Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Inpatient Hospital Quality Programs Payment Updates and Overview

Presentation Transcript

Moderator

Bethany Wheeler-Bunch, MSHA
Project Lead, Hospital Value-Based Purchasing Program
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

Speakers

Nekeshia McInnis, MSPH
Subject-Matter Expert, Hospital IQR and Hospital VBP Programs
Quality Measurement and Value-Based Incentives Group (QMVIG)
Center for Clinical Standards and Quality (CCSQ), CMS

Nichole Davick
Health Insurance Specialist, Electronic Health Record (EHR) Incentive Programs
Division of Health Information Technology (IT), CCSQ, CMS

James Poyer, MS, MBA
Director, Division of Value, Incentives, and Quality Reporting
QMVIG, CCSQ, CMS

Elizabeth Bainger, DNP, RN, CPHQ
Program Lead, Hospital-Acquired Condition (HAC) Reduction Program
QMVIG, CCSQ, CMS

October 11, 2017
2 p.m. ET

DISCLAIMER: This transcript was current at the time of publication and/or upload onto the *Quality Reporting Center* and *QualityNet* websites. Medicare policy changes frequently. Any links to Medicare online source documents are for reference use only. In the case that Medicare policy, requirements, or guidance related to this transcript change following the date of posting, this transcript will not necessarily reflect those changes; given that it will remain as an archived copy, it will not be updated.

This transcript was prepared as a service to the public and is not intended to grant rights or impose obligations. Any references or links to statutes, regulations, and/or other policy materials included in the presentation are provided as summary information. No material contained therein is intended to take the place of either written laws or regulations. In the event of any conflict between the information provided by the transcript and any information included in any Medicare rules and/or regulations, the rules and regulations shall govern. The specific statutes, regulations, and other interpretive materials should be reviewed independently for a full and accurate statement of their contents.

Bethany Wheeler-Bunch: Hello and welcome to today's webinar, Inpatient Hospital Quality Programs Payment Updates and Overview. My name is Bethany Wheeler-Bunch and I am with the Hospital Inpatient Value Incentives and Quality Reporting Outreach and Education Support Contractor; and I will be the moderator for today's event. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation and the question and answers will be posted to the inpatient website, www.qualityreportingcenter.com in the upcoming weeks, and will also be posted the *QualityNet* at a later date. If you registered for this event, a reminder email with the slides, were sent out to your email about two hours ago. If you did not receive that email, you can download slides at our inpatient website, www.qualityreportingcenter.com. If you have a question as we move through the webinar, please type your question into the chat window with the slide number associated and we will answer as many questions as time allows. Any questions that are not answered during the webinar will be posted to the qualityreportingcenter.com website in the upcoming weeks.

Now, I would like to welcome today's speakers from CMS. Our first speaker, Nekeshia McInnis, is a subject-matter expert for the Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing programs from the Quality, Measurement and Value-Based Incentives Group at CMS. Our second speaker, Nicole Davick, is a Health Insurance Specialist in the Division of Health Information Technology at CMS and will be presenting on electronic health record incentive programs. Our third speaker, Jim Poyer, is the Director of Value, Incentives, and Quality Reporting at the Quality Measurement and Value-Based Incentives Group at CMS. Mr. Poyer will be presenting on the Hospital Readmissions Reduction Program. Our final speaker for today, Elizabeth Bainger, is the Program Lead of the Hospital-Acquired Condition Reduction Program and the Quality Measurement and Value-Based Incentives Group at CMS. Thank you all for joining us today and speaking for your respective programs. This event will provide an overview of how CMS adjusts payments for the following inpatient hospital quality programs: Hospital

Inpatient Quality Reporting, also known as IQR; the Electronic Health Record (EHR) Incentive Program; the Hospital Value-Based Purchasing Program, also known as VBP; Hospital Readmissions Reduction Program, also known as HRRP; and the Hospital-Acquired Condition Reduction Program, also known as HAC Reduction Program.

Participants will be able to perform the following: identify the portion of CMS payments applicable for payment adjustments, discuss how CMS calculates payment adjustments for each of the programs, recall the location of CMS publicly reported payment files.

This slide provides a list of acronyms that we will use throughout the presentation for your reference.

Just a reminder before we start, if you have a question as we move through the webinar, please type your question into the chat window with the slide number associated so we can best address your question. Now, I would like to turn the presentation over to Nekeshia McInnis to present on the Hospital Inpatient Quality Reporting Program. Nekeshia, the floor is yours.

Nekeshia McInnis: Thank you. Hello. Thank you again for joining us on this webinar. As was mentioned earlier, I'm the subject-matter expert for the Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing programs at CMS; and I will be presenting on both the IQR and HVPB programs payment adjustment methodology.

In an effort to provide greater transparency about the quality and safety of our nation's hospitals, the purpose of the Hospital Inpatient Quality Reporting Program is twofold. First, to equip consumers with quality-of-care information to make more informed decisions about their choice of healthcare providers. And second, to improve the quality of inpatient care provided to all patients. The data is ultimately published on *Hospital Compare* and providers are financial incentivized to report this data. We will dive into how in the next slide.

Eligible and participating hospitals must meet the following IQR Program requirements for fiscal year 2018 in order to have been deemed successful by CMS:

- Complete and maintain a notice of participation agreement
- Maintain a *QualityNet* Security Administrator
- Collect and report on
  - Clinical data, such as eCQMs
  - HCAHPS Survey data
  - HAI
  - Healthcare professional influenza vaccination data via CDC's NHSN
  - Structural measures, such as the patient safety checklist
- And complete and submit the data accuracy and completeness acknowledgement form

In addition, hospitals must submit complete data by established deadlines. For example, hospitals must submit NHSN data for approximately four-and-a-half months after the end of the reporting quarter. Furthermore, hospitals must submit aggregate population and sample size counts quarterly; meet validation requirements, if selected; and lastly, display quality data on the *Hospital Compare* website.

Now, in terms of the history and evolution of the payment methodology within the IQR Program, we must begin with the Medicare Prescription Drug Improvement and Modernization Act of 2003, where it was defined that there would be a 0.4 percentage point reduction in the applicable market basket update for hospitals that fail to submit quality information, starting in fiscal year 2005 and ending in fiscal year 2006. Then for fiscal years 2007 through 2014, hospitals are subject to a full 2 percentage points reduction as defined in the Deficit Reduction Act of 2005. Currently, from fiscal year 2015 and subsequent fiscal years, hospitals are subject to a one-fourth-percent reduction of the applicable market basket update, as defined by the HITECH Act.

On slide 14, we provide more background on the market basket update and what it entails for your consideration.

Ultimately, the market basket updates are used to update payments and cost limits in our various payment systems and reflect input price inflation facing providers in the provision of medical services. Also, please note that in the Hospital IQR Program, we use the terms, market basket update and annual payment update, interchangeably.

Now, on this slide, we provided an image of the fiscal year 2018 market basket update, where we've highlighted the section that details the adjustments for failure to submit quality data for the Hospital IQR Program, which we further examine in the fiscal year 2018 IPPS/LTCH PPS final rule.

On the *QualityNet* website, we pulled lists of hospitals that either met requirements, did not meet requirements, or chose not to participate in the program, by fiscal year. Here, we presented a graph of a percentage of hospitals receiving their full adjustment payment update from fiscal year 2005 to 2018, and we can see that the percentage has consistently fallen within a 94 percent to 99 percent area over the years.

As was mentioned earlier and to provide more background, *Hospital Compare* contains information about the quality of care for thousands of Medicare-certified hospitals across the nation. It was committed through a collaborative partnership between CMS, consumers, hospitals, doctors, employers, accrediting organizations, and other federal agencies with the aim to help consumers make decisions about where basic healthcare, as well as, to encourage hospitals to improve the quality of care that they provide.

Here's a snapshot of a side-by-side comparison of three hospitals participating in the Hospital IQR Program. And, we can see the areas that are compared, such as survey of patients' experiences, timely and effective care, complications, readmissions, and deaths, use of medical imaging, and payment and value of care.

Lastly, here we provide a list of program resources you may access if you have any questions or concerns: if you would like to access our FAQs; if you would like to sign up and join program ListServes and discussion groups, which are very, very helpful; if you would like to access our monthly webinars and to register for them; and if you would like to view data on *Hospital Compare*. Thank you.

Bethany Wheeler-Bunch: Thank you, Nekeshia, for that information regarding the Hospital IQR Program. I would now like to turn the presentation over to Nicole Davick to present on the Medicare Electronic Health Record (EHR) Incentive Program. Nicole, the floor is yours.

Nichole Davick: Thank you, Bethany. Again, I'm Nichole Davick. I'm a Health Insurance Specialist in the Division of Health Information Technology at CMS. Next slide, please.

The EHR Incentive Program authorizing legislation was the American Recovery and Reinvestment Act, or ARRA, of 2009 and included the Health Information Technology for Economic and Clinical Act, or the HITECH Act, to authorize incentive payments and Medicare payment adjustments for the following: eligible hospitals, critical access hospitals or CAHs, and Medicare Advantage organizations. Next slide, please.

The eligible hospitals and CAHs receive incentive payments, received incentive payments through 2016. That's for subsection (d) hospitals, 50 States or the DC that are paid under the IPPS, critical access hospitals, and Medicare Advantage or MA-affiliated hospitals. Puerto Rico hospitals are now being paid between 2016 and 2020. That was part of Section 602 of the Consolidated Appropriations Act. The negative payment adjustments will start for Puerto Rico in 2022. Next slide, please.

The incentive program payment adjustments began in 2015 for eligible hospitals. It started with the 2013 reporting year. We use a two-year lookback. So therefore, if you met meaningful use in 2013, you would not receive a payment adjustment in 2015, and so on, 2014 and 2016. The

critical access hospitals, their payment adjustments did not start until 2015 and if you'll notice by that table there, the payment year, I mean, not the, I beg your pardon, the program year and the adjustment year align with each other. So, this year, the 2017 payment adjustments will apply to the 2017 reporting period. Next slide, please.

This payment adjustment is replied—is applied as a reduction to the applicable percentage increase to the IPPS payment rates, reducing the update to the IPPS standard amount for these hospitals. And, eligible hospitals are going to receive a payment adjustment that's tied to a specific fiscal year. Eligible hospitals that did not successfully demonstrate meaningful use for an applicable EHR reporting period in 2015 are receiving a reduction to the IPPS applicable percentage increase in fiscal year 2017. And, this is, again, a market basket update. Next slide, please.

This is a similar table that we just saw in the previous presentation. The 2.025 percentage point decrease for the meaningful EHR user decreases payment is three-quarters of the market, three-fourths of the market basket update for fiscal year 2018, or up 2.7 percent. For more information on the market basket, the link is attached there below on that slide 26. Next slide, please.

The payment adjustment applies to Medicare reimbursement for inpatient services during the cost reporting period for which the CAH failed to demonstrate meaningful use, and you'll see that's a percentage of reasonable cost. Each year the CAH fails to meet meaningful use for an EHR reporting period, the adjustment will be applied against a reimbursement for that year. Next slide, please.

We do offer EHR Incentive Program hardships. There are five hardships to choose from for the eligible hospitals and the CAHs. The hardship exemptions are allowed for five years. Each year, we open an application process; the 2017 hardship deadline for hospitals was July 1 of this year and the CAH deadline is November 30. The providers have, again, the five hardships to choose from. Next slide, please.

Lastly, here are the incentive program resources. For more information on payment adjustments and hardships, the link is there. Questions regarding EHR hardship, is the contractor for the hardships and, of course, we have Twitter and ListServe communication. The EHR Incentive Information Center information is below. I will thank you and I will now hand it over to Bethany.

Bethany Wheeler-Bunch: Thank you, Nicole. I would now like to hand the presentation back over to Nekeshia McInnis to present on the Hospital Value-Based Purchasing Program. Nekeshia, the floor is yours.

Nekeshia McInnis: Thank you. I'm back to discuss the Hospital Value-Based Purchasing [Program] payment adjustment methodology. However, to begin, I'll start by providing some background on the HVBP Programs origin and intent. The program is authorized by the Social Security Act and is designed to both promote better clinical outcome for hospital patients and to improve their experience of care during hospital stays by encouraging hospitals to eliminate or reduce the occurrence of adverse events, to adopt evidence-based care standards and protocols, to reengineer hospital processes that improve patients' experience of care, to increase the transparency of care, and to recognize hospitals that are involved in the provision of high quality care at a lower cost to Medicare.

Now, concerning program eligibility, eligible hospitals include subsection (d) hospitals as assigned in the Social Security Act. And, eligible hospitals include psychiatric, rehabilitation, long-term care, children's, 11 PPS-exempt cancer hospitals, and CAHs, Critical Access Hospitals. Excluded hospitals for example, include those subject the payment reduction under the Hospital IQR Program, those cited for three or more deficiencies during the performance period that posed immediate jeopardy to the health or safety of patients, those with an approved extraordinary circumstance exception specific to the HVBP Program, and more. To note, hospitals excluded the HVBP Program will not have their base-operating DRG payment reduced by the withhold percentage.

Here, we have a graphic of the four domains that the HVBP Program for fiscal year 2018 consists of, including their domain weights. We see that each domain—safety, efficiency and cost-reduction, clinical care, and patient- and caregiver-centered experience of care/care coordination—are each weighed equally at 25 percent. The Safety domain consists of the HAI measure, as well as the PC-01 measure. The Clinical Care domain consists of the AMI, heart failure, and pneumonia 30-day mortality measure. The Efficiency and Cost Reduction domain consists of all of the Medicare Spending per Beneficiary measure, also known as MSPB. And the Patient- and Caregiver-Centered Experience of Care/Care Coordination domain consists of a Hospital Consumer Assessment of Healthcare Providers and Systems Survey dimensions, listed here, also known as the HCAHPS Survey.

Regarding the HVBP Program scoring methodology, value-based incentive payments are based on the hospital's total performance score, or their TPS. It's determined by calculating a hospital's achievement and improvement points for each measure within each domain and summing weighted domain scores. Achievement points are awarded by comparing individual hospital's rates during the performance period with **all** hospitals' rates from the baseline period, whereas improvement points are awarded by comparing a hospital's rate during the performance period to that **same** hospital's rate from the baseline period.

In the future, we have finalized program policies to include additional claims-based measures, focusing on clinical care outcomes and efficiencies. Specifically, we are adopting or updating for outcome claim-based measures and three efficiency-based measures from fiscal year 2019 to fiscal year 2022.

The hospital HVBP Program is an estimated budget-neutral program that is funded through a reduction to a participating hospital's base-operating DRG payment amount.

The funding amount was 1 percent in fiscal year 2013, increasing by 0.25 percent each fiscal year until the maximum 2 percent is reached in fiscal

year 2017. The total estimated value-based incentive payments that will be withheld and redistributed is estimated to be $1.9 billion in fiscal year 2018. Hospitals will receive a payment adjustment factor, based on their TPS, also on their total performance score in comparison to all other total performance scores, that was payments that are from the 2 percent—percentage withhold, for a maximum reduction, to breaking even, leaving your hospital to earn 2 percent back, to have an overall increase in payment up to a few percentage points.

In terms of translating a hospital's TPS to the payment adjustment factor, the first step is to calculate your hospital's value-based incentive percentage. And, the formula is: the percent reduction times your TPS, divided by 100, times the linear exchange function slope. Value-based incentive percentage can be multiplied by the base-operating DRG payment amount to calculate the value-based incentive payment amount. Also, the sum of all value-based incentive payment amounts across all hospitals is estimated to be equal, by statute, to the total amount available for value-based incentive payments for hospitals.

The second step is to compute the net percentage change in the hospital's base-operating DRG payment amount for each Medicare discharge, which is an interim step in order to calculate the value-based multiplier. The net percentage change formula is the hospital's value-based incentive payment percentage minus the applicable percentage payment reduction.

The third step is to compute the value-based multiplier, which is the number that we multiply by the base-operating DRG payment amount for each Medicare discharge in the fiscal year; and it represents the total amount of the applicable percent reduction. And, the value-based incentive payment percentage on the base-operating DRG amount, or payment amount, which may be greater than equal to or less than one, the formula is one plus the net percentage change in the base-operating DRG payment amount.

Here, we provide a payment example of a hospital TPS of 60, with an annual total of $10 million of base-operating DRG payments for fiscal

year 2018, as well as one claim of $1,000 of based-operating DRG payments in fiscal year 2018. You also will see the exchange function slope for fiscal year 2018, as well as the percent reduction, which is 2 percent.

This slide provides additional representation of the breakdown of steps one through three that we discussed in an earlier slide. What we see is, how the value-based incentive percentage, net percentage change, and value-based multiplier is calculated.

To carry over from the previous slide, here we see the results of the calculations and what this translates to in terms of payments. The hospital, in this example, will have a 1.47 percent increase under HVB. And, this hospital's annual base-operating DRG payment amount will be increased by an estimated $146,906 for fiscal year 2018. And, the hospital's one claim base-operating DRG payment will be increased by an estimated $14.69.

Comparing HVB Program tables, Table 16 contains the proxy adjustment factors which are based on TPSs since fiscal year 2017 and it's available in the fiscal year 2018.

IPPS/LTCH PPS proposed rule tables. Table 16A contains the updated proxy adjustment factors which can be found in the fiscal year 2018 IPPS/LTCH PPS final rule, to affect changes based on more updated MedPAR data of fiscal year 2017 TPSs. Table 16B contains the actual adjustment factors after hospitals have had the opportunity to review and correct their actual TPSs for fiscal year 2018. Afterwards, we will display the table this fall and we'll include the actual value-based incentive payment adjustment factors to exchange functions slope and the estimated amount available for the fiscal year 2018 program year.

We publish the actual aggregate payment adjustment data after each fiscal year on *Hospital Compare* and we publish the hospital-specific data and scoring and after each fiscal year on *Hospital Compare*.

In every year except fiscal year 2014, more hospitals have received net increases in payments than net reductions in payment. As mentioned a few slides back to Table 16B, we anticipate releasing the fiscal year 2018 Hospital VBP Program payment adjustment factors this fall.

This slide contains resources available to your hospital regarding the Hospital VBP program. I would like to point out the resource in the middle of the slide regarding the HVB Program ListServes and discussions. If you have not signed up with the program ListServe yet, I would like to emphasize the importance of doing so. We released almost all of our communications regarding report releases, performance standards, clinical updates and upcoming webinars through the HVBP ListServe. Thank you.

Bethany Wheeler-Bunch: Thank you, Nekeshia. I would now like to turn the presentation over to James Poyer. Mr. Poyer will be presenting on the Hospital Readmissions Reduction Program. Jim, the floor is yours.

James Poyer: Hi. I'm Jim Poyer and I'll be walking through, starting with slide 47 on the Hospital Readmission Reductions Program or HRRP. I'm the director of the Division of Value Incentives and Quality Reporting at CMS.

And on slide 48, we'll provide an introduction on the Hospital Readmission Reduction Program, or HRRP. We'll provide an overview in this presentation, details on the measures utilized in fiscal year, or FY 2018., he methodology used for the FY 2018 payment adjustment factor and information where payment adjustment information data are posted in program resources.

The HRRP program was introduced in fiscal year 2013 under Section 3025 of the Affordable Care Act that modified the Social Security Act. Payment adjustment began with discharges on or after October 1, 2012. The HRRP program is an important part of CMS's continued efforts to link payment with the quality of healthcare. It provides a strong financial incentive for hospitals to improve communication and care coordination

efforts and to better engage patients and caregivers with respect to post-discharge planning.

And in fiscal year 2018, we included the following readmission measures: acute myocardial infarction, congestive heart failure, pneumonia, and elective primary total hip arthroplasty and/or total knee arthroplasty and coronary artery bypass graph surgery. The reporting period for these measures covered to July 1, 2013 discharges through June 30th, 2016 discharges. The reporting period includes both ICD-9 and ICD-10 coding and each condition is based on a specific list of codes as defined within the measure specifications.

In this slide, we show in this figure how hospital payment adjustment factors are determined under the current fiscal year 2018 methodology. As shown in Step 1, CMS assembles a hospital's Medicare claims. The individual hospital shapes represent eligible hospitals in the Hospital Readmission Reductions Program. Step two illustrates how for any given measure CMS calculation Excess Readmission Ratio, or ERR. That is the ratio of a hospital's predicted readmissions to its expected readmissions. This figure shows all four hospitals in the same tube in step two in order to represent how a hospital's ERRs are reliant on its performance relative to the performance of other hospitals. The ERR indicates how a hospital's performance compares to the average hospital that admitted similar patients. Under the fiscal year 2018 methodology, the threshold is set at 1.0, which represents the average performance across all hospitals. Step 3 shows how ERRs enter the payment formula. If an ERR is greater than 1.0, and has at least 25 eligible discharges, then it enters the payment adjustment factor formula. The payment adjustment factor formula is calculated separately for all hospitals. In Step 4, CMS applies the payment reduction to all Medicare fee-for-service or FFS claims submitted by the hospital during the fiscal year, including patients admitted not only for the conditions included in the program, but for any condition.

This slide shows the steps used to calculate the payment adjustment factors under the HRRP. The first step is to compile Medicare claims submitted by hospitals. This is the data source used to calculate the Excess

Readmission Ratios, or ERR, in Step 2. CMS calculates ERRs for each of the six measures in the program. As shown in Step 3, ERRs above 1.0 which meet the minimum case size threshold of having at least 25 cases are deemed to have excess readmissions and will enter the payment adjustment factor formula. ERRs are compared to 1.0 in the current methodology, since 1.0 is considered the average ERR across all hospitals eligible for the HRRP program. As shown in Steps 4 through 6, ERRs enter the payment formula additively.

The payment reduction is a weighted average of all six measures in the program. Once the payment adjustment factors are calculated, the maximum penalty ceiling is applied in step seven. Starting in fiscal year 2018, hospitals could have their payments reduced up to 3 percent. Finally, in the last step, a hospital's payment adjustment factors are applied to all base Diagnosis Resource Groups, or DRG, payments submitted for the fiscal year.

The fiscal year 2018 Inpatient Prospective Payment System, or IPPS, final rule, the Hospital Readmission Reduction Program, or HRRP, supplemental data file contains the payment adjustment factors under the HRRP and number of cases and Excess Readmission Ratios, or ERRs, for the six conditions: heart failure, pneumonia, acute myocardial infarction, chronic obstructive pulmonary disease, total hip, total knee arthroplasty and coronary artery bypass graphing used to calculate the payment adjustment factors. In addition, it contains information on the number of cases for each of the applicable conditions excluded in the calculation of the readmission payment adjustment factors and it contains the DRG case mix information to estimate the payment adjustment factors.

All right. And in slide 55 is a reminder that the Hospital Readmission Reductions Program was modified. Congress modified the statute via the 21st Century Cures Act and finalized policy provisions to assess performance relative to other hospitals with a similar proportion of dual-eligible patients. This is a reminder to hospitals that these provisions will not be implemented as consistent with statutory guidance from Congress until fiscal year 2019 payment.

In this slide, we display links for program resources for more information on the Hospital Readmission Reductions Program. Thank you so much.

Bethany Wheeler-Bunch: Thank you, Jim. I would now like to turn the presentation over to Elizabeth Bainger to present on the Hospital-Acquired Condition Reduction Program. Elizabeth, the floor is yours.

Elizabeth Bainger: Thank you, Bethany. Hello, everyone. I'm Elizabeth Bainger and I want to thank you for joining us today. I'm very pleased to have this opportunity to talk with you about the Hospital-Acquired Condition, or HAC, Reduction Program.

The HAC Reduction Program was established under the Affordable Care Act. It is a Medicare pay-for-performance program. That means it makes payment to the quality of care. As the name indicates, the program focuses on Hospital-Acquired Conditions, or HACs, and these refer both to healthcare associated infection and safety events. The measures included in the HAC Reduction Program include preventable conditions like surgical site infections, which take significant toll on patients and families and costs billions of dollars each year. In accordance with the Affordable Care Act, and beginning with October 1, 2014 discharges, the Secretary of Health and Human Services is required to adjust payments to hospitals that rank in the worst performing 25 percent of all subsection (d) hospitals with respect to the HAC Reduction Program quality measures.

CMS may reduce these hospital payments by 1 percent of what would otherwise be paid for all of discharges. I'll be describing more about this in just a bit, but I do want to mention that Maryland hospitals are exempt from payment adjustments on data HAC Reduction Programs because they currently operate under a waiver agreement.

This slide shows the measures included in the HAC Reduction Program. Remember that I said HACs include safety events. Hospital performance with regard to safety is captured by the PSI 90 measure. As you can see, for the first three years of the program we used the recalibrated version of

the PSI 90. For fiscal years 2018 and 2019, we are using the modified recalibrated patient safety and adverse events composite. HACs also include healthcare-associated infection and the HAC Reduction Program has grown through the years to include five HAI measures. CLABSI, CAUTI, surgical site infection, MRSA, and *c. diff*.

The total HAC score is based on the six quality measures I just discussed and they have been separated into two domains. Domain 1 focuses on safety and counts towards 15 percent of the total HAC score. Domain 2 includes the five HAI measures. Domain 2 counts toward 85 percent of the total HAC score. If a hospital has only one domain score, CMS applies a rate of 100 percent to that domain. This slide also shows the performance periods for measures included in the HAC Reduction Program. Generally speaking, the HAC Reduction Program uses a two-year performance period; however, you can see that when we transitioned to the modified recalibrated patient safety and adverse events composite, the performance period for Domain 1 was shortened. Though not shown for the fiscal year 2020 program, we are returning to a two-year performance period for all measures.

Last month, we presented a webinar that included a graphic which showed how HAI data moved along the continuum from the time it was created during a patient's admission until it was publicly reported on *Hospital Compare*. If you weren't able to attend that webinar, it will be archived and available on qualityreportingcenter.com. I encourage you to view that webinar for more information. If you're a visual person like I am, I think the graphics really help to show the flow of data. Today's webinar focuses on payment. So, I want to provide some general information about the HAC Reduction Program's review and corrections process. Each year, CMS calculates your hospital's recalibrated PSI 90 composite measure results and measures scores, your CLABSI, CAUTI, SSI, MRSA and *c. diff* measure scores, domain 1 and 2 score, and your hospital total HAC score. Now, these scores are important to your payment status because they determine how your hospital compares with others. Remember, the hospital with the worst 25 percent will be the hospitals that receive a

payment reduction under the HAC Reduction Program. These scores are included in Hospital Specific Reports, or HSRs. The HSRs are distributed via the *QualityNet Secure Portal* usually in August, but here's a reminder: I want to strongly encourage you to keep your *QualityNet* account up to date, so that you're able to access your hospital's HSR as soon as it becomes available. After the scores are calculated and the HSRs are distributed, you have 30 days to review and request recalculation of your hospital scores. We call this 30-day period the Review and Corrections Period. So, the Review and Corrections Period allows you an opportunity to submit questions about the calculation of your hospital bill and request corrections of calculation errors. So, I've explained what the Review and Corrections Period is for, now let me tell you what it's not for. The Review and Corrections Period does not allow you to correct underlying data. It is not the time to submit corrections to claims data for the recalibrated PSI 90 composite, or to add new claims to the data extract used to calculate the result. I want to stress that you do have opportunities prior to the Review and Corrections Period to correct your underlying data. Hospitals are encouraged to review and correct their claims data in compliance with the time limits in the Medicare claims processing manual. So, with respect to the HAC Reduction Program, the deadline for fiscal year 2018 has passed. The deadline for fiscal year 2019 has passed. The deadline for fiscal year 2020 will be next September, September of 2018. Let me say that again. With respect to the fiscal year 2018 HAC Reduction Program, the deadline for submitting corrected claims was September 30, 2016. With respect to the HAC Reduction Program for fiscal year 2019, the deadline for submitting corrected claims was September 2017. So that's just passed. With respect to the HAC Reduction Program, we are now looking ahead to fiscal year 2020, and the deadline for submitting correct claims will be in September 2018. Again, these deadlines are in accordance with the Medicare Claims Processing Manual. So, if your hospital submits the corrected claim after the applicable deadline, it will not be included in your Hospital Specific Report. Let's move on to HAI data.

Under the Hospital Inpatient Quality Reporting Program, hospitals can submit, review, and correct their HAI data in NHSN for four and a half months following the end of the reporting quarter. I want to take this opportunity to strongly encourage you to review and correct your hospital's data prior to the HAI submission deadline. This is your opportunity to correct the underlying data that will be used to calculate your measure scores. Immediately following the submission deadline, the CDC effectively creates a snapshot the data and sends this to CMS. Now during last month's webinar, I remember someone asking for clarification about that, so I want to be clear that CDC creates the snapshot and sends it to CMS. CMS does not receive or use data entered into NHSN after the submission deadline. So, just like with claims data, you can continue to correct your HAI data. You can update your data in NHSN, but, with respect to the HAC Reduction Program, CMS does not receive or use data corrections that are submitted after the applicable deadline. I'd like you to think of this as a two-staged approach. First, you have a chance to review and correct your hospital's underlying data before the specified deadline. And second, you have the 30-day Review and Corrections Period, which allows you the opportunity to review and correct your hospital's measure calculations that are based on that underlying data.

As I mentioned earlier, once your scores are calculated your hospital is compared to other subsection (d) hospitals. Hospitals in the worst performing quartile receive a 1percent reduction in what could have otherwise been paid. The fiscal year 2018 payment reduction will be effective with October 1, 2017 discharges and the reduction is applied when CMS pays hospital claims.

Now I just said that hospitals receive a reduction based on what could have otherwise been paid. What does that mean? There's a hierarchy to the payment adjustment. In the fiscal year 2015 IPPS final rule, CMS stated the HAC Reduction Program payment adjustment will be applied after the application of the other program requirements including add-on payments consisting of outliers, disproportionate share hospitals, uncompensated care, and indirect medical education. So, a hospital's

Medicare payments are calculated under HVBP and HRRP, noting that DSH and IME payments are included as well, if they apply. Then, if a hospital is in the worst performing quartile for the HAC Reduction Program, the resulting Medicare payment is reduced by one percentage point. Let's look at those bottom three bullets and consider an example. For this example, we are going to consider that a hospital had a $1 million base operating DRG payment amount. And, for this example, we're going to say that the hospital was subject to a 2 percent reduction under the Hospital Value-Based Purchasing Program and a 2 percent reduction under the Hospital Readmission Reduction Program. Two percent of $1 million is $20,000. Two programs – HVBP and HRRP – combine to be $40,000. One million dollars minus $40,000 equals $960,000. If the hospital is also subject to the HAC Reduction Program adjustment, then CMS bases the 1 percent reduction on $960,000, which means the 1 percent reduction for the HAC Reduction Program before the $960,000 in this example.

As with the other programs that have been discussed, the HAC Reduction Program has an obligation to publicly report. And here's breaking news that was just finalized even since these slides were developed. Going forward, *Hospital Compare* will be the HAC Reduction Program's only vehicle for public reporting. So, if you've printed off these slides, scratch that third bullet because we will no longer be posting the payment file on CMS.gov. Currently, CMS is displaying fiscal year 2017 data on *Hospital Compare* and we plan to post fiscal year 2018 data and scoring in December 2017.

And this brings us to the last slide about the HAC Reduction Program. Here we've provided links to additional resources related to program methodology, general information about the program, and the Review and Corrections Period. If you have questions about the program, you can always direct them to HACRP — H–A–C–R–P— at Lantanagroup.com or contact the *QualityNet* Help Desk. Thank you very much for your time and attention. And now I'd like to pass the presentation to Bethany Wheeler-Bunch.

Bethany Wheeler-Bunch: Thank you, Elizabeth. I just want to cover a few more slides and then we will answer some of the questions submitted during today's presentation.

This slide contains a summary table with much of the information that was presented today regarding payments. Please note, though, that this presentation was not inclusive of all hospital settings such as outpatient, ASC, labs, or inpatient psychiatric care settings, for example.

Generally speaking, if you have a question regarding your hospital's payment, it is best to start by contacting your Medicare Administrative Contractor, also known as a MAC. There is a link provided on this slide if you would like to learn more about CMS's MACs. Now I believe we are ready to start our question and answer session.

So, our first question is for the Hospital IQR Program. Is there a reference list or anything that we can download for the Hospital IQR Program requirements that are similar to what's available and listed on slide 12? I will go to slide 12 for reference to that question, as well.

I believe the answer to that question is yes. There is on *QualityNet*, under the Hospital Inpatient drop-down, if you go to the Hospital Inpatient Quality Reporting Program, on that landing page, if you scroll down to about the middle of the page there is a reference checklist for fiscal year 2019 that's available for you to download. Also available on *QualityNet*, are the reporting quarters for fiscal year 2019 payment determination, a program guide for new facilities in fiscal year 2019, Hospital IQR Program changes for fiscal year 2019 and also a quick start guide for accessing and using your provider participation report. That's just a few of the items available on that landing page for you to use to reference the Hospital IQR Program requirements. Also available on *QualityNet*, if you click the Measures tab once you've landed on the Hospital IQR Program page, two very useful resources are available for you. There is a measure comparison guide specific to the Hospital IQR Program that goes through each of the measures that hospitals report for Hospital IQR. Also, there is what's called Acute Care Hospital Quality Improvement Program

measures. Currently, we only have fiscal year 2019 available on *QualityNet*. We do plan to put out fiscal year 2020 relatively soon. But this document is a larger Excel spreadsheet that's been PDFd that contains each of the measures included in the Hospital IQR Program, the EHR Incentive Program, Hospital VBP, HRRP, and HACRP — so all the programs that we discussed on today's webinar. I would say those are two of the most useful resources available out on *QualityNet*. Also, just one more thing to cover on *QualityNet*. There's a tab called APU Recipients. That tab contains three lists per fiscal year. One is hospitals receiving full APU, one is hospitals not receiving full APU, and then one is hospitals that chose not to participate. Each of those lists will contain the CCNs that fall within those specific categories. And I believe we discussed that specifically. Nekeshia discussed that when we were referencing slide 17, which is now displayed.

The next question is in regard to slide 13, so I will move to slide 13 before I read the question. Okay. Why is Hospital IQR in fiscal year 2015 and subsequent years payment not given as a percentage point? Why is one fourth MBU used? So that's a great question. When Hospital IQR started out in fiscal year 2005 through fiscal year 2006, you can see that there was a 0.4 percentage point reduction to the market basket update if either your hospital didn't participate or didn't meet one or more of the program requirements. In fiscal year 2007 through fiscal year 2014, the percentage decreased. It went from 0.4 percentage points to 2.0 percentage points. And then in fiscal year 2015 and subsequent fiscal years, we then switched over to one fourth of the market basket update. So, the difference between percentage points and percents may be the underlying question. And to better grasp exactly what we're talking about, I'm going to switch over to slide 16. So, slide 16, you can see in the first line the market basket rate of increase for fiscal year 2018 is 2.7, and that's actually 2.7 percent. Now if we were talking back in fiscal year, let's say, 2014, 2013—some of those earlier years for the Hospital IQR Program—we were using a 2-percentage point decrease to the market basket update. So, if this was fiscal year 2013, for example, that second line for adjustment for failure to submit quality data, that's the Hospital IQR adjustment, that would've been 2.0.

And so automatically, if you do not participate in IQR, did not meet those requirements, it would be 2.7 minus 2, which would be 2 percentage points. Now in fiscal year 2015, 2016, and 2017, and then subsequently in 2018 what we're seeing is one fourth of the market basket update. And we can correlate that change in fiscal year 2015 to the addition of the meaningful use or the EHR Incentive Program that was added to reduce payments for the market basket update. So, what CMS did in these tables, is one fourth of that market basket update in fiscal year 2018 is allocated to reducing payments for the Hospital IQR Program for non-participation or failure to meet requirements. Three-fourths of that is then for the third line, which is the meaningful EHR user reduction if you're not participating or did not meet requirements under that program.

So, if you add the 6.75 to the 2.025 that you see in line 3, that should equal 2.7, which is the one-fourth and the three-fourths.

Next question is for the EHR Incentive Program. Does the EHR Incentive Program adjust payments based on the calendar year or a fiscal year?

Steven Johnson: Hi. This is Steven Johnson with the Division of Health Technology. The EHR payment adjustments are based on the fiscal year. So, for example, the fiscal year 2018 payment adjustments were for the 2017 program year would begin on October 1, 2017 and will continue for the entire fiscal year, which would end on September 30, 2018.

Bethany Wheeler-Bunch: Thank you. The next question is also for the EHR Incentive Program in regards to slide 27. I've moved the slide deck to that slide number for your reference. Can you clarify the payment percentages on slide 27? If a CAH does not meet the requirements, the percentage will be 100 percent in fiscal year 2018. What would it be if the hospital met the requirements? Then, an additional, similar question: CAHs are already at 99 percent of allowable costs due to the sequestration, but slide 27 shows EHR adjustment to 100 percent. Does that mean there will be no adjustment below the 99 percent or will we lose 1 percent beyond 99 percent?

Steven Johnson: Yes. This is Steven Johnson again. That is a really great question. So, what we take into account outside of the sequestration, we'd have to get back to you regarding what the amount is because it's sequestration. But it is obviously CAHs normally reimbursed at 101 percent of reasonable cost. Therefore, on this side, you could see that every time a CAH is not a meaningful user their reimbursement is reduced accordingly. Currently the reduction is at 100 percent of reasonable cost, which is — as you can tell — 1 percent less than 101 percent. Regarding the sequestration, again, we'll have to get back to you on that regarding how that impacts the CAHs reimbursement.

Bethany Wheeler-Bunch: Great. Thank you. The next question is what is the difference between the IQR Program reflected on *Hospital Compare* and the Hospital Value-Based Purchasing Program? So essentially the Hospital Value-Based Purchasing Program is built on the framework and the types of the measures that are included in the Hospital IQR Program. But that doesn't mean that everything is exactly the same between the two programs. For example, most recently — and I guess the biggest — change that you would probably notice is in the fiscal years leading up to fiscal year 2019 — so fiscal year 15 through fiscal year 18 — the ARC PSI 90 Composite generally use a different software version in between the Hospital IQR Program and the Hospital Value-Based Purchasing Program. And that could have led to varying results if you're comparing directly in between the Hospital IQR Program and the Hospital Value-Based Purchasing Program. Another type of change that you would see in between the programs are the reporting periods used for each of the measures. So, the Hospital Value-Based Purchasing Program uses baseline and performance periods, and those baseline and performance periods may not necessarily line up exactly with what is being reported on *Hospital Compare* for purposes of the Hospital IQR Program. Also, when you go out to *Hospital Compare*, the Hospital IQR Program's data is generally included in the type of compare pages that you would think of when you go out to *Hospital Compare*. When you go and you can compare up to three hospitals, the data that you can flip through on the various tabs, that is

generally what's reported under Hospital IQR. In order to see what's reported for the Hospital Value-Based Purchasing Program and to view the scores — including measure scores, domain scores, and total performance scores — for the Hospital Value-Based Purchasing Program you would go to the main page on *Hospital Compare*, scroll to the bottom and all the way to the right, in the Linking Quality to Payment section, Hospital Value-Based Purchasing link and there are a handful of tables generally separated out at the domain level that display the scores for the Hospital Value-Based Purchasing Program.

The next question is please explain further the calculations on slide 37. Okay. So, slide 37 is the first calculation listed in translating the total performance score to a hospital's payment adjustment factor in the Hospital Value-Based Purchasing Program. I think in order to explain this most effectively, I'm going to move the slide deck over to slide 41. And this shows all three steps put together.

So, in order to translate your TPS factor to a payment adjustment factor, you need to follow these three steps. First, you would calculate your value-based incentive percentage. You do that by multiplying the percent reduction in fiscal year 2018 and all the years subsequent to fiscal year 2018. That reduction is 2 percent. You may also hear this reduction number termed as a withhold amount. You then multiply your total performance score over 100. You can find your total performance score on your hospital's Percentage Payment Summary Report, which you can run in the *QualityNet Secure Portal*. And then you multiply that against the linear exchange function slope. The linear exchange function slope is also available on your Percentage Payment Summary Report on that first page. So, you multiply the 2 times 60 over 100 times the 2.89 number — the exchange function slope. You come up with the 3.46 percent. Now that's the number that your hospital will receive in incentive payments, but that does not account for the withhold amount of that 2 percent, and that's what we're going to do in the second step.

You take your hospital's value-based incentive percentage — so what we just calculated in Step 1 — and you subtract that percent reduction or that

percent withhold. So, we take the 3.46 percent and we subtract 2 percent. That gives us 1.46 percent for your increase or your net change amount, but numerically — which is important for the next step — is 0.0146. All we did was move the decimal place over to the left two places. Now the third step is you take your net change amount, which is the numeric value — the 0.014 — plus the value of 1. So, 1 plus 0.014 equals 1.014. You take that number and you multiply it against your base operating DRG amount to see what your base operating DRG amounts will be when you account for the Hospital Value-Based Purchasing Program. This is also what the MACs use when they calculate your payment adjustment factors, and this value is also included on your Percentage Payment Summary Reports, and this is the value that will be listed in Table 16B when it is released this fall. The next question is do these programs include critical access hospitals? So, I think I'm going to go around the room and I will start with the HAC Reduction Program and Hospital Readmission Reduction Programs.

Elizabeth Bainger: No. The HAC Reduction Program or the Hospital Readmission Reduction Program does not include critical access hospitals.

Bethany Wheeler-Bunch Thank you. For the Hospital Value-Based Purchasing Program, CMS also does not include critical access hospitals in the calculations or payment adjustments. For the EHR Incentive Program, can you comment on critical access hospital status?

Nichole Davick: Yes. Hi. Yes, critical access hospitals are included.

Bethany Wheeler-Bunch: Great. Thank you. And for the Hospital IQR Program, critical access hospitals do not receive payment reductions from non-participation or failure to meet one or more of the requirements. However, CMS does encourage hospitals — critical access hospitals — to report the data for their own quality improvement purposes for the data to be available out on *Hospital Compare*, and then also for other initiatives that may be out there that use this data.

The next question is where is the actual rate in the Hospital Readmission Reduction Program and what is the difference between predicted and actual for the Hospital Readmission Reduction Program, and finally — sorry, this is a three-pronged question — what diagnosis would be used in the predicted over expected population that would trigger a higher expected score?

HQRPS: So I'm going to start with the first part of the question. I say the Hospital Readmission Reduction Program uses the Excess Readmission Ratio to assess performance and the Excess Readmission Ratio is calculated at a ratio of predicted readmissions to expected readmissions. Predicted readmissions are the number of unplanned readmissions predicted for your hospital on the basis of your hospital's performance with its case mix and the estimated effect of readmissions, which is known as your hospital's specific effect. And then the expected readmission, so the number of unplanned readmissions expected based on a hospital's average performance with its case mix and the average hospital's effect. And so, when you take that ratio, if your hospital's deemed to have excess readmissions then the ratio will be above one.

Bethany Wheeler-Bunch: Great. Thank you. The next question is also for the Readmissions Reduction Program in relation to slide 55. Can you speak more to the changes that are anticipated based on the 21st Century Cures Act Provisions for fiscal year 2019 on slide 55? Also, does this mean that there wouldn't be any payment adjustments for fiscal year 2018 or just that these changes are applicable to FY 2019 and forward?

HQRPS: So it means that these changes are applicable for fiscal year 2019 and moving forward. The old methodology will be used for fiscal year 2018, and information for the new methodology was provided in the fiscal year 2018 IPPS final rule. And so, if you're interested in that information that's currently the best resource to use.

Bethany Wheeler-Bunch: Great. Thank you. The next question is for the HAC Reduction Program. You mentioned using the modified recalibrated PSI composite. Can you

tell me what metrics fall into this and how the metrics are different from the previous PSI composite?

Elizabeth Bainger: Sorry. Sure. Sorry about that. Yes. So, there was a few changes to the HAC Reduction Program Domain 1 and that was the change to the modified PSI composite and that included the removal of PSI 7 and the addition of PSI — I'm sorry, off the top of my head — I think it's 10, 11, and 12. Correct me if I'm wrong, Bailey. Okay. And you can find more information on QualityNet.org under the Hospital-Acquired Condition Reduction Program and there's a section for measures. Also, our Frequently Asked Questions talks about the changes to the HAC Reduction Program for fiscal year 2018. And I'm sorry, it was the – but it's question number 14 on the Frequently Asked Questions, and it's 9, 10, and 11 that was added and PSI 7 that was removed.

Bethany Wheeler-Bunch: Great. Thank you.

The next question is also for the HAC Reduction Program. We are a small hospital. How is our score handled when we don't meet the minimum of one predicted infections and one or more of the HAI measures in the HAC Reduction Program?

Elizabeth Bainger: Yes. So, for the HAC Reduction Program, it follows the minimum set by CDC for the predicted infection, so that's one predicted infection. And in the case where a hospital does not meet that prediction, which could be for a small hospital, then that measure is not taken into account in the scoring for the HAC Reduction Program. So, a hospital that only met the predicted infection for two of the measures in Domain 2 rather than 5, their Domain 2 score will be based on those two measures rather than all five measures.

Bethany Wheeler-Bunch: Great. Thank you. The next question is for the Hospital Readmissions Reduction Program. Is there a minimum eligible claim amount for the calculations in HRRP?

HQRPS: Yes. So, in order for your Excess Readmission Ratio to be eligible to enter the payment adjustment factor formula, you need to have at least 25 cases for the measure.

Bethany Wheeler-Bunch: Great. Thank you. The next question is for each of the programs, can you tell us when the results will be available to hospitals? I will take the first one for the Hospital Value-Based Purchasing Program. So, the Percentage Payment Summary Reports, which are the reports that CMS uses to inform hospitals of their data and scoring — so how they performed on each of the measures — and then their total performance score, in addition to their payment adjustment factor. Those are included on the Percentage Payment Summary Reports, and those are available through the *QualityNet Secure Portal*. Those are released each year on or around August 1. For the fiscal year 2018 program, we released those reports in late July. I believe that date was July 27. After that, hospitals then have a time period to review and correct their measure scores. What that means is they can request a recalculation of their scores if they find a calculation error. That doesn't mean, I believe Elizabeth touched on this earlier, if you find a calculation error based on the data you've submitted, so let's say that you identified that there was an error in submission data for one of the HAI measures, it doesn't mean that you can correct that underlying data. What it means is you can review the improvement points, achievement points, measure scores — those types of calculations — and that there's an error in one of the CMS calculations, then you can request recalculation of that value. That occurs for 30 calendar years — excuse me — calendar days after the release of that report. Then after hospitals have a chance to review it and request recalculation, we post Table 16B in the fall and we are anticipating, again, for Table 16B that that will come within the next month or two. And that would contain the payment adjustment factors for fiscal year 2018. And then finally in December, we anticipate posting the Hospital Value-Based Purchasing data and scoring results to *Hospital Compare*. I'll let the HAC Reduction Program go next on when their results are published to hospitals.

HQRPS: Sure. Absolutely. Thank you, Bethany. So, the HAC Reduction Program had our initial Review and Corrections Period on July 19 through August 17 of 2017 and those reports were delivered to Hospital Secure File Transfer via *QualityNet*. And then there was an error discovered with SSI. So, the second review and correction period began September 14 and it ends October 13. And hospitals are only allowed to review those data elements directly affected by the SSI error during the second Review and Corrections Period. And then the results will be posted — as Elizabeth mentioned — only out on *Hospital Compare*. We'll no longer be posting the results on *CMS.gov* starting this year.

Bethany Wheeler-Bunch: Thank you. Hospital Readmissions Reduction Program, you're up next.

HQRPS: For HRRP for fiscal year 2018, the hospital's Excess Readmission Ratios and eligible discharges are provided to them in the Hospital-Specific Report, which is distributed via *QualityNet* to chart transfer. And that is to release the hospitals of the target for Review and Corrections Period, which this year started on June 1. And then with the release of the IPPF final rule in August, the hospital's payment adjustment factors are posted on the CMS website in sections related to the IPPF final rule.

Bethany Wheeler-Bunch: Thank you. For the EHR Incentive Program, do you have results that you post generally in a file publicly? If so, when is that file or report ready for hospitals to view?

Steve Johnson: Hi. This is Steve Johnson, again. So, we have our public use files that are posted on our EHR Incentive Program website. And it just goes by the hospital level, usually using the MPI that provides the payment year and the — if the database successfully attested. We have information as far as this year of March 21 in 2017 that is currently posted on our website. In this it does have different information regarding the objectives and measures and the percentage that the hospital has met the thresholds that we've laid out in the program. That is probably like the most up-to-date information that we have that was posted on our website publicly.

Bethany Wheeler-Bunch: Great. Thank you. And I believe that's all the time that we have today for questions. I will now turn the presentation over to Deb Price to present on continuing education, and then she will pass it back to me to close out the webinar and provide some important reminders for the upcoming month. Thank you.

Debra Price: Well thank you for that introduction. And now I will start talking about the continuing education credit. This is Debra Price. Today's webinar has been approved for 1.5 continuing education credits by the boards listed on this slide. We are now a nationally accredited nursing provider, and as such, all nurses report their own credits to their respective boards using our national provider number shown on the last bullet here. It's number 16578. It is your responsibility to submit this form to your accrediting body.

We now have an online CE certificate process. You can receive the CE certificate two different ways or two different times. One, if you've registered for the webinar through ReadyTalk®, you will get a survey at the end of our slide. The survey will allow you to get your certificate. However, you will only be able to get that certificate if you are the one that registered. The second way to get a certificate is, within 48 hours, we will be sending out a separate survey. When you receive this survey, please give people who are in your room listening, but did not register through ReadyTalk, please give them the survey. They take the survey and then they will get the certificate themselves. After the completion of the survey and you click the Done button on the bottom of the page and another page will open, you will need to choose to register as either a new user or an existing user. If you've been receiving certificates with us all along and you haven't had any problems, go ahead and click on the Existing User link. If you have never received a certificate or if you've had problems in the past getting your certificate, please register as a new user using a personal email. Just a note that healthcare facilities have firewalls that are continually being upgraded and you may have firewall

up on this event that wasn't up last week, if you've attended any of our other events.

If you do not immediately receive an email to the address that you've registered with after the survey, that means that there is a firewall up and what you'll need to do is go back and register as a new user, using your personal email address.

This is what the survey will look like. It will pop up again at the end of the event. And again, we will send you a survey within 48 hours. You see in the bottom right hand corner, the little Done button? That's what you're going to click on when you are finished with the survey.

This is the page that pops up when you click the Done button. This is what I was taking about previously where you have two links — a New User link, and an Existing User link. New User is if you have never gotten a certificate from us or if you've had problems in the past getting a certificate. Use a New User link and make sure you fill in the form for your personal email. If you have been receiving certificates all along, please click on the Existing User link.

This is what the New User screenshot looks like. So, if you clicked on the New User link, you put your first name, your last name, your personal email, and a phone number that will be identified with that email. Remember, again, to use a personal email because hospitals and other healthcare facilities have firewalls that are constantly changing and being upgraded.

This is what the existing User screen looks like. If you've been receiving certificates all along, please fill in your username — which is your email address, complete with what's ever after the at sign, so it'd be your complete email address — and whatever password you used when you registered. And if you don't remember what your password is, then you'll have to get back with us and we'll have to reset your password. And now I will pass the webinar back to your host. I hope you do not have any problems getting your certificates. If you do, my email will be on the

survey today, as well as the survey you're going to receive in 48 hours. Thank you for your time and have a great rest of the day.

Bethany Wheeler-Bunch: Thank you, Deb. I just wanted to cover just one more important reminder and update, and that is our upcoming educational offering through the month of October. So, on October 18, the Hospital OQR Program will be presenting a webinar titled "What Report? Whose Report? and Where Did You Get That?" It's an in-depth review of reports available for the Hospital OQR Program. They will discuss how to run the reports, the data, purposes and functionality of the reports, and why it is helpful in the reporting for their program. For the ASC Program, they will be presenting on October 25 for a webinar titled, "The Express Train to Success: The Reporting of ASC 8," which is an overview on successful reporting of the ASC 8 Measure in NHSN. The presentation will focus on the most common hurdles and trouble spots, specifically for ASCs. On October 26, the PCHQR Program will present "Why Your Participation Matters." This presentation will review the formative intent of the PPS-exempt Cancer Hospital Quality Reporting Program, relating how participation in the program guides participants along the path to attaining the goals of the program. And finally, on October 31, the IPFQR Program will present the IPF Readmission Measure Dry Run. This presentation will provide participants with an overview of the 30-day readmission measures intent, readdress the measure specifications, and discuss the measure dry run in advance of the 2018 public reporting.

In order to register for each of these events, we recommend you go out to www.qualityreportingcenter.com. On that website, you will see a link to register for each of these upcoming events. Also available is an archive of all of our previous events, which will also include this one, once it's available online. In addition, the slide deck for this presentation is also available at that website. That is all we have to cover today and we are now out of time. So, I want to thank you all for joining us today. I hope that we presented something that was of use to you and your programs as we know that you're very busy at your hospitals. So just want to say thank you for giving us your time today, and as always, the excellent questions

that you submit to us – they're very much appreciated. So, with that, I want to say thank you again and have a great rest of your day. Thank you.