Quality Reporting Program

Support Contractor

CY 2019 OPPS/ASC Final Rule: Hospital Outpatient Quality Reporting (OQR) Program

Presentation Transcript

Moderator:
Karen VanBourgondien, Education Lead
Hospital Outpatient Quality Reporting (OQR) Program

Speaker:
Anita Bhatia, PhD, MPH, Program Lead, Centers for Medicare & Medicaid Services
Hospital Outpatient Quality Reporting (OQR) Program

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Karen VanBourgondien: Hello, and welcome to the Hospital OQR Program webinar. Thank you for joining us today. My name is Karen VanBourgondien, the Education Lead for the program. Our speaker today is Dr. Anita Bhatia. Dr. Bhatia is the Program Lead for both the Hospital Outpatient and the ASC Quality Reporting Programs. She received her PhD from the University of Massachusetts Amherst and her Masters in Public Health from Johns Hopkins University. Dr. Bhatia plays a crucial role in the development of the OPPS Proposed and Final Rulings. Her contributions to the rulings are essential to the continuing success of the Hospital OQR Program. We are fortunate to have Dr. Bhatia's commitment to this program and ultimately to patient care outcomes. I will turn things over to Anita in just a few moments.

Please join us for our next webinar in January, The Specifications Manual Update. This presentation will discuss the Specifications Manual and will cover all the changes in the manual since last year. As always, ListServe notifications will be sent regarding the webinar.

The learning objectives for this webinar are listed here on this slide. This program is being recorded. A transcript of today's presentation, including the questions and answers received in the chat box and the audio portion of today's program, will be posted at qualityreportingcenter.com at a later date. Today, if you have a question, please put that question in the chat box located on the left side of your screen, and one of our subject matter experts will respond.

Today we are going over the Calendar Year 2019 Final Rule. For those of you who are new to the Hospital OQR Program let me give you a very simplified version of the rule process. Each July, after months of evaluation, research, and

writing, the Proposed Rule is published. From the Proposed Rule release date, the public has sixty days to submit comments regarding the proposed changes to the program. Then, in November, after reviewing and considering all of your comments, the 2019 Final Rule is published. Let me briefly demonstrate how to locate the Final Rule.

To find the OQR Final Rule in the *Federal Register* begin with accessing the federalregister.gov link. The Hospital OQR section begins on page 59080. Included here on this slide is the direct link to the PDF version of the Final Rule in the *Federal Register*, and we will discuss that in just a moment. Let's go find the OQR portion of the Final Rule from the home page of the *Federal Register*. So, if you enter federalregister.gov into your browser, the home page of the Federal Register will display. To find the Final Rule you will enter the information needed. In the box you can see that we've typed the volume number 83, FR for *Federal Register*, and then the page number which, of course, for OQR it is 59080. So, once you have entered this information just click the enter key on your computer.

That search brings up the link to the Final Rule. The area highlighted in yellow displays the 83 FR 59080 that we just entered. Below this you can see the link to the Final Rule in blue. When you click the title in blue, it will take you to the Final Rule. This is the page you will see next. This is the Final Rule. So, let me just point out a couple of things here. You can simply just scroll down this very long page until you reach the Hospital OQR section; however, to make it easier you could just use your find feature and enter the page number, which we know is 59080, and I've put this at the top of this slide, and once you enter that, that will take you to the Hospital OQR portion which is Section 13. If you are a person that prefers to view this document as a PDF, you could just click on that PDF link circled here and again use your find feature and enter that same page number 59080.

And here you are. You can see at the top in the box the page number, the volume number, which is 83, and the date it was published, Section 13 where the Hospital OQR portion of the Final Rule can be seen here next to the arrow. So, now you know how to find the Final Rule. So, let's discuss what was finalized for this program. Without further delay let me turn things over to Dr. Anita Bhatia. Anita?

Anita Bhatia: Thank you, Karen. Welcome everyone. I am Anita Bhatia, and I am the Program Lead for the Hospital Outpatient Quality Reporting Program at CMS. We began our preamble test this year discussing the importance of improving beneficiary outcomes including reducing health disparities. We also discussed our commitment to ensure that medically complex patients, as well as those with social risk factors, receive excellent care. We discussed in this section how studies show that social risk factors such as being near or below the poverty level as determined by the Department of Health and Human Services, belonging to a

racial or ethnic minority group, or living with a disability can be associated with poor health outcomes and how some of this disparity is related to the quality of healthcare. The National Quality Forum, or NQF, is now undertaking an extension of the socioeconomic status trial discussed in this section, and this trial is further examining social risk factors in outcome measures. While we did not specifically request comments on social risk factors in the Calendar Year 2019 Proposed Rule we received several comments with respect to social risk factors. Commenters encouraged us to stratify measures by other social risk factors such as age, income, and educational attainment. We thank commenters in the Final Rule for sharing their views and their willingness to support the efforts of CMS and NQF on this important issue. We take this feedback seriously and will continue to review social risk factors on an ongoing and continuance basis.

Moving on to where we finalized to codify several previously finalized proposals of noting that codification requires proposal and public comment, we did not receive public comments on these proposals, so we are finalizing our proposals to codify retaining measures from a previous year's Hospital Outpatient Quality Reporting Program measure set for subsequent years measure sets; also using the regular rulemaking process to remove a measure for circumstances for which we do not believe that continued use of a measure raises specific patient safety concerns; also, using a process for immediate retirement which we later termed removal of Hospital Outpatient Quality Reporting Program measures based on evidence that the continued use of the measure as specified raises patient safety concern, and using a set of factors for determining whether to remove measures from the Hospital Outpatient Quality Reporting Program which includes a case-by-case approach where a measure will not be removed solely on the basis of meeting any specific factor.

Some specifics about Removal Factors were also covered in this rulemaking cycle. We proposed to update Measure Removal Factor 7 and to add Measure Removal Factor 8. We also clarified a Measure Removal Factor that dealt with topped-out criteria. So here are the details on that. We finalized our proposal to change Removal Factor 7 to "collection or public reporting of a measure leads to negative unintended consequences other than patient harm" so that this Measure Removal Factor now aligns with Measure Removal Factor 7 in the Ambulatory Surgical Center Quality Reporting Program. We believe the wording in the ASC Quality Reporting Program is more appropriate because measures causing patient harm would be removed from the program immediately outside of rulemaking and in accordance with our previously finalized policy to immediately remove measures as a result of patient safety concerns. We also finalized our proposal to adopt an additional factor to consider when evaluating measures for removal, and that would be Measure Removal Factor 8 "the costs associated with a measure outweigh the benefit of its continued use in the program." We believe that this additional Measure Removal Factor will assist our efforts to ensure that the Hospital Outpatient Quality Reporting Program measure set continues to promote

improved health outcomes for beneficiaries while minimizing the overall costs associated with the program, and in this rule section we outline the Meaningful Measures Initiative and CMS' commitment to reducing costs and burden. These proposals are effective beginning with that of the Calendar Year 2019 OPPS/ASC Final Rule with comment period.

As mentioned, we clarified our topped-out criteria which is Measure Removal Factor 1. Since for some measures lower rates are better we clarified how measures are topped-out so as to utilize a methodology that results in a truncated coefficient of variation, or TCOV, that is comparable to that calculated for other measures where higher rates are better; thus, allowing assessment of rare event measures by using our previously finalized topped-out criteria. We finalized our clarification to Measure Removal Factor 1 and codified the Removal Factors for this program effective with the Calendar Year 2019 Final Rule.

So, here on this slide you can see we proposed the removal of measures from the program. We proposed the removal of ten measures. Let's now discuss how these proposals happened through the rulemaking cycle in more detail. The measures on this and the following slide were proposed for removal. Beginning at the top of the slide are the claims-based imaging measures OP-9, -11, and -14. Then you can see the chart-abstracted measure OP-5 Median Time to ECG, and at the bottom of the slide you can see the first of the web-based measures proposed for removal, OP-12 The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data. All of these measures were proposed for removal beginning with the Calendar Year 2021 Payment Determination.

This slide reflects the rest of the web-based measures that were proposed to be removed. All of the measures listed here were proposed for removal beginning with the Calendar Year 2021 Payment Determination with the exception of OP-27 Influenza Vaccination Coverage among Healthcare Personnel. OP-27 was proposed for removal beginning with the Calendar Year 2020 Payment Determination. So, let's turn our attention to how these proposals were either finalized or not finalized.

Let's begin this discussion with the measures that were proposed for removal but have been finalized to remain in the program. OP-29. This measure is a chart-abstracted measure which tracks the number of beneficiaries who had a recommended follow-up interval of at least ten years for repeat colonoscopy documented in their colonoscopy report. We have proposed to remove this measure based on burden concerns; however, based on comments received and other data we re-evaluated this measure and now believe it provides important information to beneficiary on the avoidance of inappropriate colonoscopies. As such, we no longer believe that the costs associated with this measure outweigh the benefits of its continued use in the program. In fact, we believe the costs of

this measure are justified by the avoidance of inappropriate use and of potential subsequent harm to beneficiary.

OP-31. We stated in our removal proposal that we came to believe that it can be operationally difficult for facilities to collect and report this measure and that removing this measure from the Hospital Outpatient Quality Reporting Program would reduce burden, costs, and complexity of the program. However, we also believe that Hospital Outpatient Departments should be a partner in care with physicians and other clinicians using their facility, and this measure is an opportunity for hospitals to demonstrate this capability if they choose to report it. Thus, due to the voluntary nature of this measure, we have reassessed our evaluation that the costs of this measure outweigh the benefits and believe that it is inherently not more burdensome than valuable to the facilities that voluntarily report, and so, we did not finalize our proposal to remove OP-31.

So, OP-29 and OP-31 were finalized in a manner to remain in the program. Let's now discuss the measures finalized for removal. For your convenience, at the end of this section we have a handy chart that provides the last date you will need to report data for each removed measure.

OP-5; this measure is a chart-abstracted measure which alone is not sufficient justification for removal under Factor 8; however, the costs and burden to both facilities and CMS, such as, program oversight, measure maintenance, and public display associated with keeping this measure in the program can be viewed as outweighing the limited benefit associated with the measure's continued use. Additionally, while this measure is not topped-out we have come to the conclusion that the benefit of this measure is limited. As outlined in the rule, the variation in average measure performance between hospitals is minimal on this measure with a difference in median time to ECG of less than two minutes between the 75^{th} and 90^{th} percentile. Also, the minimal variation in hospital performance does not help beneficiaries to make informed care decisions since distinguishing meaningful differences in hospital performance on this measure is difficult. Therefore, we have finalized removal of this measure, Median Time to ECG, beginning with the Calendar Year 2021 Payment Determination. The last time you will report data for this measure is August 1, 2019 for Quarter 1 2019 encounters.

OP-9 Mammography Follow-up rates. OP-9 is a claims-based measure assessing mammography follow-up rates. It's proposed removal was based upon non-alignment with current clinical guidelines consistent with Measure Removal Factor 3. As currently specified, the measure does not adequately capture recent shifts in clinical practice which include a broader, more comprehensive spectrum of mammography services. Many commenters supported the proposal to remove OP-9 from the Hospital Outpatient Quality Reporting Program measure set and agreed that the measure does not align with current clinical guidelines. And so,

after consideration of the public comments we received, we finalized our proposal to remove OP-9 from the program.

The next two claims-based measures, OP-11 and OP-14, were proposed to be removed under Removal Factor 1 “measure performance among providers is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made.” That is, these measures are topped-out. We stated our belief that removal of these measures from the Hospital Outpatient Quality Reporting Program measure set was appropriate as there is little room for improvement on these two measures. And so, after consideration of the public comments we received, we finalized our proposal to remove these two imaging used measures.

OP-12 and OP-17 measure data are submitted via a web-based tool. We proposed removal of these two measures under Removal Factor 2 “performance or improvement on a measure does not result in better patient outcomes.” One of the goals of our Meaningful Measures Initiative is to utilize measures that are outcome-based where possible. We do not believe that OP-12 and OP-17 add to these goals. In fact, we believe that provider performance in the measure is not an indicator for patient outcomes and continued collection provides little benefit. And so, after consideration of the public comments received we finalized our proposal to remove OP-12 and OP-17 beginning with the Calendar Year 2021 Payment Determination and for subsequent years. The last time you will report for these measures will be May 15, 2019 using encounters from January 1, 2018 through December 31, 2018.

OP-27 Influenza Vaccination Coverage among Healthcare Personnel. As we discussed in the rule text, CMS agrees that influenza vaccination is important; however, as we also discussed, we wish to minimize burden for participating facilities as per our Meaningful Measures Initiative. Our assessment of this measure concluded that while the OP-27 measure as specified continues to provide benefits, these benefits are diminished by other factors and are outweighed by the costs and burden of reporting this measure. We have retained this measure in the Hospital IQR Program to address concerns about influenza as a public health issue. In addition, we believe the affects of removing this measure from the Hospital Outpatient Quality Reporting Program are mitigated as the topic is addressed by other initiatives, such as, state laws and employer programs that require influenza vaccination of healthcare workers. As a result, we do not believe that the removal of this measure from the Hospital OQR Program would result in lower rates of vaccination coverage among healthcare personnel. Thus, after consideration of the public comments we received, we finalized our proposal to remove OP-27 NHSN Influenza Vaccination Coverage among Healthcare Personnel from the Hospital Outpatient Quality Reporting Program beginning with the Calendar Year 2020 Payment Determination and for subsequent years. As such, you will no longer be required to report this measure for this program.

Please remember that this measure is still a component in the Hospital Inpatient Quality Reporting Program and may also be included in any state or employer mandate that you may have.

Next up is the OP-30 measure, Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use. We finalized the removal of this measure from the program. Earlier in this presentation we discussed the retention of OP-29, another colonoscopy interval measure. So, why the difference in outcome for these two measures in this rulemaking? So, in regard to the OP-30 measure, to be responsive to stakeholder comments while balancing the clinical value of measures with the costs, we believe it is appropriate to retain OP-29 while finalizing the proposal to remove OP-30 due to the costs of data collection and submission being burdensome, the availability of this measure in other programs that adverse patient outcomes are tracked by another measure, the OP-32 measure. So, we finalized removal of OP-30 beginning with the Calendar Year 2021 Payment Determination and subsequent years. The last time you will report for this measure will be May 15, 2019 using encounters from January 1, 2018 through December 31, 2018.

This slide begins a summary of measures finalized for removal and when to cease data reporting. A frequent point of confusion for people is between Calendar Year and Payment Determination Year. So, I would like to clarify for you when you will stop being required to report for the measures that have been finalized for removal from this program in this chart here and on the following slide. All the measures on this slide are finalized for removal for the Calendar Year 2021 Payment Determination. Beginning with OP-5 the last time you will report data for this measure will be August 1, 2019. That submission will contain the Quarter 1 2019 data using encounter dates of January 1, 2019 through March 31, 2019. For the claims-based outpatient imaging measures of OP-9, OP-11, and OP-14 claims will not be used to calculate these measures, and the last date of collection for these measures will be June 30, 2018.

This slide reflects the web-based measures finalized for removal. OP-27, the Influenza Vaccination measure, is the only web-based measure removed beginning with Payment Year 2020. This means you will no longer be required to report data for this measure. Your last data submission was in May 2018. Let me reiterate that this applies to this program only. Please be aware, again, that this measure is still being reported for other programs. Additionally, you would want to be certain that you are meeting any state requirements related to this measure. With regard to the other web-based measures, OP-12, OP-17, and OP-30, the last time you will be required to report data for these measures will be this coming May 15, 2019. This reporting will utilize the reporting period of January 1, 2018 through December 31, 2018.

Future Considerations. During this rulemaking cycle we requested public comments on future measure topics for the Hospital Outpatient Quality Reporting Program. We seek to develop a comprehensive set of quality measures to be available for widespread use for informed decision making and quality improvement in the Hospital Outpatient setting. We are moving toward greater use of outcome measures and away from use of clinical process measures across our Medicare quality reporting and value-based purchasing programs. We invited public comment on possible measure topics for future consideration in the Hospital Outpatient Quality Reporting Program. We specifically requested comments on any outcome measures that would be useful to add to the program, as well as, any process measures that should be eliminated from the program.

So, here we can see that several commenters recommended measure topics for future consideration in this program some of which are noted here. Recommendations included antibiotic use related measures to assess inappropriate prescribing, cancer care measures including two measures related to referral to radiation therapy for both post breast conserving surgery and post mastectomy, psychiatric care and behavioral health measures, rural health measures, measures assessing access to care, measures assessing substance abuse, surgical site infections, or SSI, and medication safety measures such as the ambulatory breast procedure surgical site infection outcome measure, and adult immunization measure. Several commenters also noted support for outcome measures that commented on the value of process measures for addressing topics where there is insufficient evidence for standardized data to assess an outcome. We thank these commenters for their recommendations and suggestions and agree that there are additional high priority topic measure areas that may be appropriate for the Hospital Outpatient Quality Reporting Program. We will consider these suggested topic areas for future rulemaking and intend to work with stakeholders as we continue to develop the Hospital Outpatient Quality Reporting Program measure set.

Let’s move on to administrative aspects contained in this Final Rule for the Hospital Outpatient Quality Reporting Program. The Notice of Participation. With respect to the Notice of Participation, also referred to as the NOP, we proposed to update our requirements related to this form. Specifically, we proposed to remove submission of the NOP form as a requirement for the Hospital Outpatient Quality Reporting Program. After re-evaluating program requirements, we concluded that this form does not provide CMS with any unique information and, as such, we believe it is unnecessarily burdensome for hospitals to complete and submit. In place of the NOP form we proposed that submission of any Hospital Outpatient Quality Reporting Program data would indicate a hospital’s status as a participate in the program. This includes submitting just one data element. Instead, hospitals that wish to participate in the Hospital Outpatient Quality Reporting Program will register on the QualityNet website before beginning to report data, identify and register a QualityNet Security Administrator, and lastly, submit data, and we

finalized our proposal that hospitals would no longer be required to submit the Notice of Participation, or NOP form, as was previously required.

So, now we move to talking about release of the Specifications Manual, and this proposal was in regard to the frequency of manual versions. We stated in our proposal that instead of having a Specifications Manual released every 6 to 12 months, we would release the manual every 12 months and release addenda as necessary. We believe it can be confusing for participants in the program if we unnecessarily release a manual more than once per year. After consideration of the public comments received, we finalized that we will release the Specifications Manual once every 12 months and release addenda as necessary. We finalized this policy beginning with Calendar Year 2019 and for subsequent years.

In this rule cycle, we proposed and finalized to change the reporting period for OP-32 from one year to three years beginning with the Calendar Year 2020 Payment Determination. This would use claims data from January 1, 2016 through December 31, 2018 for calculation of the measure and going forward would utilize a three-year time period. The annual reporting requirements for facilities does not change because this is a claims-based measure; however, with a three-year reporting period the most current year of data would be supplemented by the addition of two prior years of data. This finalized proposal changes the reporting period for OP-32 from one year to three years beginning with the Calendar Year 2020 Payment Determination and for subsequent years, and we did finalize this proposal. Ok, we made it through the Hospital Outpatient Quality Reporting Program requirements as contained in the Calendar Year 2019 Final Rule with comment period. I can now return this session to Karen.

Karen VanBourgondien: Thank you, Anita. We always appreciate your time in bringing all this great information to everyone. You certainly have covered a lot. So, let me just try to summarize.

To sum things up, here's another way of looking at the measure set by measure type for this program. Listed here are the claims-based measures for this program. Through this rulemaking cycle CMS removed OP-9, OP-11, and OP-14 all beginning with the Calendar Year 2021 Payment Determination. All of the other claims-based measures for this program are listed here and continue on as before.

On this slide we have the web-based measures listed. OP-12, OP-17, and OP-30 were all finalized for removal for the Calendar Year 2021 Payment Determination. The last time you will report data for these measures will be May 15, 2019, and this will be using the reporting period of January 1, 2018 through December 31, 2018. OP-27 was finalized for removal beginning with the Calendar Year 2020 Payment Determination. So, what that means is you will no longer report data for this measure. Please note, as Dr. Bhatia mentioned earlier,

that the measure is removed for this program only. Please make sure you comply with requirements you have with other programs and/or state regulations. OP-31 was also not finalized for removal and reporting will continue unchanged. As a reminder, it is still a voluntary measure, so you can choose to report or not. Either decision will not affect your payment. If you do report data for OP-31, it will be publicly displayed. OP-29 and OP-33 were not finalized for removal and will also continue to be reported as you have been.

With respect to the clinical chart-abstracted measures, OP-5 was finalized for removal beginning with the Calendar Year 2021 Payment Determination. What this means is the last time hospitals will be required to report data for this measure will be August 1, 2019 for Quarter 1 2019 encounters. The other measures you will report just as you have been. The implementation of the survey measures, OP-37a through 37e, were delayed during the Calendar Year 2018 Final Rule, and they continue in that status.

We have a couple of quick links here on this slide for you. The first one will take you directly to the first page of the Final Rule in the *Federal Register*, and again, you would just utilize your find feature. The second link will take you directly to the PDF version of the Final Rule. By the way, you must download this powerpoint to have the links be active and clickable.

Anita, we have a few minutes. Do you mind if we just take a few questions with regard to some of the information you covered here today?

Anita Bhatia: Oh, Karen, that would be great.

Karen VanBourgondien: Okay, the first question is why did CMS remove OP-27 from the program? Isn't influenza vaccination a public health issue?

Anita Bhatia: Yes, Karen. CMS agrees that influenza vaccination for both patients and healthcare personnel are important in the outpatient hospital setting, as well as, other healthcare settings, and we believe that these activities are intended to address the public health concern of reducing influenza infection. We believe the affects of removing this measure from the Hospital Outpatient Quality Reporting Program are mitigated as the issue is addressed by other initiatives, such as, state laws and employer programs that require influenza vaccination of healthcare workers. Further, we have retained the measure in the Hospital Inpatient Quality Reporting Program, thus, requiring reporting in the short-term acute care hospital setting.

Karen VanBourgondien: Thank you, Anita, and the next question is about OP-5, and the question is in

our emergency room ECG findings are important in managing acute coronary symptoms and affect patient's morbidity. Why remove OP-5? It is not overly burdensome to report.

Anita Bhatia: Well, that's another great question. We agree that ECG findings are important, but our assessment indicates that the variation in performance, and therefore, the opportunity to improve the management and a patient morbidity associated with acute coronary symptoms are severely limited. Additionally, we disagree that the measure is not burdensome to report overall, as it requires chart abstraction and because many commenters supported removal of this measure and cited burden reduction as a benefit of this proposal. As a result, we believe it is appropriate to remove this measure, and we do not intend to retain or revise it. We believe that the minimal variation in hospital performance does not help beneficiaries to make informed care decisions since distinguishing meaningful differences in hospital performance on this measure is difficult. As such, the measure benefit is limited, no longer meaningfully supports program objectives of informing beneficiary choice.

Karen VanBourgondien: Great, thank you, Anita. The next question is why is OP-30 being removed? Physicians may not follow the recommended guidelines for colonoscopy screening which may lead to patient harm from unnecessary colonoscopies. Also, solely retaining the measure in MIPS is an insufficient reason, it seems, because the measure is voluntary in that program.

Anita Bhatia: Well Karen, that's an incredibly well thought out question. We agree that adherence to clinical guidelines for colonoscopy screening intervals is an important issue due to many studies that document inappropriate use. Additionally, although the measure is voluntary in the MIPS Program, we believe that MIPS reporting would mitigate the impact of removing this measure and provide meaningful data in this clinical area.

Karen VanBourgondien: Thank you, Anita. Along those lines there's another question about OP-30 indirectly here. The question is why are you retaining OP-29 but removing OP-30?

Anita Bhatia: Well Karen, we touched a little bit on this topic in the presentation. We believe that OP-29 is a critical measure for the Hospital Outpatient Quality Reporting Program because there is demonstrated substantial overuse of surveillance colonoscopies among low risk patients. We believe it is especially important to assess this topic due to the high volume of these procedures that occur in the outpatient setting. OP-29 focuses on adherence to guideline recommendations for screening colonoscopies follow-up intervals. Despite the costs and burden of chart abstraction for the presence of other measures assessing a similar clinical topic,

after considering comments and re-evaluating our data we believe OP-29 is a more critical measure to the Hospital Outpatient Quality Reporting Program than the OP-30 measure.

Karen VanBourgondien: Thank you Anita. Thank you very much for that explanation. I think we have time just for one more question, and the last question is why is OP-31 being retained? It seems that the data is related more to physician level use and not so much facility level.

Anita Bhatia: Another good question, Karen. To address that, in response to comments requesting that measures, including OP-31, be retained, we re-evaluated this measure and the data that we have in the program. We found that a core group of facilities reported on this voluntary measure, so, although only a subset of hospitals voluntarily report data for this measure, we believe this measure is considered very meaningful by those that do report. Because this subset of hospitals have consistently reported this measure, we are able to make the data publicly available year after year. We believe providing data on this voluntary measure is helpful for the public because it shows how a hospital outpatient department performs over time and in comparison to other like facilities. Furthermore, this is the only measure in the Hospital Outpatient Quality Reporting Program measure set that deals with cataract surgery which is commonly performed in the hospital outpatient department setting. If we remove this measure, the program will have a gap in coverage for this clinical area. As a result, we now believe that this measure maintains coverage in an important clinical area in the Hospital Outpatient Quality Reporting Program, and meaningful information can be provided to consumers regarding those facilities that do report.

Karen VanBourgondien: Thank you, Anita. Thank you so much. I think that's all the time we have. Again, thank you Anita so much for explaining the Final Rule to us. As a reminder, all questions and answers received in the chat box will be posted on our website at www.qualityreportingcenter.com at a later date. Thank you for joining us today. I am going to now turn things back over to our host to go over the CE process. Have a great day everybody.