were also provided to hospitals on the CJR data portal with wage factors incorporated.
- To determine the applicable prospective target prices for an episode, reference the EPISODE_PERIOD (or anchor begin date). The prospective target price is also included in the RECON_EPI file under the STD_TARGET_PRICE variable.

Slide 27:

- At reconciliation, PY6-8 prospective target prices are adjusted for:
    - Beneficiary-level risk adjustment factors*
    - Normalization factor*
    - Market trend factor*
    - Geographic wage factors
    - Quality performance
- Note that PY6 episodes with PY5.2 target prices will NOT receive the first three adjustments, only wage factors and quality.
- Because the adjustments for PY6-8 have been updated to include *episode-level* adjustments, episodes with the same episode type and period may have different target prices.
- You can see the fully adjusted reconciliation target price for each episode in the RECON_EPI csv file, referencing the RECON_TP variable.

Slide 28:

- One of the major changes to target prices for PY6 is the beneficiary-level risk adjustment factors. These factors adjust target prices at the *episode level* to account for patient-driven episode expenditure variation within episode types.

- The model uses three factors to adjust target prices: CJR hierarchical condition category, or HCC, count; dual-eligibility for Medicare and Medicaid; and age bracket.

- Risk adjustment multipliers are calculated prospectively and posted on the CMS website at the same time as target prices.

- Let's review these 3 risk factors in more detail.

Slide 29:

- CJR HCC count is based on a patient's total number of clinical conditions, as determined by a patient's number of CMS Hierarchical Condition Categories, or HCCs.

    - HCCs are a way of grouping similar diagnoses into categories, such as pancreatic disease, vascular disease, or congestive heart failure.

    - HCCs are identified by CMS as part of the CMS-HCC Risk Adjustment Model. The HCC count is based on a beneficiary's Medicare claims data during a given calendar year, across providers and settings. It is *not* calculated by the CJR model team using episode data.

    - A beneficiary is assigned a HCC count based on the calendar year of the anchor begin date. For example, if a beneficiary had an episode start in June 2022, they would be assigned a HCC count calculated based on claims data from calendar year 2022.

    - Beneficiaries are assigned to brackets that include 0, 1, 2, 3, and 4+ HCCs

- Dual eligibility is based on patient's eligibility for full Medicaid benefits on the first day of the episode. This factor is a binary yes or no.

- Age bracket is based on the beneficiary's age on the first day of the episode.

    - Brackets are age <65, 65-74, 75-84, and 85+

Slide 30:

- The next adjustment to target prices is the normalization factor. The normalization relates to the beneficiary-level risk adjustment factors.

- It is applied at the national level so that risk adjustment does not result in an increase or decrease to the national average target price.

- At reconciliation, the normalization factor is calculated as the national mean target price across all episodes divided by the national mean risk-adjusted target price across all episodes.

- The normalization factor is a single value and is applied uniformly across all episode types and regions.

Slide 31:

- For our last new adjustment, we have the market trend factor.

- This factor is applied to target prices at reconciliation to adjust for regional spending trends and to account for recent variations in the underlying structure of the market.

- It is calculated as the average cost for performance year episodes divided by the average historical cost for target price base year episodes.

- This is calculated separately for each region and episode type combination.

- That's the last of the *new* target price adjustments, now we'll do a quick review of the usual adjustments.

Slide 32:

- Prospective target prices include a standard 3% discount, which can be reduced or eliminated based on your hospital's quality performance.

- A smaller discount raises your target prices so you will either receive larger reconciliation payments or need to make lower repayments.

- In PY6, CMS provides hospitals with a greater reduction in the discount factor for good (1.5%) and excellent (3%) performance, as determined by your composite quality score. Hospitals with excellent performance will have a 0% discount to their target prices.

- On the other end, hospitals with below acceptable performance are not eligible to receive a reconciliation payment. If they owe a repayment, those hospitals will have the standard 3% discount to target prices.

Slide 33:

- Now we will go into a bit more detail on how we determine your hospital's composite quality score, or CQS. The CQS calculations have not changed for PYs 6-8, so this will be a review for most.

- Your composite quality score is your quality measure performance points plus your improvement points, plus points for PRO submission.

- Quality measure performance points are based on your hospital's quality measure results and are assigned based on performance percentile.

- Please note that CMS assigns hospitals without reportable quality measure values to the 50th percentile.

- PRO data for PY6 is based on THA/TKA procedures between July 1, 2021 and June 30, 2022.

- Additional information on quality measure performance points, percentiles, and results is included in your reconciliation report. Additionally, detailed information on quality measurement can be found in the QM file that is delivered with your report. Information on the quality measure deciles is also available in the README on the data portal.

Slide 34:

- On this slide we've included the weight that is given to the two quality measures: THA/TKA Complications measure, which is weighted at 50% with a max of 10 points and the HCAHPS Survey measure, which is weighted at 40% with a max of 8 points.

- The THA/TKA voluntary PRO and limited risk variable data submission has a 10% weight where two points are given just for successful submission.

- Quality improvement points can be earned if a hospital's quality performance on a measure increases from the previous performance year by at least two deciles.

Slide 35:

- On this slide we show how a hospital's composite quality score impacts the discount factor.

- This includes the reductions in the discount factor for the excellent and good quality categories. There is no change to the discount factor for hospitals with acceptable or below acceptable quality categories.

Slide 36:

- Moving onto the last section of the PY6 reconciliation review and updates, net payment reconciliation amount (or NPRA) adjustments.

Slide 37:

- Your NPRA is the difference between your hospitals' adjusted episode spending and reconciliation target price, with three additional potential adjustments:
    - Stop-loss or stop-gain limits
    - Any excess post-episode spending

    - Payment eligibility based on quality performance

- We've already discussed payment eligibility, but we'll review these first two adjustments in the next slide.

- As a reminder, reconciliation amounts are expressed in "real dollars" with wage factors reintroduced.

Slide 38:

- Loss and gain limitations remain the same from previous performance years. They prevent the NPRA for each performance year from exceeding a stated percentage of the target spending.

- In this case, stop-loss limits reconciliation *repayments* to 20% of total target spending, and stop-gain limits reconciliation *payments* limited to 20% of total target spending.

Slide 39:

- The methodology for excess post-episode spending has also remained consistent with prior reconciliations.

- Post-episode spending includes Medicare Part A/B claims for services in the 30 days *after* an episode ends. If average post-episode spending exceeds three standard deviations above the regional average, this is considered "excess post-episode spending" and the excess amount is subtracted from the NPRA.

Slide 40:

- You may recall that in PYs 1-5, we applied an adjustment to certain hospitals' payments or repayments at reconciliation to account for ACO shared savings.

- This adjustment, which impacted a small number of hospitals, will no longer apply to PY6-8 reconciliations.

- However, PY6-8 reconciliations will continue to exclude certain episodes that overlap with ACO models. Specifically, it excludes beneficiaries prospectively assigned to a Shared Savings Program ACO in the ENHANCED track.

Slide 41:

- To recap the information we just went through, here are the key PY6 updates for reconciliation:

    - There will be a single reconciliation for each PY going forward

    - We are now including outpatient episodes

- High-cost episode cap calculation changed from 2 standard deviations to the 99th percentile
- There are additional adjustments for suspension of sequestration
- New adjustments applied to prospective target prices at reconciliation, including beneficiary-level risk adjustment, normalization, and the market trend factor
- We'll apply greater reductions in discount factors for good and excellent quality performance, and
- No more ACO recoupment

Slide 42:

- Moving on, we'll now go through the data and reports available on the CJR data portal for participants.

Slide 43:

- Participants received several updated files on the data portal, including the Reconciliation Claims Data zip file, containing claims and beneficiary data for performance year 6 episodes. Note that if you are looking to replicate the reconciliation results, you should use the claims data in this folder, rather than the monthly claims data, as this uses the correct run-out dates for reconciliation.
- The Reconciliation Reports zip file contains:
  - The reconciliation report HTML file, which will contain your calculated reconciliation amounts and quality scores.
  - The reconciliation amount and hospital reconciliation summary files, which show your reconciliation calculations, summary of spending for each episode type and period combination, and other summary statistics.
  - Quality measures summary file, with detailed information on the quality measure data used to calculate the composite quality score.
  - And a calculation error or "CE" form, with instructions on how to submit an appeal.
  - Additionally, there is one *new* file included in the reconciliation reports folder this year – the Reconciliation episode file. We'll walk through that in the next slide.
- The data portal also contains a Patient Reported Outcomes Hospital-Specific Report file, which provides detailed quality measure results for hospitals that did not successfully submit PRO data.

- And finally, the README and data dictionary zip file, which includes reconciliation, target price, and episode definition specifications, an updated data dictionary to help you understand all your data files, quality measure decile cutoffs, and a log of changes that describes reconciliation technical changes.

- If you're looking for information on PY5.2 reconciliation, the PY5.2 Final Reconciliation report and summary files are available in the archived reconciliation reports file.

Slide 44:

- As I just mentioned, we've added a new reconciliation episode file to the reconciliation reports folder this year. RECON_EPI provides an episode-level look at your reconciliation results, showing episode spending, target price adjustment factors, and reconciliation target prices for each episode.

- Recognizing that target prices now differ within an episode type/period combination, this file was added to help hospitals understand their episode-level target prices and adjustments.

- The new file also has the added benefit of making it easier to understand the episode-level adjustments made as a result of the new PY6-8 extension methodology and to examine specific episodes that may be disproportionately contributing to payments.

- For more information on how to interpret this file, see the CJR data dictionary in the README zip folder.

Slide 45:

- Now we'll do a live walkthrough of the report. You may notice some changes to the report this year to reflect changes in the methodology for PYs 6-8. [Review the main sections of the reconciliation report.]

    - At the top, we have the amount your hospital will receive from or owe to CMS. This will be the difference between your hospital's episode spending and reconciliation target price, with any adjustments applied.

    - Below that is the reconciliation summary. This contains information on the timeline, high-level reconciliation calculations and NPRA adjustments, and your quality score.

    - Next, we have the financial performance section, which provides a breakdown of reconciliation payment/repayment calculations by episode type and period. We include a definition of each episode type upfront, then we have the table sharing the results broken down by each episode type and episode period combination.

    - Then we move into a section describing the adjustments to the target prices made at reconciliation. This shows the risk adjustment factors, normalization factor, market trend factors, quality discount factor, and wage factors. One important

note here is that the information on median CJR HCC count, age, percent dual eligible, and mean risk adjustment multiplier are presented for informational purposes only. Target prices are risk adjusted at the episode-level, so you'll need to consult the RECON_EPI file for episode-level details. These summary data in the report can give you a sense of how risk factors vary across different episode types and periods.

- We also have the quality performance and improvement section here, which remains largely the same compared to prior reconciliations.
- Moving into the next section, Reconciliation *episode* spending adjustments. This is where you can see the overall impact of adjustments for disaster and COVID-19 episodes, as well as capping for high-cost episodes.
- More information on COVID-19 and disaster episodes can be found in Table 9.
- Finally, we get to Reconciliation NPRA adjustments. This section should look familiar, with adjustments for excess post-episode spending and loss and gain limitations.
- Lastly, the report includes an appeals section describing how to submit a calculation error form.

Slide 46:

- That takes us into a good segway for our next topic, the appeals process. The CJR reconciliation appeals process is outlined in section 310 of the final rule, and remains largely the same for PY6.

Slide 47:

- For your appeal to be considered, you need to email a completed calculation error form within 45 calendar days of the issuance of the reconciliation report.
- Appeals are due by **December 21, 2023 at 11:59 pm ET** and must be emailed to CJRreconciliation@cms.hhs.gov.
- Only participant hospitals can submit appeals, not consultants or contractors.
- If a calculation error form is not submitted within this 45-day period, the CJR reconciliation report is deemed final.
- Appeals are limited to episodes in PY6. Participants submit multiple calculation errors using one form.
- Note that the appeals process is for financial and methodological concerns and is not intended for feedback on model design or scope.

Slide 48:

- No personally identifiable information or personal health information is needed on the calculation error form. However, if you feel you need to send PII or PHI for an appeal, please upload the calculation error form to the data portal.

- If you do so, notify CMS of your upload via the reconciliation appeals inbox – but do not attach PII or PHI itself to the email. The calculation error form and instructions will have additional guidance on how to upload PII or PHI.

Slide 49:

- Here, we've outlined the types of calculation errors that can be submitted, including:

    - Inclusion or exclusion of Medicare beneficiaries or episodes in the baseline or performance year.

    - Inclusion or exclusion of specific claims within episode spending in the baseline or performance year.

    - Reconciliation amount calculation errors.

    - And the application or use of composite quality scores during reconciliation or in determining the performance decile.

Slide 50:

- This flow chart shows an overview of the appeals process.

- The top half of the flow chart is for the first level of appeals. If a participant hospital agrees with the reconciliation report or no calculation error form is submitted within 45 calendar days of reconciliation report issuance, then the determination is deemed final.

- If a participant submits a calculation error form within 45 calendar days, CMS should respond within 30 calendar days. CMS reserves the right to an extension of this 30 calendar day period upon written notice to the participant.

- On the bottom half you see the second appeal level. Participants may submit a request for reconsideration within 10 calendar days of receiving CMS' written response. If no request is received, then payment (or repayment) proceeds.

- If a request for reconsideration is received, CMS will schedule a review within 15 days and respond within 60 calendar days.

- The written determination will be final, and payment or repayment will proceed. As a reminder, these are calendar days, rather than business days.

Slide 51:

- As a reminder, PY6 will undergo a single reconciliation. This means the 45 day period after appeals is the *only* opportunity to submit appeals for this performance year.

Slide 52:

- And that takes us to the end of today's webinar. If you have any questions regarding today's webinar materials or your reconciliation report, send an email to CJRSupport@cms.hhs.gov.

- And if you have any questions about a reconciliation episode, please follow the appeals process.