Hospital Outpatient Quality Reporting (OQR)/Ambulatory Surgical Center Quality Reporting (ASCQR) Programs

Support Contractor

You have Reached Your Destination: CY 2020 OPPS/ASC Final Rule

Transcript

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Karen: Hello everyone, and welcome to today's webinar. Thank you for joining us today. My name is Karen VanBourgondien. Our speaker today is Dr. Anita Bhatia. Anita is the CMS Program Lead for the Hospital OQR and ASCQR Programs. She received her PhD from the University of Massachusetts Amherst and her master's in public health from Johns Hopkins University. Dr. Bhatia plays a crucial role in the development of the OPPS/ASC proposed and final rulings. Her contributions to the rulings are essential to the continuing success to both of these programs. We are fortunate to have Dr. Bhatia's commitment.

The learning objectives for the program today are listed on this slide. This program is being recorded. A transcript of today's presentation, including the questions and answers received in the chat box, as well as the audio portion of today's program will be posted on our website, QualityReportingCenter.com, at a later date. During the presentation, if you have a question, please put that question in the question box located on your screen. One of our subject matter experts will respond. Additionally, the slides are available on our website at QualityReportingCenter.com. Just click on today's event and you will be able to download the slides.

In the proposed rule webinar, we discussed CMS' navigation to success. Through that journey of the proposed rule, we took you on the road through the proposed rule. Well, here we are, our destination, the final rule. Today, we will be taking a hike through the forest, walk some of trails, and view the various aspects of the terrain. Through the details of the topography we will be presenting both the Hospital OQR and the ASCQR together, as these two programs are both the outpatient setting and CMS is seeking to align programs moving forward to the

extent that it is possible. There are many changes within CMS geared to reduce burden and increase quality of care. So, without any further ado, let me turn things over to Dr. Bhatia for further explanation of this and the final rule. Anita?

Dr. Bhatia: Hello everyone. Thank you for attending today's webinar!

We begin today with our vision for quality measurement. On October 30, 2017, CMS Administrator Seema Verma announced the Meaningful Measures Initiative, which has the goal of identifying the highest priorities to improve patient care through quality measurement and quality improvement efforts. As on this slide, of this new approach for CMS, Ms. Verma said, "Our overall vision is to reinvent the agency to put patients first" and that "we want to partner with patients, providers, payers and others to achieve this goal."

The Meaningful Measures Initiative is extremely important and an integral part of the rulemaking process.

The image here captures the essence of the Meaningful Measures Initiative. The strategic goals and meaningful measure domain areas are well demonstrated, and reference will be made to this image's information as we move through the presentation. We have discussed this aspect of the initiative in detail in previous presentations. So, we will not be spending time today reviewing this again. However, you may access information on this initiative or simply review previous presentations of ours including a recent one covering our proposals i n the calendar year 2020 OPPS/ASC proposed rule, if you would like more information or clarifications.

CMS works with stakeholders to define measures of quality across multiple settings with the goal of aligning measures across programs to the extent possible. Currently, the first three measure sets listed here are aligned between the Hospital Outpatient Quality Reporting Program and the ASC Quality Reporting Program. There were no changes in the final rule for these measures. The last measure set here is another alignment for two measures formed as a result of this year's final rule. Through these measures, information is collected and reported for the use by patients and other stakeholders for comparing care delivered in different settings. Here, we have measures for surgical procedures that are performed in both hospital outpatient departments and the ambulatory surgical centers.

OP-29 and ASC-9: The Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients: OP-29 for the Hospital Outpatient Quality Reporting Program and ASC-9 for the ASC Quality Reporting Program. This measure falls under the domain of Promote Effective Prevention & Treatment of Chronic Disease and the Meaningful Measure Area of Preventive Care. You may recall that we did propose removal of this measure from both of these programs in the calendar year 2019 rulemaking cycle, but we did not finalize that proposal. We believe retaining this measure provides for pertinent information about

colonoscopies occurring at inappropriate intervals that may contribute to increased costs to Medicare beneficiaries and other patients as well as to CMS and the Medicare Trust Fund.

OP-31 and ASC-11: This cataract surgery quality measure, Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery, is designated as OP-31 for the hospital side and ASC-11 for ASCs. This measure falls under the domain Promote Effective Communication & Coordination of Care and the Meaningful Measure Area of Seamless Transfer of Health Information. This measure was also proposed for removal in the calendar year 2019 rulemaking cycle, but this proposal was not finalized, and the measure retained. While a primary concern regarding this measure was one of burden to the provider, as reducing burden is one of CMS' categories relating to the Meaningful Measures Initiative, which I spoke to earlier, reporting for this measure is voluntary. That is, facilities are not required to submit these data. Those facilities that do report data for this measure, do so voluntarily and they have reported consistently over the years despite any burdens. Because of this, we believe the measure is meaningful to the core group of facilities that do consistently report. This measure is an opportunity for hospitals and ASCs to demonstrate this capability if they choose to collect and report these data.

OP-32 and ASC-12: The Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure is referred to as OP-32 for the Hospital Outpatient Quality Reporting Program and ASC-12 for the ASC Quality Reporting program. This measure falls under the domain Promote Effective Communication & Coordination of Care and the Meaningful Measure Area of Admissions and Readmissions to Hospitals. When we adopted OP–32 and ASC-12, we believed this measure could reduce adverse patient outcomes associated with preparation for colonoscopy, the procedure itself, and follow-up care by capturing and making more visible to facilities and patients all unplanned hospital visits following the procedure.

And, our last two aligned measures, OP-36 and ASC-19: For the Hospital Outpatient Quality Reporting Program, we have OP-36 and for ASC Quality Reporting [Program], ASC-19. OP-36 is called Hospital Visits after Hospital Outpatient Surgery, and ASC-19 is Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers. These measures have slightly different names but utilize the same initial event, a general surgery procedure, though the surgical procedures differ due to differences in case mix, and the same outcome, 7-day hospital visits after such a procedure. These two measures align with the meaningful measure area of Admissions and Readmissions to Hospitals.

There are a couple [of] statistical variances between the two measures. ASC-19 reports the outcome as a risk-standardized ratio rather than a rate because a diverse mix of procedures included in the proposed and finalized measure can

have higher varying levels of risk of unplanned hospital visits. Also, OP-36 is calculated with one year of data; whereas, ASC-19 will utilize two years of data. Details on these measures are summarized in preamble text and are more completely contained in referenced technical specifications documents.

This concludes discussion on the measures that are currently aligned within these two programs. Let's now discuss more of the final rule. Much like finding your way on a hike with a trail map, let's find our way through the CY 2020 OPPS/ASC Program review and updates using the final rule as our guide.

To find the final rule in the *Federal Register* that includes sections for both the Hospital Outpatient and the ASC Quality Reporting Programs, you would begin with accessing the FederalRegister.gov link. This link is here on the slide. The *Federal Register* link provided here will take you directly to the CY 2020 OPPS/ASC Final Rule. To access the PDF version, you would just click on the PDF link. The Hospital Outpatient Quality Reporting section begins in Section XIV, page 61410. The ASC Quality Reporting section begins in Section XV on page 61420.

CMS has many quality reporting programs, or trails. As discussed, CMS seeks to align programs to the extent possible. The first trail we are going down is for the Hospital Outpatient Quality Reporting Program. Let's discuss the finalized proposals for this program as contained in the CY 2020 OPPS/ASC Final Rule. For our ASC attendees, stay tuned, the ASC program will be reviewed shortly.

In the CY 2020 OPPS/ASC Proposed Rule, we proposed to remove one measure from the Hospital Outpatient Quality Reporting Program, the OP-33 measure, External Beam Radiotherapy for Bone Metastases, or EBRT. We wish to clarify here in this final rule that the measure would be removed beginning with calendar year 2020. These encounter dates will be used rather than beginning in October 2020, as incorrectly stated in the proposed rule. We did consider removing this measure beginning with the calendar year 2021 payment determination, but we decided to propose a delayed removal of the calendar year 2022 payment determination to be sensitive to facilities' planning and operational procedures given that data collection for this measure began during calendar year 2019 for the calendar year 2021 payment determination. We believe that removing OP-33 is appropriate at this time because the costs associated with this measure outweigh the benefit of its continued use in the program; this is per measure removal Factor 8. This measure was also adopted into another CMS quality reporting program, the PPS-exempt Cancer Hospital Quality Reporting, or PCHQR, Program previously. That program also removed this measure because it is overly burdensome and because the measure steward is no longer maintaining the measure. As such, the PCHQR Program stated that it can no longer ensure that the measure is in line with clinical guidelines and standards. The removal of this measure from the Hospital Outpatient Quality Reporting Program aligns with the PPS-exempt Cancer Hospital Quality Reporting Program.

We did receive comment about the proposal of removing OP-33. A few commenters expressed concern about the proposal to remove OP-33. One commenter stated that the OP-33 measure gives valuable information for monitoring hospital performance improvement. A few commenters requested that the removal of OP-33 begin with the calendar year 2021 payment determination rather than the calendar year 2022 payment determination due to the significant burden of the reporting requirements. One commenter recommended CMS to remove OP-33 as soon as possible. Along the same line as the PCHQR Program, one commenter also stated that, because the measure steward is no longer maintaining the measure, CMS should either continue to maintain the measure or identify an entity to act as the measure steward to allow the measure to remain in the Hospital OQR Program. Regarding measure maintenance, as stated, the measure steward is no longer maintaining this measure and there are issues with the measure as specified for the hospital outpatient setting. We do not seek to become the steward for this measure, as we do not believe that we can maintain this measure in the Hospital OQR Program in a way that ensures that the measure is in line with clinical guidelines and standards and has specifications that are not overly burdensome for which to collect data. Thus, after consideration of the public comments received, we finalized removal beginning with January 2020 encounters to be used in the calendar year 2022 payment determination and subsequent years.

To reiterate, our Meaningful Measures Initiative provides a measurement framework that prioritizes patient and consumer needs while limiting provider burden. Consistent with this framework is the removal of OP-33. Again, this was the only measure removal in this rule-making cycle for the Hospital Outpatient Quality Reporting Program.

We sought comment on the potential future adoption of four patient safety measures for the Hospital OQR Program that were previously adopted for the ASCQR Program. These measures are ASC-1, ASC-2, ASC-3, and ASC-4. We requested public comment on potentially adding these measures with an updated submission method using a CMS online data submission tool. These measures are currently specified for the ASC setting. If specified for the hospital outpatient setting, we would seek collaboration with the measure steward.

We believe these measures could be valuable to the Hospital OQR Program because they would allow us to monitor these types of events and prevent their occurrence to ensure that they remain rare and because these measures provide critical data to beneficiaries and further transparency for care provided in the outpatient setting that could be useful in choosing a hospital outpatient department. In addition, these measures address an important Meaningful Measure Initiative quality priority, Making Care Safer by Reducing Harm Caused in the Delivery of Care.

Several commenters stated that these four measures should be adopted in the Hospital Outpatient Quality Reporting Program in order to align with the ASC Quality Reporting Program and to provide meaningful data for patients to compare performance in ASCs and hospital outpatient departments (HOPDs). Several commenters expressed concern that the measures are not endorsed by the National Quality Forum. A few commenters stated concerns about the burden that would be created if these measures are added to the Hospital OQR Program. One commenter stated that, because these events are rare in the outpatient setting, the data [are] at risk of becoming identifiable if disclosed and publicly reported. We will take these valuable suggestions into consideration as we consider adding these measures to the Hospital Outpatient Quality Reporting Program in the future.

We also requested public comment on future measure topics. Specifically, we requested public comment on any outcome measures that would be useful to add as well as feedback on any process measures that should be eliminated to further our goal of developing a comprehensive set of quality measures for informed decision-making and quality improvement in hospital outpatient departments.

CMS moved towards greater use of outcome measures and away from use of clinical process measures across our Medicare quality reporting programs in order to better assess the results of care. Through future rulemaking, we intend to propose new measures that support our goal of achieving better health care and improved health for Medicare beneficiaries who receive health care in the informed decision-making and quality improvement in hospital setting, while aligning quality measures across the Medicare program to the extent possible.

So, let’s take a moment to sum things up and review the measures for the Hospital OQR Program moving forward. Listed here are the claims-based measures for this program. In this rulemaking cycle, we did not propose any changes to these measures and, thus, did not have any changes in our final rule.

On this slide, we have the web-based measures listed. We finalized the removal of OP-33 beginning with the calendar year 2022 payment determination and subsequent years. So, remember, you will report data for OP-33 for the last time this coming May. Specifically, the deadline for that submission is May 15, 2020.

With regard to the chart-abstracted clinical measures for the Hospital OQR Program, we did not propose any changes. Thus, those measures will continue to be reported as they have been. The implementation of the survey measures OP-37a through OP-37e were delayed with the CY 2018 OPPS/ASC Final Rule and these measures continue in that status.

In this rulemaking cycle as it relates to the Hospital OQR Program, CMS proposed to apply the reporting ratio, when applicable, to all HCPCS codes to which we have proposed particular status indicator assignments. CMS proposed

to continue to exclude services paid under New Technology APCs. We also proposed to continue to apply the reporting ratio to the national unadjusted payment rates and the minimum unadjusted and national unadjusted copayment rates of all applicable services for those hospitals that fail to meet the Hospital OQR Program reporting requirements. It was proposed to continue to apply all other applicable standard adjustments to the OPPS national unadjusted payment rates for hospitals that fail to meet the requirements of the Hospital OQR Program. Similarly, it was proposed to continue to calculate OPPS outlier eligibility and outlier payment based on the reduced payment rates for those hospitals that fail to meet the reporting requirements. These proposals were finalized. Hospitals may want to review the HCPCs affected to prevent billing surprises in the event of receiving a payment penalty.

So, onto our next trail. Like with hiking trails, there are some similarities, and this is true for the Hospital Outpatient and the ASC Quality Reporting Programs. So, now let's look at the finalized proposals for the ASC Quality Reporting Program.

For the ASC Quality Reporting Program, we proposed to adopt one new measure, ASC-19: Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers. While ambulatory surgery is considered low risk for complications, there are well-described and potentially preventable adverse events that can occur after ambulatory surgery leading to unplanned care at a hospital, such as emergency department visits, observation stays, or hospital admissions. Quality measurement of the number of unplanned hospital visits following general surgery procedures performed at ASCs, coupled with transparency through public reporting, would make these outcomes more visible to Medicare beneficiaries as well as other patients and stakeholders. Therefore, CMS expects that this will encourage ASCs to incorporate quality improvement activities to reduce the number of unplanned hospital visits and track quality improvement over time. So, let's layout some details about this new program measure.

So, as we mentioned earlier, the ASC-19 measure aligns with the Admissions and Readmissions to Hospitals and Preventable Healthcare Harm Meaningful Measure Areas of our Meaningful Measures Initiative. This measure was developed with input from a national Technical Expert Panel, consisting of patients, surgeons, methodologists, researchers, and providers. We also held a three-week public comment period soliciting stakeholder input on the measure methodology and publicly posted a summary of the comments received, as well as our responses.

Importantly, the ASC-19 measure addresses the identified priority measure area of addressing preventable healthcare harm, such as surgical complications.

Again, as we discussed, the ASC-19 measure is claims-based and, additional information, is for patients aged 65 years of age and older and uses Part A and Part B Medicare administrative claims and Medicare enrollment data to calculate

the measure. We proposed and finalized the data collection period for the proposed ASC-19 measure would be the two calendar years ending two years prior to the applicable payment determination year. For example, for the calendar year 2024 payment determination, the data collection period would be calendar years 2021 to 2022. Because the measure data are collected via claims, ASCs will not need to submit any additional data directly to CMS. To provide some specifics to the outcome, the outcome for this measure is all-cause, unplanned hospital visits within seven days of any general surgery procedure performed at an ASC. For the purposes of this measure, "hospital visits" include emergency department visits, observation stays, and unplanned inpatient admissions.

As with our other claims-based measures, CMS intends to conduct a preliminary data collection and presentation, or what is known as a "dry run," before the official data collection period or any public reporting. For the dry run, we intend to use the most current two-year set of complete claims available at the time of the dry run. For example, if the dry run is scheduled to begin in June 2020, the most current two-year set of data available would likely be July 2017 to June 2019. These confidential dry run results are not publicly reported and do not affect payment. We expect the dry run to take approximately one month to conduct, during which facilities would be provided the confidential report and the opportunity to review their results and provide feedback to us.

We received public comment recommending the removal of procedures deemed outside the scope of general surgery and to review the cohort procedure list with general surgeons to ensure appropriateness. In response to this feedback, we reviewed the cohort of procedures incorporating feedback from general surgeons and removed 15 individual skin/soft tissue and wound procedure codes from the measure that are outside the scope of general surgery practice. There was also a concern that many small-volume ASCs will not meet the minimum criteria threshold for reporting. We have sought to include as many procedures on Medicare's list of covered ASC procedures that fit within the scope of general surgery practice. We received other types of comments as well. One commenter recommended that we adopt the measure sooner than the calendar year 2024 payment determination. One commenter requested that dry run reports be provided as early as 2020 to allow sufficient time for ASCs to review their performance and ask questions. We note that the timeline proposed for implementation of this measure was to allow adequate time to conduct a dry run with at least two years of data and to collect data with sufficient reliability prior to the measure being used toward payment determinations. Thus, we believe that the calendar year 2024 payment determination best fits these needs. We finalized our proposal to add ASC-19 beginning with the calendar year 2024 payment determination and for subsequent years to the ASC Quality Reporting Program.

As discussed earlier in the presentation, with the addition of the ASC-19 measure in the ASC Quality Reporting Program, we have another alignment between this program and the Hospital OQR Program. Again, as mentioned earlier, the OP-36

measure is calculated with one year of data, whereas ASC-19 will be calculated using two years of data.

Moving on to the measures ASC-1 through ASC-4. In the Calendar Year 2019 OPPS/ASC Final Rule with comment period, we expressed concern that the data submission method for these measures may impact the completeness and accuracy of the data due to the inability of ASCs to correct errors in submitted quality data codes (QDCs) that are used to calculate these measures. An ASC that identifies an erroneous or missing quality data code is unable to correct or add a quality data code if the claim has already been submitted and been processed. We also stated that we believe that revising the data submission method for the measures, such as via *QualityNet*, would address this issue and allow ASCs to correct any data submissions errors, resulting in more complete and accurate data. In addition, these measures address an important Meaningful Measure Initiative priority, Making Care Safer by Reducing Harm Caused in the Delivery of Care.

CMS has considered updating the data submission method to a CMS online data submission tool. We recognize that updating the data submission method to a CMS online data submission tool would add some burden to the ASC Quality Reporting Program due to the additional time for submitting any of these four measures via *QualityNet* for any payment determination year. We appreciate everyone's comments. We will take them into consideration as we determine future updates to these measures.

So, here is our recap for the ASC Quality Reporting Program measure set. The measures here and on the next few slides are in numeric order so that we can easily view the finalized changes for any measure. The claims-based measures ASC-1 through ASC-4 have been suspended, pending further rulemaking decisions, which we just discussed. You will continue abstracting and reporting data for the ASC-9 measure

There were no changes to these measures depicted on this slide. A few points of interest are ASC-11 remains voluntary; ASC-12 is claims-based and does not require active abstraction and reporting on the part of the ASC; ASC-13 and ASC-14 are new and were reported for the first time with the last data submission back in May 2019; and the OAS CAHPS measures, 15a through 15e, remain delayed.

So, just to review, ASC-17 and ASC-18 are previously-adopted, claims-based measures. These measures begin with the calendar year 2022 payment determination.

Our final measure is ASC-19. As discussed, addition of this measure was just finalized and will begin with the calendar year 2024 payment determination. Remember, this measure is claims-based and data for this measure will be collected via paid Medicare claims. No manual abstraction on the part of the ASC will be necessary.

This concludes my discussion on the Hospital Outpatient and ASC Quality Reporting Program alignments and finalized proposal for the CY 2020 OPPS/ASC Final Rule. Thank you so much for taking this tour with us. Karen, that's all I have today. Back to you.

Karen: Thank you, Anita. As always, we appreciate your time and being here to discuss the final rule with us. Again, the direct links to the final rule for both programs are on this slide. The first link will take you to the ASC/OQR final rule in the *Federal Register*. The second link will direct you to the PDF version for either program. We also have a link to our website, so you can access the presentation itself if you do not already have that.

Anita, we have just a few minutes. Would it be all right with you if we take a few questions from the chat box?

Dr. Bhatia: That would be great, Karen.

Karen: Our first question: We are a large hospital. I know CMS was requesting comment on the safety measures potentially becoming a part of the Hospital OQR Program in the future; but, I am not sure of its value in the hospital setting. Also, shouldn't these measures be specified for the hospital outpatient department setting and field tested? That's a big question there, Anita.

Dr. Bhatia: It is, but we can answer that. We believe these measures could be valuable to the Hospital Outpatient Quality Reporting Program because these measures would allow monitoring of these types of events and potentially prevent their occurrence to ensure that they remain rare. We have reviewed studies demonstrating the high impact of monitoring patient transfers and admissions because facilities can take steps to prevent and reduce these types of events. In addition, as I mentioned during the presentation, these measures address an important Meaningful Measures Initiative quality priority, Making Care Safer by Reducing Harm Caused in the Delivery of Care. Further, the future addition of these measures would further align the Hospital OQR and ASCQR Programs which would benefit patients because these are two outpatient settings that patients may be interested in comparing, especially if that are able to choose in which of these two settings they receive care.

Karen: Thank you, Anita. Here's another question and we got this question a lot. People are wanting to know: Why couldn't the removal of OP-33 be immediate?

Dr. Bhatia: We discussed this a little bit in the presentation. We chose this time frame to be sensitive to facilities' planning and operational procedures given that data collection for this measure began during calendar year 2019 for the calendar year 2021 payment determination. As this measure is web-based and entered annually, hospitals must report data submitted via a web-based tool between January 1st and May 15th of the year prior to the payment determination with respect to the

encounter period of January 1st to December 31st of two years prior to the payment determination. Thus, these data would be entered this year in May 2020, for a data collection period that is now already ended.

Karen: Thank you, Anita. Here's a question for the ASC side. The question is for ASC-19. Why delay this measure until payment determination 2024?

Dr. Bhatia: Okay Karen. The timeline finalized for implementation of ASC-19 is to allow adequate time to conduct a dry run with at least two years of data and to collect data with sufficient reliability prior to the measure being used towards payment determination, and we believe that the calendar year 2024 payment determination best fits these needs.

Karen: Thank you, Anita. There are quite a few questions about ASC-19, actually. So, here is another one. Why does ASC-19, why does that measure include a limited number of surgical procedures? Why not include all ASC surgical procedures that are performed?

Dr. Bhatia: This is a very important question. We identified and included clinical classification system categories within the scope of general surgery and only included individual procedures if they were within the scope of general surgery practice. We did not include in the measure calculations gastrointestinal endoscopy, endocrine or vascular procedures other than varicose vein procedures because reasons for hospital visits are typically related to patients' underlying comorbidities.

Karen: Thank you, Anita. Again, we have another question about ASC-19. Wouldn't the required reporting of ASC-19 possibly discourage patient transfers to a higher level of care?

Dr. Bhatia: We believe that adverse impact on clinical decisions will be minimal due to risk adjustment. Risk adjustment ensures that ASCs are given credit for providing care to more complex patients who are at greater risk of hospital visits. A team of clinical consultants and the national TEP provided input on the measure risk adjustment model at multiple points during development, and the measure passed the National Quality Forum surgery committee's scientific acceptability criteria. We believe that this is not an issue.

Karen: Thanks again, Anita. We are going to switch gears. So, the next question is for ASC-1 and ASC-4. Would the ASC and hospital outpatient be required to report the same data?

Dr. Bhatia: Okay, Karen. We have not put forth any proposals on these measures reporting at this time. Both programs were presented with the request for comments on these measures and possible reporting methods. But, again, this final rule did not address the measure criteria on measure acceptance into either program.

Karen: Thank you, Anita. Here's another one for ASC-19. The question: How are the unplanned hospital admissions captured? Are they captured from hospital reporting?

Dr. Bhatia: No, Karen, they are not. All data for this measure will be captured via paid Medicare claims. There will be no need for manual abstraction and reporting on the part of the hospital or an ASC for this measure.

Karen: Okay. One last question: We have an ASC that is part of our hospital, and it does not have a separate Medicare billing number. Would the ASC measures apply to us?

Dr. Bhatia: Okay. If this facility is billing using their hospital CMS Certification Number, or CCN, then your outpatient surgical facility should report with the Hospital Outpatient Quality Reporting Program. If this surgery center bills under their own NPI number, or National Provider Identifier, then the facility will be responsible to report to the ASC Quality Reporting Program.

Karen: Thank you, Anita. We do get that question a lot. I think that is all the time we have for questions right now. Thanks again, Anita. I appreciate you joining us. I know everybody really enjoys having CMS discuss things that are important, such as the final rule. So, I appreciate your time.

Remember, everyone that you can always find all our educational webinars on our website, QualityReportingCenter.com under the Archived Events tab. As a reminder again, all questions and answers from the chat box, the presentation slides, and the recording of this event are all posted on our website. They are also posted on *QualityNet.org*. That's all the time we have today. Thank you for joining us. Thank you again Dr. Anita Bhatia. Now, I am going to turn things over to our host to go over the CEU process. Thank you, everybody. Have a great day.