Hello, and thank you for joining today's Hospice Quality Reporting Program "Updates to Public Reporting in Fiscal Year 2019: Hospice Comprehensive Assessment Measure and Data Correction Deadlines" webinar. This webinar will include two trainings. In the first part of the webinar, representatives from the Centers for Medicare and Medicaid Services will discuss the Hospice Comprehensive Assessment Measure.

The second portion will cover the "4.5-Month Data Correction Deadline for Public Reporting" policy update that was finalized in the Fiscal Year 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule.

Please note that there will a 10-minute Q&A session after each training. You may submit questions through the Q&A box or by dialing into the phone line. The phone number will be on the slides following each training.

You can listen to the presentation through your computer speakers. If you cannot hear the audio through your computer speakers, please contact CMSQualityTeam@ketchum.com. Questions will be taken via the phone line and question box at the end of Part I and Part II of the presentation. I would now like to introduce Cindy Massuda, Health Insurance Specialist at CMS. Ms. Massuda, you may now begin.

Thank you so much. And welcome, everyone, to today's webinar. I am Cindy Massuda, and I am the Hospice Quality Reporting Program Coordinator here at CMS. We are pleased to provide webinars and trainings to hospice providers and interested stakeholders. These webinars are provided on about a quarterly basis, and we maintain all our trainings on the Hospice Quality Reporting Program website under the Training and Education Library. At this time, there are several trainings available 24/7, 365 days on this website. Our goal is to provide trainings in a variety of formats and styles to reflect the diversity of learning styles. We also do our best to make these trainings broken down by topics for ease to review specific topics and to be sensitive to your limited time in order to do these trainings. We're proud of the high quality of all these trainings and have proven that with hospices taking these trainings, their understanding of and compliance with the Hospice Quality Reporting Program requirements are being met more and more. Our goal is to achieve 100% compliance. All trainings, like today's webinar, are meant to be collegial with time for questions and answers, and, as the moderator was saying, we're going to have not one but two question-and-answer sessions on today's webinar because we have two very important topics, and so we will be providing questions and answers after each section of the webinar today. And, as always, we're available and accessible through our Help Desk and our website. Our Hospice Quality Reporting website is chock-full of information. With that, let's get started with today's webinar, and I will turn it over to Dorothy Wu. Thank you very much.

Thank you, Cindy. Next slide, please. So, our presenters today will be Dorothy Wu and Elizabeth Fehlberg from RTI International. This training will be split into two parts covering two separate topics. During Part I of this training, we will be going over the Hospice and Palliative Care Composite Process Measure, also known as the Hospice Comprehensive Assessment Measure. Because this measure was added to Provider Preview Reports in September 2018 and is now being publicly reported on Hospice Compare, we wanted to take the opportunity to dive into the details of this measure to be sure that providers understand how this measure is calculated. Following Part I of the training, we will have a brief question-and-answer session. Then, during

Part II of the training, we will be reviewing the 4.5-Month Data Correction Deadline for Public Reporting Policy Update that was finalized in the Fiscal Year 2019 Hospice Final Rule. Following Part II of the presentation, we will host an additional question-and-answer session. Next slide, please. And, as previously mentioned, today's speakers will be Dorothy Wu and Elizabeth Fehlberg from RTI International. Next slide, please. Slide 3 here contains a list of acronyms that will be used in the presentation. Without further ado, let's begin with Part I, where we will be reviewing the Hospice and Palliative Care Composite Process Measure -- Comprehensive Assessment at Admission. Next slide, please. So, let's start out with a brief overview. You may be more familiar with this measure by its short measure name, which is the Hospice Comprehensive Assessment Measure, which is how we'll refer to it in this presentation. This measure was implemented in the Hospice Quality Reporting Program on April 5, 2017, and is calculated using existing Hospice Item Set, or HIS, data items from the HIS Version 2. The motivation behind the Hospice Comprehensive Assessment QM is to account for the fact that there are many things that a hospice is expected to do when a patient is admitted to hospice in order to provide high-quality care.

The Hospice Comprehensive Assessment Measure captures, in a single measure, whether multiple care processes are done when a patient was admitted. I want to pause here for a second and define a term that you are going to hear used during this training. That term is "composite measure." A composite measure is a measure like this one that captures multiple aspects of quality in one measure. Next slide. So, I mentioned on the prior slide that as a composite measure, the Hospice Comprehensive Assessment Measure looks at multiple care processes at once. I'll now go over which care processes are captured by or make up the composite measure. Historically, hospices have been using the HIS to report data on seven processes of care that should be delivered when patients are admitted to hospice. Those seven measures are listed here in Table 1. CMS began public reporting of these seven measures on Hospice Compare last year, and these measures were reported individually so consumers could look at how hospices performed on each individual measure. Next slide, please. The Hospice Comprehensive Assessment Measure takes these seven individual measures and combines them into a single metric. As such, the Hospice Comprehensive Measure captures in a single measure the proportion of hospice patients for whom the hospice performed all seven of these care processes, as applicable. This means that in order to get credit for this composite measure for a particular patient, the hospice must perform all seven of the care processes for which the patient is eligible. We'll talk more about how hospices get credit for this measure on the next slide, but, first, I want to define one more term that you are going to hear us use during this training. That term of "component measure." When we combine multiple individual measures together into a composite measure, we refer to those individual measures that make up the composite as “component measure.”

So, we would refer to the seven individual HIS measures as the component measures that make up the composite measure, the Hospice Comprehensive Assessment Measure. You will hear us use the term "component measures" and "composite measures" throughout the rest of this presentation. Next slide, please. So, there are many different types of composite measures. Two of the most common are "all-or-none" composite measures and average-based composite measures. The Hospice Comprehensive Assessment Measure is calculated as an "all-or-none" composite measure. This means that in order to receive credit on the Hospice Composite Measure, the hospice must perform all seven care processes, as applicable, to receive credit for the measure for any given

patient. In effect, the "all-or-none" requirement means that your hospice does not receive any partial credit for performing most of the seven care processes and that the score is not an average of your individual performance on each of the seven care process measures. We'll go through an example of this "all-or-none" approach next, as well as the implications of using the "all-or-none" approach. Next slide, please. So, on the prior slide, we introduce the concept of an "all-or-none" approach. So I'm now going to go over an example of the "all-or-none" approach and the implications that it has. For example, if your hospice completes six out of the seven care processes for a patient upon admission, then that sounds like a pretty good job. Six out of seven means that your hospice completed an average of 86% of the seven required care processes. However, the composite measure has an "all-or-none" standard, and by the "all-or-none" standard, your hospice would not receive credit for that patient on this composite measure because not all care processes were completed. As such, the "all-or-none" approach sets a higher bar for performance as it requires you to do all seven things, as applicable, and does not give partial credit for completing less than seven care processes. Next slide, please. There's an additional implication of the "all-or-none" criterion that has been a point of confusion for this measure, so I want to call your attention this important point. This composite measure, being an "all-or-none" measure, means that it is possible for your Hospice Comprehensive Assessment Measure score to be lower than your lowest composite measure score. For example, your hospice's Comprehensive Assessment Measure score may be lower than your hospice's Dyspnea treatment measure score, which is one of the component measures. A lot of providers find this point confusing because they think that the Hospice Comprehensive Assessment Measure is an average-based measure when it is not.

To explain this particular point, we are going to use a simplified example of a school performance. Next slide, please. So, in this simplified example, the school only has three students, named Alex, John, and Erin. The school is required to teach the student three subjects, which are math, science, and English. Next, we are going to look at how well the school performed at teaching Alex, John, and Erin all three subjects. Next slide. So, the school taught Alex two of the three subjects, as annotated by the green checkmarks. Alex was taught math and science. The school also taught John two of the three subjects. He learned science and English. Finally, the school taught Erin all three subjects. She learned math, science, and English. Next slide. Now we are going to look at the school's performance in two different ways. The first way is how well did the school do at teaching these three students each subject. Note that this is the same approach that is used for calculating your scores on each of the seven HIS component measures. So, how well did the school do at teaching math? Well, the school taught two out of three students math, so they scored 67%. What about science? The school taught three out of three students science, so that would be 100%. And, finally, English. The school taught two out of three students English, so that is also 67%. Now we are going to look at how well the school did at teaching each student all three subjects. This is where the example is representative of a composite measure because we are looking at, in a single measure, how well the school performed on multiple things. Also, this is an "all-or-none" composite measure of school performance because we specify that we wanted to know how well the school did at teaching each student all three subjects. So, how well did the school do? Well, the school only taught one student, Erin, all three subjects, so they scored 33%. So, the difference is that with the first approach, we are looking at each measure, or subject, individually, and we allow partial credit. The school did not

teach math to everyone, but they taught it to two out of three students, so they get a 67%. In the second table, with an "all-or-none" approach, there is no partial credit. Instead, we are trying to figure out, for each student -- did the school teach all three subjects to that student? So, looking at Alex, we see that he was taught two out of three subjects, but under the "all-or-none" approach, teaching two out of three is not enough to receive credit. The school did not teach all three subjects to Alex, so the school gets a 0% for Alex. Each time the school gets a 0% for a student, that brings down the school's overall performance on the measure, as we know that zeroes quickly bring down overall scores. Thus, we see that the school's final score of 33% is much lower than the school's scores on any one individual subject. The same logic applies to the hospice composite measure, and if we think about the logic underlying this approach, it makes sense. Although we are holding the school to a higher bar for performance with this "all-or-none" approach, the school should be responsible for teaching students all three subjects. So, taking this back to the HQRP, for the Hospice Comprehensive Assessment Measure, the hospice must perform all seven care processes, as applicable, for a patient in order to receive credit for that patient.

Before we move on from this example, let's look at the school's performance in one other way. Next slide, please. So, here on Slide 14, this table emphasizes what we just went over but in a slightly different way. Slide 14 compares how you would calculate a composite score under an "all-or-none" approach versus an average-based approach.

The first orange column walks through what would happen under an average-based composite approach. With an average approach, the school would get credit for what they did teach, giving the school a 67% for Alex and John and 100% for Erin. If we average across those scores, the school doesn't do great, but they do okay. They get a 78%. The "all-or-none" approach is much stricter because it gives no partial credit. Alex was taught two out of three subjects, but since that wasn't all three, the school doesn't get any credit for Alex. You can see here that the main difference between the "all-or-none" composite and the average composite approach is that, for the "all-or-none" approach, there are only two scores that the school can get for any one student -- either 0% or 100%. And, as discussed on the previous slide, zeroes quickly bring down your score. Here, in the "all-or-none" approach, we see that the school got two zeroes and only 100%. This means that the overall score is 33%, which is much lower than if we had used an average-based approach. Similarly, for the Hospice Comprehensive Assessment Measure, the hospice must perform all seven care processes, as applicable, for a patient in order to receive credit for that patient. There is no partial credit for performing most of the care processes, but instead, the hospice either gets a 0% or 100% for each patient depending on whether the hospice performed all seven care processes, as applicable. Next slide.

So, we talked a lot this far about the "all-or-none" approach the composite measure employs and the implications of that. I'd love to turn now to discussing another detail of the Hospice Comprehensive Assessment Measure methodology -- conditional measures. Of the seven component measures that make up the Hospice Comprehensive Assessment Measure, three of them are what we call “conditional measures”. You can see the conditional measures listed in the table on Slide 15. Conditional measures are measures where inclusion in the denominator is dependent or conditional on a response to a previous item. For example, for a patient to be included in the denominator of the Dyspnea treatment measure, the patient must have screened positive for

Dyspnea. This is because the hospice would not initiate treatment for shortness of breath unless a patient was actually short of breath. Along these same lines, for a patient to be included in the Pain Assessment Measure, the patient must first screen positive for pain. Finally, for a patient to be included in the denominator of the Patient Treated with an Opioid who are Given a Bowel Regimen measure, the patient must be taking a schedule opioid. So, how do these conditional component measures get treated in the composite measure? Next slide.

Well, the Hospice Comprehensive Assessment Measure treats conditional measures differently. When the composite measure is calculated, the hospice will, by default, receive credit for conditional measures when the patient does not meet the denominator criteria for that conditional measure. Note that this methodology of receiving credit for conditional measures when the patient does not meet the denominator criteria only applies to the calculation of the Hospice Comprehensive Assessment Measure. It does not apply to the calculation of individual component measures. This might sound a bit confusing, so let's talk about what this would look like in a brief example. Next slide.

If a patient screens negative for Dyspnea, then that patient would be ineligible for the denominator of the Dyspnea treatment measure. In other words, that patient would be considered neutral for the Dyspnea treatment measure. This means that the hospice would not receive credit for that patient, and the hospice would not be penalized for that patient. Now, when it comes to calculating the composite measure, these conditional measures are treated differently. Instead, if a patient screens negative for Dyspnea, the hospice would receive credit for the Dyspnea treatment component of the composite measure. This means that if a patient screens negative for Dyspnea, that patient will not count towards the individual Dyspnea treatment measure score. However, the hospice will receive credit for that patient when calculating the composite score. Next slide.

Looking across all three conditional measures, if a patient reports that they do not have pain during their pain screening, then when calculating the Hospice Comprehensive Assessment Measure score, your hospice will automatically receive credit for this patient. Similarly, if a patient is not on a scheduled opioid, then your hospice will receive credit for NQS #1617, Patients Treated with an Opioid who are Given a Bowel Regimen, when calculating the composite measure score. And, as a reminder, this methodology of counting patients that do not qualify for conditional measures towards the composite measure score only applies to the calculation of the composite measure. So patients will continue to not count towards the individual component measure scores when they do not meet the denominator criteria. Next slide.

Now we are going to walk through the steps for calculating this composite measure. Step One is to identify the patients that are eligible for inclusion in the measure denominator. All patients are eligible for inclusion in this measure unless they were admitted before April 1, 2017, or if they meet any of the exclusion criteria. You may be wondering why patients need to be admitted after April 1, 2017, to be included in this measure. Well, you might remember, at the beginning of this training, we mentioned that the composite measure was implemented in the HQRP on April 1, 2017. This is why patients must be admitted after April 1, 2017, to be included in the composite measure. Note that patients admitted prior to

April 1, 2017, will continue to be eligible for the seven-component HIS measures.

So, patients admitted before April 1, 2017, are not eligible, and patients that meet any of the exclusion criteria listed at the bottom of this slide are also not eligible. This exclusion criteria includes patients that are younger than 18, patients that have not been discharged, and patients that are missing their HIS Admission Record. Next slide. Once you have identified the patients that are eligible for the measure denominator, Step Two is identify whether your hospice met the requirements for each of the seven HIS component measures for each of these patients, as applicable. And the reason that we say "as applicable" is because of the conditional measures that we just went over. Remember, for the purposes of calculating the composite measure, if a patient does not meet the denominator criteria for the one of the conditional measures, your hospice will, by default, receive credit for the conditional measure.

For example, if a patient screens negative for Dyspnea and is thus not eligible for the Dyspnea treatment measure, for the purposes of calculating the composite measure, mark that hospice met the requirements for the Dyspnea treatment measure as a component of the Hospice Comprehensive Assessment Measure. Next slide. Next, for each patient that qualifies for the denominator, you should add up the number of HIS component measures for which your hospice met the requirements. Remember, this is an "all-or-none" measure, and that means that you must receive credit for all seven measures, as applicable, to receive credit for this measure. Next slide. So, once you add up the number of component measures that you receive credit for, if this number equals seven, then that patient qualifies for the numerator for the composite measure, and your hospice will receive credit for that patient for this measure. An example of this is Patient A on the left. If the number is any less than seven, then that patient does not qualify for the numerator for the composite measure, and your hospice will not receive credit for that patient for this measure, just like Patient B on the right. Next slide.

Finally, to calculate your hospice's score on the Hospice Comprehensive Assessment Measure, you need to divide the number of patient stays that met the numerator criteria by the number of patients that met the denominator criteria and multiply that by 100 to get the score. Next slide. Now that we've talked about how the composite measure is calculated, next, we want to talk about the different resources that are available to providers to review and monitor their hospice's Comprehensive Assessment Measure score. Providers can use their CASPER reports, including the Hospice-Level and Patient-Stay Level Quality Measure reports, or QM reports, to monitor their hospice's performance on the composite measure. CASPER reports can be run on-demand, and they enable hospice providers to view and compare this performance to the national average for a reporting period of their choice. For example -- For more information on the CASPER QM reports, we refer readers to the CASPER QM fact sheet that is linked to the bottom of this slide. Additionally, providers are able to view their Hospice Comprehensive Assessment Measure scores on their Preview Reports in advance of public reporting on Hospice Compare. Note that this measure was added to Hospice Compare with the November 2018 refresh. Next, we are going to walk through some examples of how providers can use their CASPER QM reports to understand their hospice's performance on the Hospice Comprehensive Assessment Measure. Thank you.

Let's look at this example of a Patient Stay-Level CASPER QM report. You can see that we have four sample patients listed in the first column. Across the top, you can see each of the seven HIS component measures and the Hospice Comprehensive Assessment Measure. The Hospice Comprehensive Assessment Measure is indicated here by the arrow. Before we dive into this example, let's go over a quick refresher of what all of these different letters mean. Next slide. So, in this table, you can see that the letter X means that the hospice received credit for a patient on a particular Quality Measure. Xs are good, and we like to recommend that you remember them by think "X marks the spot." In contrast, the letter B means that the hospice did not receive credit for a patient on a particular Quality Measure. To remember this, we recommend that you think of Bs as "bad." The letter E means that the patient was excluded from the denominator, which means that the patient was not included in the measure. These patients are considered neutral from a performance perspective. The letter C in the Admission Date column means that the HIS admission record is missing for that particular patient and that the provider should submit the HIS admission record as soon as possible so that the patient can be included in future Quality Measure calculations. Finally, the letter D might be a footnote that providers are not used to seeing. This is a newer footnote in the hospice setting, and it means that the measure was implemented after the patient's admission date. You might remember that earlier we said that the Hospice Comprehensive Assessment Measure was implemented in the HQRP on April 1, 2017, and that patients admitted to hospice before this implementation date are not eligible for this composite measure. So, this means that if you have a patient that was admitted before April 1, 2017, then you will see a letter D for them under the composite measure on your Patient-Level CASPER QM report. These patients will still be eligible for the other seven component HIS measures. Next slide.

Moving back to our example Patient Stay-Level CASPER QM report, if you look at the red circle under the Patient Admission Date column, you can see that Patient F here was admitted on January 1, 2017. Because this patient was admitted prior to the April 1, 2017, date, this patient is not included in the measure calculation for the composite measure. This is why there is a letter D under the Hospice Comprehensive Assessment Measure column. I like to remember what the letter D means by remember "D means date." This footnote will display when a patient's admission date was prior to the implementation date of the Hospice Comprehensive Assessment Measure. Next slide.

Now let's look at Patient G. You can see here that Patient G has a letter B under the composite measure column. Remember, the letter B means "bad." So the hospice did not receive credit for this patient on the composite measure. If we want to know why, then we can look across the row at the hospice's performance on the other seven HIS component measures. For Patient G, we can see that the hospice also has a letter B under the Pain Screening Measure, which means that the hospice did not complete a pain screening for Patient G. Since the pain screening is not a conditional measure and the hospice did not complete this care process, this hospice will not receive credit on the composite measure. Remember, the way that the composite measure is calculated is that all seven care processes must be completed for the patient, as applicable, to receive credit. Next slide.

Now, let's look at the hospice's performance for Patient H. There is a letter X for all seven HIS component measures for Patient H, and since the letter X marks the spot on treasure maps, this is a good thing. It means

that the hospice received credit for this patient on all seven component measures. You can also see that since the hospice successfully completed all seven care processes for Patient H, the hospice received credit for this patient for the composite measure. Next slide. Now we are going to take a look at Patient J. As you can see in the arrow, there's a letter X to indicate that the hospice received credit for Patient J for the composite measure. Looking across at the other seven component measures, you can see that the hospice also received credit for the first five measures, but then there's a letter E under Dyspnea Treatment and Bowel Regiment. The letter E means that the patient was not eligible for inclusion in the measure denominator for these two measures, probably because the patient screened negative for Dyspnea and that the patient was not taking a scheduled opioid. However, as we mentioned, to get credit for the composite measure, the hospice must complete all seven HIS care processes, as applicable. And the reason that we say "as applicable" is because three of the seven measures are conditional measures, meaning their inclusion in the denominator is dependent or conditional on a response to a previous item. Patient J is excluded from the Dyspnea Treatment and Bowel Regimen measures, and because these are conditional measures, the hospice still receives credit for this patient for Hospice Comprehensive Assessment Measure. Now that we have reviewed how to interpret this measure on the Patient Stay-Level CASPER QM reports, let's take a look at the Hospice-Level QM Report. Next slide.

Here, we are looking at a simplified version of a Hospice-Level CASPER QM Report. Looking at the bottom row of this table, you can see that for the Hospice Comprehensive Assessment Measure, this sample hospice had five patients that met this numerator criteria out of a total of seven patients included in the denominator. This led to a measure score of 71.4%. Looking down the last column of this table, you can also see the hospice's performance for each of the seven component HIS measures. You might notice that out of this column, the Hospice Comprehensive Assessment Measure score is the lowest performance score for this hospice. So the hospice's score on the composite measure is lower than the hospice's lowest component score. Remember, that earlier in this training, we went over the school example and explained that this is possible because of the higher bar that is set by the "all-or-none" scoring approach of the composite measure. Next slide. As we are wrapping up Part I of this presentation, here on Slide 32, you can find some additional resources related to the Hospice Comprehensive Assessment Measure. Next slide. We will now pause for a brief 10-minute Q&A session with our CMS experts to cover questions on Part I of our presentation, the Hospice Comprehensive Assessment Measure. Note that we will have a second Q&A session at the end of Part II of this webinar.

To ask an audio question, please press star, then the number 1 on your telephone keypad. Again, to ask an audio question, press star, then the number 1 on your telephone keypad. There are no audio questions at this time.

Thank you. If there are no audio questions at this time, we will read some questions from the chat box. The first question is related to the HIS 2% compliance. When do the HIS submissions begin and end for Fiscal Year 2019 and Fiscal Year 2020? I see Fiscal Year 2020 has started, and thought the HIS 2% compliance for timeliness went from January to December. Please explain.

Yes. This is Alexis from RTI, and I'm happy to take that question. I think, essentially, that this provider is asking for some clarification on kind of

which HIS records get included in compliance calculations for which year. For a point of context, this wasn't discussed specifically in this training, but we're happy to take this question. So, essentially, the rule I like to use in my head is the Plus-Two Rule. So we're in 2018 right now. So 2018 plus 2 is Fiscal Year 2020. So that means right now, data you're submitting right now will ultimately impact your APU in Fiscal Year 2020. So to get to the provider's question about which exact records will be included in the Fiscal Year 2020 sample, the answer to that question depends on the target date of their record, which is the patient's admission or discharge date. So to be included in the Fiscal Year 2020 sample, the admission or discharge date on their record must be sometime within Calendar Year 2018, and I'll give an example of that because I know it's probably hard to think about in your head. So, we're coming up on the end of 2018. So, say that your hospice had a patient admission that occurred on New Year's Eve. So, on December 31st. You're probably not going to submit that record until 2019, but because the target date -- in this case, the admission date -- was during 2018, that goes in the sample for 2018, which is Fiscal Year 2020. So the provider is correct, that the sample is driven by the calendar year, so it does run January to December, but it's driven by the date of admission or discharge, not the date on which you submit the record.

Thank you. This is Cindy Massuda. I think another good thing to point out at this point -- As we're ending the year, we are beginning, since this question was asked, we're going to be starting Calendar Year 2019 Hospice Quality Reporting Program data submissions for both the Hospice Item Set and the CAHPS Hospice Survey. So it's good timing to be aware that starting January 1st, it starts the Calendar Year 2019 data submissions, and so we're excited about that, and as Alexis was saying, when you do "Plus Two," that will affect your annual payment update in Fiscal Year 2021.

Thank you, Cindy. The next two questions are related, so I will read them both. The Comprehensive Assessment QM is only for patients that have discharged from hospice. What is the reasoning for having the patient discharge rather than include all admissions? These calculations are not made until a patient discharges, correct?

So, the company has this assessment quality measure. The calculation unit for this measure is a patient's stay, and a stay is defined by a paired HIS assessment and a discharge assessment. So to answer both of the questions, the second question is, yes, the patient will have to be first discharged in order to be included in the measure calculation, and the answer to the first question is -- All the patient admissions will be included in the calculation of the Comprehensive Assessment Quality Measure, but they have to wait until the patient has been discharged, therefore, has a complete assessment and the discharge assessment to be paired in order to go into the calculations. Thank you.

Thank you. The next question is -- Please review when the Public Reporting at the Comprehensive Measure Reporting starts.

Public Reporting of the Hospice Comprehensive Assessment Measure started in November. It was posted to Hospice Compare at the end of November, November 30th, I believe, and it is displayed for patient stays discharged between Quarter 2.2017 and Quarter 4.2017. So from April 2017 through December 2017.

We have an audio question from Annette.

Can you hear me?

Yes.

Okay, we have a question pertaining to the Comprehensive Pain Assessment, and what we're up against, oftentimes, with patients who are unable to participate in the Comprehensive Pain Assessment. So how do you get five criteria when they cannot answer those questions, nor do you have a caregiver that can answer those for them.

Yeah. The first thing I would recommend that you do is take a look at the HIS manual, and I don't have the exact page number off the top of my head, but if you go to the Coding Instructions and the Special Tips for that item, which is J0910, it does go through examples of how you can capture those seven characteristics for patients that are non-verbal and don't have a caregiver. So I know the situation you asked about was when there's not a caregiver, but for others on the line that may have similar questions, I'll talk about the role of the caregiver, as well, and I'll do that first. So, if a patient is non-verbal, you can ask the caregiver adhere any attempt to ask if the caregiver counts. So, if you ask the patient's daughter about the duration of pain and the daughter said, "Oh, I'm not sure, you know, I wasn't with Mom the past two days," that counts, even though the caregiver didn't have the information because the hospice made an attempt. For non-verbal patients, we have examples of how you can collect this information kind of using staff observation, and we do note that for non-verbal patients, when there is no caregiver, character is probably going to be the one that you can't really collect because it's hard to. You can't really observe character pain. But, for example, for location, if you notice that the patient was bracing or guarding their right elbow, that could give you an indication of location. For things like duration, the nurse noted that the patient was grimacing throughout the entire duration of the visit. That could be an indication. And the HIS manual essentially goes through examples like that for most of the characteristics, where it is possible to gather that information using staff observation.

Thank you.

Mm-hmm.

Were there any other questions from the phone?

No additional audio questions at this time.

Well, thank you all for your questions regarding the Hospice Comprehensive Assessment Measure. As a reminder, we're going to have a second Q&A session at the end of Part II of this webinar, and if you have any unanswered questions about the composite measure, you can ask them during that time. But next, we're going to move on to Part II of this training. Next slide.

Thank you. So, during Part II of this presentation, we're going to be reviewing the new 4.5-Month Data Correction Deadline for Public Reporting Policy. This policy was finalized in the Fiscal Year 2019 Hospice Final Rule. Next slide. First, let's start out with an overview of the current process for updating data for Hospice Compare as of December 2018. Hospice Compare only shows a snapshot of data, meaning that the data on Hospice Compare is not updated in real-time. Instead, the data on Hospice Compare is updated on a quarterly basis. Prior to the Hospice Compare refresh,

providers received Preview Reports about 2.5 months before the Hospice Compare refresh. These reports allow providers to preview what their QM scores are going to look like on Hospice Compare following the upcoming refresh. However, to ensure that the data that are displayed in the HIS Preview Reports are an accurate representation of the snapshot of data that are going to be displayed on Hospice Compare, CMS instituted "freeze dates," which occur about 15 days before the preview period begins. Next slide. As a reminder, freeze dates are the latest possible date that providers can correct their data and have that corrected data displayed on Hospice Compare for a given refresh. If providers correct their data after the freeze date, then the corrected data will not displayed on Hospice Compare until the following refresh. This is how things currently work as of December 2018. However, starting next month, in January 2019, this process will be changing. Next slide. As we mentioned before, with the old policy, providers could correct data after a freeze date, but those corrections would only influence the data displayed on the following Hospice Compare refresh, not the upcoming refresh. However, to align with other care settings, as well as to make data corrections more timely and to ensure that Hospice Compare is displaying a consistent representation of a hospice's quality, CMS finalized the new 4.5-Month Data Correction Deadline for Public Reporting in the Fiscal Year 2019 Hospice Final Rule. With this new policy, providers will now have approximately 4.5 months after the end of each calendar year quarter to review and correct their HIS data with target dates in that quarter.

As a reminder, target dates are for the patient's admission or discharge dates. So, this means that if your patient was admitted or discharged in a particular quarter, then your hospice will have approximately 4.5 months after the end of that Calendar Year quarter to review and correct that data if necessary. So, how does this new policy compare with the old freeze-date policy? Well, freeze dates are cyclical, and they occur about three months before a Hospice Compare refresh. If you missed one freeze date, then you can correct data before the following freeze date, and that corrective data would then be displayed with the following Hospice Compare refresh. In comparison, the 4.5 Month Data Corrections Deadline will create a hard cut-off. Any data corrections that occur after the 4.5-Month data correction deadline will not be reflected on any future Hospice Compare refreshes. This new Data Correction Deadline for Public Reporting will go into effect starting January 1, 2019. Next slide. So, one of the big differences between the old freeze-date policy and the new 4.5 Month Data Correction Deadline Policy is that with the new policy, any corrections made to data after the 4.5-Month deadline will not be reflected on Hospice Compare. Or, in other words, your data will be permanently frozen for the purpose of public reporting after the 4.5-Month deadline has passed. Next slide.

The table on this slide displays what the 4.5-Month Data Correction Deadlines will look like starting in January 2019. So, Quarter 1 refers to January through March, Quarter 2 refers to April through June, Quarter 3 refers to July through September, and Quarter 4 refers to October through December. Let's look at an example of how this new deadline is going to work. Next slide. Looking at Quarter 1 2019, which is January through March, you can see that the Data Correction Deadline for Public Reporting is August 15, 2019, which is about 4.5 months after the end of March. This means that for HIS records with target dates or admission and discharge dates in Quarter 1 of 2019, you will have approximately 4.5 months after the end of March to review the data contained within these HIS records and correct this data if necessary. This means that you'll have until about August 15, 2019,

to review and correct HIS records with target dates between January through March 2019.

If you correct this data after August 15, 2019, then those changes will not be reflected on Hospice Compare because this data will be considered permanently frozen for the purposes of public reporting. Next slide. We also want to point out the first row of this table. Please note that HIS records with target dates prior to January 1, 2019, need to reviewed and corrected if necessary before August 15, 2019. This means that HIS records with target dates prior to January 1, 2019, will have the same Data Correction Deadline as HIS records with target dates in Quarter 1 of 2019. Next slide. One question that might be running through your head is whether there is still going to be freeze dates.

Well, the 4.5-Month Data Correction Deadline Policy will eventually replace the freeze-date policy, but as this new policy is being implemented, there will be a couple of Hospice Compare refreshes that will still require freeze dates, specifically, the first 4.5-Month Data Correction Deadline of 2019 will be August 15, 2019, and the February, May, and August Hospice Compare refreshes are going to occur before this deadline. This means that we will still need to have a freeze date for the February, May, and August Hospice Compare refreshes. Next slide.

However, for the November 2019 Hospice Compare refresh, the freeze date and the 4.5-Month Data Correction Deadline will both be August 15, 2019. So, essentially, the freeze date will not be necessary for the November 2019 refresh since we will have the 4.5-Month Data Correction Deadline. Then, after the November 2019 Hospice Compare refresh, there will no longer be a freeze date because the 4.5-Month Data Correction Deadline will occur prior to the freeze date. Next slide. Now that we've given a basic overview of this new policy, there are a couple of key features that we want to make sure that you understand. First, the 4.5-Month Data Correction Deadline Policy is based on the record level, not the patient level. This means that the Data Correction Deadline is based on each individual record's target date. Therefore, it is possible that one patient's HIS admission and HIS discharge records may have different Data Correction Deadlines. This could happen if the patient's admission date was in one quarter but their discharge date was in a different quarter. Further, if you had a long-stay patient, it's possible that by the time the patient had been discharged, the Data Correction Deadline for their HIS admission record could have already passed.

We're going to talk through an example of how this is possible on the next slide, but first we want to emphasize that this means the providers need to be reviewing their HIS records early and often to help identify any errors in submitted data. Next slide. As an example, if a provider had a patient that was admitted on February 15, 2019, then that patient's admission target date would fall in Quarter 1 of 2019. If this patient was not discharged until December 15, 2019, then their discharge date would fall in Quarter 4 of 2019. This means that the admission record needs to be corrected by the Quarter 1 deadline, which occurs in August 2019, and the discharge record needs to be corrected by the Quarter 4 deadline, which occurs in May 2020. What we really want to draw your attention to in this example is that the 2019 Quarter 1 4.5-Month Data Correction Deadline is August 15, 2019, and this means that the correction deadline for this patient's admission record occurs before the patient is discharged from the hospice. This means the provider should not wait until the patient has been discharged to review the

admission data because, at that point, it may be too late to correct errors in the admission record. Next slide.

Another key feature of this policy is that it's based on which quarter the record's target date falls under, not the record submission date. This is an important feature because hospices have up to 30 days to submit HIS records, and this means that it is possible that a record target date could be in one Calendar Year quarter, but the submission date could fall in a different Calendar Year quarter. Let's walk through an example. If a patient was admitted on March 15, 2019, and the provider submitted their HIS admission record on April 5, 2019, which is within the 30-day submission deadline window, that patient's admission date would be in Quarter 1, which means that the correction deadline for that record would be the Quarter 1 deadline of August 15, 2019. It does not matter that the provider did not submit the record until Quarter 2. Therefore, since this policy is based on a target date and not the submission date, the Data Correction Deadline is based on which quarter the target date falls under regardless of when the provider submits the record. Next slide. You may be wondering how this new Data Correction Deadline Policy is going to impact other HIS submission and data-correction policies. Well, this policy will not affect the established 30-day HIS submission deadline policy. This means that providers will continue to have 30 days from the record's target date to submit HIS data before that record will be considered late. Additionally, modification and inactivation requests will continue to be permitted for up to 36 months.

The change is that even though you have 36 months from the record target date to correct your data, these corrections will only be reflected on Hospice Compare if you make the corrections prior to the 4.5-Month deadline. For example, this means that you can still collect an HIS record one year after the record target date, but these corrections will not be reflected on Hospice Compare because this would be past the 4.5-Month deadline for public reporting. Next slide.

The process for reviewing and submitting corrections for data is not changing, meaning providers will continue to have the same resources currently available to review their data and make corrections if necessary. However, we'll go ahead and review these existing processes now. Providers should review their data for accuracy prior to submitting their HIS data to CMS. Additionally, providers are encouraged to use their CASPER QM reports to review their data prior to the 4.5-Month Data Correction Deadline for Public Reporting. CASPER QM reports are available on-demand so providers can run these reports at any time review their data for a reporting period of their choice. As a reminder, CASPER QM reports only tell you if patients were included in the QM calculations once they are discharged. If providers identify any errors in a patient's data while they're reviewing, then providers should admit either an HIS modification or inactivation request, depending on the identified issue. To ensure that any needed updates are reflected on Hospice Compare, be sure to confirm that the modification or inactivation request is accepted by QIES ASAP system before the Data Correction Deadline. Next slide.

The next step for providers to prepare for the implementation of this new policy on January 1, 2019, includes that providers should review all HIS records with target dates prior to 2019 and in the first quarter of 2019 to ensure that they are complete and accurate. If you do identify any errors, then you should submit and HIS modification or inactivation request and ensure that request is accepted by the QIES ASAP system before August 15,

2019, which is the first Data Correction Deadline of 2019. Next slide. To summarize, let's take a look at how the new 4.5-Month Data Correction Deadline for Public Reporting compares with the Freeze Data Policy. Starting with things that are staying the same, the concept of having a date by which providers must modify HIS records for those modifications to be reflected on Hospice Compare will continue to exist. The thing that's changing is the deadline for correcting the data. Other things that are staying the same are that providers will continue to have 36 months to submit modification and inactivation requests and 30 days to submit their HIS data before that data will be considered late. Let's look at what is different between these policies. Whereas the freeze date occurs about 15 days before the release of HIS provider preview reports, the 4.5-Month Data Correction Deadline for Public Reporting will occur approximately 4.5 months after the end of each Calendar Year quarter. With the freeze date policy, providers must ensure that all HIS records are going to be included in the upcoming Hospice Compare refresh has been corrected by the freeze date for those corrections to be reflected on the upcoming Compare refresh. For the 4.5-Month policy, providers must ensure that all HIS records with target dates in that Calendar Year quarter are corrected by the 4.5-Month deadline for those modifications to be reflected on Hospice Compare.

So the freeze date policy -- if you modify records after the freeze date, then those modifications will be reflected in future Hospice Compare refreshes, just not the upcoming refresh. With the 4.5-Month policy, if you have a modification to an HIS record after the 4.5-Month deadline, then those modifications will not be reflected in any Hospice Compare refreshes. Additionally, the freeze date policy will be phased out after the August 2019 Hospice Compare refresh. The 4.5-Month data correction policy will be implemented on January 1, 2019. Finally, some key features of the new 4.5-Month policy that we discussed over slides 44 through 46 are that the Data Correction Deadline is based on which Calendar Year quarter the HIS record's target date falls under, not the date the HIS record is submitted. Additionally, this policy is based on the record level, not the patient-stay level, meaning that a patient's HIS admission and HIS discharge records may have different Data Correction Deadlines. This means that providers should not wait until the patient has been discharged to review admission data because, at that point, it may be too late to correct errors in the admission record. Next slide.

Finally, on Slide 49, we have included some additional resources related to the 4.5-Month Data Correction Deadline Policy for Public Reporting. Next slide. We'll now have a Q&A session with our CMS experts. Please ask questions about Part II of the presentation, which related to the new 4.5-Month Data Correction Deadline for Public Reporting. Or if you have any unanswered about the composite measure, you can ask them now, as well.

Again, if you would like to ask an audio question, please press star, then the number 1 on your telephone keypad. Again, star, then the number 1 to ask an audio question.

Thank you. We will take questions from the chat box first, and then open up the phone lines. The first question is -- Please re-explain Slide 31.

Great. So, I can provide a little bit more detail on Slide 31. I'm not sure what the exact question was, so if you have something specific about Slide 31, feel free to mention that on the chat box. So, essentially, Slide 31 is showing you what your Hospice-Level CASPER QM report is going to look like

in terms of the seven individual component measures, as well as a composite measure. So going down the rows, those are the measures, and for the seven individual component measures, those are being calculated the same way that they've been calculated since the inception of the HQRP. So, essentially, what's going on there is that each of those seven measures has its own denominator inclusion criteria and exclusion criteria, its own rules for how you meet the numerator or get credit for the measure, and, essentially, what it's showing you is in the denominator column, it's showing you how many patients were eligible for that measure. So, for the first row treatment preferences, there were eight patients that were eligible for that measure. And then the numerator column shows you how many of those eight did I end up receiving credit for? So, in this situation, it was seven. So then what happens for those individual component measures is you do 7 over 8, and turn it into a percent, which is 87.5%, as you can see here. So that's how all of those are calculated, and what you'll notice about the seven individual component measures is that since they all have their own individual denominator and numerator criteria, the denominator and numerator are different for all of them. So the denominator isn't the same across all seven, nor is the numerator, and those are just a basic numerator over denominator percent. So, then, the final line is that Hospice Comprehensive Assessment Measure. And when you look at it in this display, I think this is where a lot of the questions come from, of "How is my composite measure score so much lower?" Because when it's put together in one table like this, it's very easy to think in your head, "Oh, okay, this composite measure score is just the average of everything that came above it. And that's not the case, and that's kind of the point that we were trying to emphasize with the training. So I almost like to separate the seven and the composite measure in my head and not think of them as kind of being in this one table because they're calculated so differently. So, essentially, what this line of data about the composite measure is showing you is, again, it went back to the patient level and looked all of the eligible patient stays that you had during the reporting period and figured how many of those patients met the denominator criteria for the composite measure, and then, to calculate the numerator, it said, "Okay, patient A is in the denominator. For Patient A, did you do all seven things, or not? And so if you did all seven things, as applicable, essentially, you get a 1. So you can think of the numerator for the composite measure as like eyeing up ones and zeroes and then dividing by the denominator. And then you, again, get kind of your overall score, which, in this case, was 71.4%.

Thank you. The next question is related to Part I. If the patient is admitted on 12/31/2018 but doesn't pass until June 2019, is it included in 2020?

Yep. So, this is an example -- So, say the patient was admitted 12/31/18 -- that was the example I gave earlier -- how does that patient get attributed, to which compliance calculation, for which reporting cycle? So, the first thing I want to point out is that your compliant determinations, unlike your QM calculations, your compliance determinations are done at the record level. So you don't have to wait for that patient to be discharged for it to end up in your compliance calculations. As soon as you submit either an admission or a discharge record, then that record gets attributed to the compliance denominator for whatever reporting year we're in. So say, for example, the patient was admitted 12/31/18. It's unlikely that you're going to submit your HIS submission record that day, so let's assume you submit sometime in January 2019. Although you submitted it in 2019, the admission date was still in 2018, so it gets counted as a 2018 record. So do your

little mental trick of 2018 plus 2, and that patient's going to count towards the Fiscal Year 2020. So, when that same patient dies in June 2019, then June 2019 would be the discharge date, or the target date, for that HIS discharge record. So, again, you should be submitting those within 30 days, which means you should be submitting it sometime in June or July, but, actually, you know, again, it's based on the target date. So if they pass in June 2019, that target date is 2019, so it goes into the 2019 sample, which 2019 plus 2 is 2021, so they count towards the Fiscal Year 2021.

Thank you. The next question is -- This data collection is only for the purpose of public reporting, correct? So we want our numbers to reflect complete and accurate admission data for public review.

Yes, so that is correct. The 4.5-Month Data Correction Deadline is intended to ensure that data on Compare is as complete, as accurate, and as consistent as possible for consumers of the site.

Thank you. The next question is -- How do we evaluate the error messages on HIS submissions? Are all errors serious and should be addressed and re-submitted, or are some errors informational only?

Yep. So, that's a great question. So, when you think about errors that are triggered when you go to submit a record, there's two buckets of them. So, there's what are called fatal errors and what are called warning errors. And I kind of like to think of them as, like, red light, yellow light. So, those fatal errors are your red light errors. A fatal error means that there is something fatal with your record, and that means that you're not going to be able to submit it the QIES ASAP system until you correct that error. So that means, although you're attempting to submit, it's not going to go through and it's not going to come to CMS. So if you don't resolve that fatal error, even though you're attempting to submit it, it never makes its way to CMS. So you definitely want to go back and resolve the fatal error and then re-submit the record so that you can make sure that it's going through. And the way that you make sure your records are going through is by checking the final validation reports, which you should always do. So, the second bucket of errors are what I call the warning errors, and I call those -- they're in my head as the yellow light errors. So they're not fatal. Your record can still go through to the QIES ASAP system with a warning error, but, really, what the system is trying to tell you to do is it's saying, "Hey, slow down, pause, there may or may not be something wrong with your record. Go back and double-check it, just to make sure that the response that you provided is correct."

Thank you. The next question is -- When submitting HIS measures, I have seen errors. However, the assessment was completed correctly according to the Registered Nurse. For instance, if an opioid is being used for something other than pain and the pain question is answered "None."

Yep. So this is actually a great follow-up question to what I was just talking about, and I'll talk about the specific example that was provided in the question, which is one of those warning errors that comes up when you state that the patient was on an opioid but you answered "No" to pain-active problems. So that is warning error 3077, if you see it pop up in QIES. It's got this specific kind of tag number. And, again, because that's a warning error, it's one of those yellow light errors. So it's not saying, "Hey, stop, there's something definitely wrong." It's saying, "Hey, slow down. Check it out. There may or may not be something wrong." So this is a

question that we get commonly on the Help Desk, and, essentially, you're right. As long as that opioid is being used for symptoms other than pain -- So, for example, if they had shortness of breath, then you can still answer "No" to pain-active problem, and that's completely correct, but it's going to give that warning message anyway, just as kind of a flag to say, "Hey, double-check and make sure this is correct." But if you get that warning message, just check the indication of the opioid medication and make sure it's for something other than pain, and as long as it is and there is no other kind of evidence that pain was an active problem for the patient, you can still answer "No" to that pain-active problem item and get that record submitted successfully through QIES because that is just a warning error.

Thank you. The next question is -- Can you give an example of a common correction error?

Mm-hmm. So, we've got several questions kind of related to this, and we actually don't have any examples of common-correction errors, but I can just talk a little bit more kind of about the correction process in general in case that would be helpful. And the first thing that I want to point out is just the difference between the error messages that I was just talking about, the warning and fatal error messages and the correction process. So, those two really aren't necessarily related. So those error messages that pop up in QIES are going to pop up before their record is submitted to CMS, and it's trying to tell you that there may or may not be something wrong with your data. So the correction process that Liz was talking about is essentially your record has gotten through the QIES system, but you have since, after the fact, realized that there was an error. So it was some sort of incorrect data that you submitted that didn't likely trigger one of those warning or fatal error messages by the QIES system, but you realized somehow that it was incorrect. And I can give a couple of examples but these aren't most common. So, say, for example, you realized that for the pain screening question, the nurse answered "No" when she really should have answered "Yes," and you may have detected that by going back and doing some sort of chart audit or talking to your nurses during training about the correct way to answer yes or no to those questions. So that would be something that's in a record that you've already submitted. It didn't trigger one of those warning or fatal error messages in QIES, but sometimes after you submitted the record, you discovered the error. So that's why it's really important to build in some front-end quality assurance processes so that you can try and prevent as many errors as possible and to also kind of have thorough review processes in place. So making sure that all of the staff were completing HIS items, have reviewed the HIS manual for the proper coding guidance, having staff kind of double-check just to make sure there aren't any transcription errors, if you're moving kind of data out of the clinical medical record into the HIS record. Things like that can really help prevent those errors in the first place.

Thank you. We received two separate questions in the chat box that are related, so I will be reading them together. Currently, on the patient-stay-level report, if a patient does not have a discharge date, then an E appears for each measure. Is this going to change so patients not meeting a measure can be identified even if there is no discharge date? Just to clarify, the CASPER Patient-Level Data Report includes incomplete records, meaning those without a discharge HIS.

Yes, so that is correct for the second part of that question. If the CASPER QM reports, the patient-level data report, particularly, contains data for

incomplete records or open stays -- so those that have been admitted but not discharged yet, or those that the discharge assessment has not be submitted for yet. Because I think, as Tracy had talked about earlier, that in order to calculate a quality measure, we need a pair of records. We need both the admission and the discharge record. So, because of that, as it currently stands, the E will show up in your patient-stay-level report if the patient has not been discharged because they are excluded from quality measure calculation.

Thank you. The next question is also referring back to Slide 31. Should the numerator for the comprehensive assessment be 5 or 4?

This is a good question, and I think this actually kind of relates back to the relationship between the individual component measures and the composite measure. So, I'm assuming this question -- I'm not sure where they were getting 5 or 4 from, but I'm thinking they may have been looking at the pain assessment measure and thinking that was the one that had the lowest numerator. So how come the composite isn't as low as that? So, again, you know, I just want to re-emphasize what we talked about kind of throughout this presentation, which is that the composite is an "all-or-none," so it's not an average-based measure. And so when you're thinking about calculating the composite measure and you're trying to read, kind of, essentially, the last row in this table that's on your hospice-level QM report, I actually think that the easiest way to try and interpret that is not to look at any of the rows that come above it. So don't look at the individual component measures. I think the easiest way to figure out what's going on with that measure is actually to go to the patient-level report because there isn't a one-for-one kind of relationship between any single individual score on any single individual component measure in the composite. The composite is calculated at the patient level, which means that the numerator and the denominator for the composite can be different than the numerators and denominators for your component measures. So that's why it's possible that the numerator for that measure is a 5, but your lowest-scoring component measure of the numerator was a 4.

Thank you. The next question is -- We had a patient that was erroneously entered into our EMR as having died. In this instance, HIS was completed and submitted to CMS prior to the error being recognized. How do we notify CMS of this error?

Yep. So, there are essentially -- When something like this happens -- so when you need to make a correction to your data after their record has already been submitted to and accepted by the QIES ASAP system, there's essentially one of two processes that you're going to use to make the corrections to the data. So you're either going to use what's called a modification request or you're going to use an inactivation request. An inactivation request is used when one of the key patient identifiers was the data item that was incorrect, so something like the patient's name or their birth date or a key record or event identifier was incorrect. So, in this case, essentially, you submitted an HIS discharge because you thought the patient died, but the patient had not died. So, essentially, that event did not take place, which means you want to use an inactivation request, and, essentially, what you want to do is you need to inactivate that HIS discharge record you submitted because the death did not occur. So that's what you would do in that instance, and the modification requests are used to correct other items on the HIS that are not one of those kind key patient or record or event identifiers.

Thank you. At this time, we will go ahead and open the phone line for an additional one to two questions.

Again, if you would like to ask a question, please press star, then the number 1, on your telephone keypad. Again, that's star, then the number 1, to ask an audio question.

There are no audio questions at this time.

This is Cindy. I want to thank you very much for this wonderful webinar training. It's been most informative, very educational, and I think that it goes well with the other trainings that are on our website because there are a lot of questions people are asking about understanding their CASPER reports, and we do have historical trainings -- we did one very recently using RTI's amazing staff, who presented today, on CASPER, and you can find that on our Training and Education Library. It was back in April of 2018. And so this training today will also be on that webpage and always available 24/7, 365 days a year, so you can always go back and learn and re-learn and pick up pointers because it is a fabulous and chock-full of information today. I want to thank Alexis and Liz Fehlberg and Dorothy Wu and Tracy Xiang and the rest of the RTI team along with Charles Padgett, my colleague for today's fabulous webinar training. I'll turn it back over to the moderator.

Thank you. At this time, we're going to go ahead and close the call.

Thank you. This concludes today's conference. You may now disconnect. Speakers, please hold the line.