CY 2023 Hospital OPPS/ASC Payment System Proposed Rule: Streaming Through the Rule Presentation Transcript

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Karen VanBourgondien: Hello everyone. My name is Karen VanBourgondien, and I am with the support contractor for the [Hospital] OQR Program. We sure appreciate you joining us. Today, we will be discussing the proposed rule as it relates to the [Hospital] OQR Program and the new Rural Emergency Hospital Quality Reporting Program.

We're gonna be starting off on our tablet here, and we're going to be streaming through the proposed rule.

Our speakers today are Shaili Patel and Dr. Anita Bhatia. Shaili is the CMS Program Lead for the Hospital OQR Program. She has a master's degree in public health, and started her federal career in 2009 with the Social Security Administration. She joined CMS in 2012. We are extremely fortunate to have Shaili involved with the program. Anita is the CMS Program Lead for the Rural [Emergency] Hospital Quality Reporting Program. She received her PhD from the University of Massachusetts, Amherst, and her master's degree 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 of all the programs. We are fortunate to have Dr. Bhatia's commitment.

We have a great line up today. We will discuss the various requests for information that extend across programs. Shaili will go over the proposals for the Hospital OQR Program. Anita will provide an overview of the new Rural Emergency Hospital Quality Reporting Program. Lastly, I will be discussing with you how to locate the rule and how to comment, and we're going to review some program important dates and information.

I'd like to make certain that the content covered on today's call should not be considered official guidance. The webinar is only intended to provide information regarding program requirements.

Please refer to the proposed rule, located in the *Federal Register* to clarify and provide a more complete understanding of the modifications and proposals for the program both Shaili and Anita will be discussing. The proposed rule was published in the *Federal Register* on July 26. The comment period does close on September 13, so please make sure you comment. CMS really does want your feedback.

So, without any further delay, let me hand things over to our firs speaker, Shaili Patel, and our first network RFI. Shaili?

Shaili Patel: Thank you, Karen. Welcome everyone. Our first here is our Requests for Information, or RFI, that's across programs, and Request for Comment, or RFC, on program-specific topics for future consideration. For the RFI, as the name implies, this is a Request for Information on topics that could impact multiple hospital programs in the future. We encourage all stakeholders to review and submit comments on these topics as we consider them for potential future rulemaking.

Our RFI topic is around health equity. CMS recently announced its comprehensive health equity strategy. In it, we articulate our commitment to advancing health equity as a key pillar of CMS's strategic vision and a core agency function. We define health equity as the attainment of the highest level of health for all, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and any other factors that affect access to care and health outcomes. In this RFI, we are specifically interested in stakeholder comments on potential use of stratified reporting on our quality measures as a way to provide hospitals with actionable and comprehensive data. Specifically, we are seeking comment on our approach to stratifying measures, including which social risk factors to use to stratify data, as well as seeking comment on how we are prioritizing which measures to stratify, and on how we plan to share those stratified results with hospitals.

Our goal is to describe key considerations in determining how to develop future policies around the use of measure stratification as one quality measurement tool to address healthcare disparities and advance health equity across our quality programs. This is important as a means of setting priorities and expectations for the use of stratified measure results. We invite comments on the principles and approaches listed previously, as well as additional thoughts about disparity measurement or stratification guidelines suitable for overarching consideration across our quality programs. These RFIs can be found in the IPPS final rule and the direct link to the PDF version of that document is on this slide. We ask that readers review the full RFI for full details on these considerations. For comments and feedback on the application of these principles to the Hospital OQR Program, please respond in this proposed rule.

For the RFC, we are seeking comment on OP-26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedure measure. This structural measure of facility capacity collected surgical procedure volume data on eight categories of procedures frequently performed in the hospital outpatient setting. We are considering reimplementing the OP–26 measure or another volume measure because of the shift from the inpatient to outpatient settings. Additionally, we are considering the reintroduction of a facility-level volume measure to support potential future development of a pain management measure. Different ways of data collection and submission and the feasibility and barriers may be encountered to reduce data collection burden while maintaining data integrity. This may include potential reporting of volume by procedure type instead of procedure category or Medicare versus non-Medicare.

While developing this RFC, we took several key points into consideration. For example, volume has a long history as a quality metric; however, quality measurement efforts have moved away from procedure volume as it was considered simply a proxy for quality, rather than directly measuring outcomes.

While studies suggest that larger facility surgical procedure volume does not alone lead to better outcomes, it may be associated with better outcomes due to having characteristics that improve, making volume an important component of quality. Also, the shift from the inpatient to outpatient setting has placed a greater importance on tracking the volume of outpatient procedures. Additionally, patients may benefit from the public reporting of facility-level volume measure data that reflect the procedures performed across hospitals and provide the ability to track volume changes by facility and procedure category. Volume is an indicator for patients for which facilities are experienced with certain outpatient procedures. Lastly, we found that pain management procedures were the third most common procedures in the calendar year 2019 and 2020 and concluded that a pain management measure would provide consumers with important quality of care information. Thus, a volume measure in the Hospital Outpatient Quality Reporting Program's measure set would provide information to Medicare beneficiaries and other interested parties on numbers and proportions of procedures by category performed by individual facilities, including for hospital outpatient procedures related to pain management. Keeping these points in mind, we highly encourage all our stakeholders to provide your comment on this topic as it would aid CMS with decision-making.

Now, turning our attention to proposals in the calendar year 2023 OPPS/ASC [payment system] proposed rule. In this program lineup, we will discuss proposals for a previously adopted measure and proposals related to form, manner, and timing of data submission.

Our first program is a proposal for a previously adopted measure. In the calendar year 2022 OPPS/ASC [payment system] proposed rule, we finalized mandatory reporting for the OP-31 measure, beginning with the calendar year 2025 reporting period for the calendar year 2027 payment determination. Since the publication of that final rule, interested parties have expressed concerns about the reporting burden of this measure given the ongoing COVID-19 public health emergency.

As the OP–31 measure uniquely requires cross-setting coordination among clinicians of different specialties, we believe it is appropriate to defer mandatory reporting at this time. We will consider mandatory reporting of OP–31 after the national PHE. We intend to consider implementation of mandatory reporting of OP-31 measure via the future rulemaking as this measure addresses an area of care that is not adequately addressed in our current measure set, and the measure serves to drive the coordination of care.

Based on the feedback we have received, we are proposing to change the reporting of the OP-31 measure from mandatory back to voluntary beginning with the calendar year 2025 reporting period for calendar year 2027 payment determination. Note, hospitals would not be subject to a payment reduction for failing to report this measure; however, we strongly encourage hospitals to gain experience with the measure. To be clear, there are no changes to reporting for calendar year 2023 and calendar year 2024 reporting period as it is already voluntary for that timeframe.

Some of the considerations for this change, as I alluded to, is that interested parties have indicated that they are still recovering from the COVID-19 PHE and that the requirement to report OP-31 would be burdensome due to national staffing and medical supply shortages coupled with unprecedented changes in the patient-case volumes. These shortages have lasted longer than initially expected, which has led us to reconsider our previously finalized timeline for mandatory reporting. Therefore, we believe that due to the continued impact of the COVID-19 PHE, the two-year delay of mandatory reporting for this measure is no longer sufficient. We invite public comment on this proposal.

Our next program will be proposals regarding form, manner, and timing of data submission. Let me begin by addressing patient encounter quarters. The patient encounter quarters for chart-abstracted measure data submitted to Hospital OQR Program are not aligned with the calendar year, meaning from January 1 through December 31.

Because these quarters are not aligned with the calendar year, as they are for the other CMS quality programs, this misalignment has resulted in confusion among some hospitals regarding submission deadlines and data reporting quarters. In this proposed rule, we are proposing to align Hospital OQR Program patient-encounter quarters for the chart-abstracted measures to the calendar year beginning with the calendar year 2024 reporting period or calendar year 2026 payment determination. If this proposal is finalized as proposed, all four quarters of patient- encounter data for chart-abstracted measures would be based on the calendar year two years prior to the payment determination year.

To facilitate this process, we propose to transition to the newly proposed timeline for the calendar year 2026 payment determination and subsequent years and use only three quarters of data for the chart-abstracted measures in determining the calendar year 2025 payment determination. Keep in mind, with this proposal, the submission deadlines would not change.

We are proposing this change to align the patient-encounter quarters for chart-abstracted measures with the calendar year schedule for the Hospital OQR Program with those of the Hospital IQR Program since some hospitals may submit data for both programs and [we want to] mitigate confusion regarding submission deadlines and various reporting quarters. Additionally, this proposed alignment would also provide more time for the Annual Payment Update determinations by increasing the length of time between the last data submission deadline and APU determinations. Let’s look at what this proposed alignment would look like.

On the top table, you see the quarters for this program in their current state and for the calendar year 2024 payment determination. The below table is what we are proposing. To begin the alignment for the calendar year 2025 payment determination, we will only use three quarters of data. So, Quarter1 data will not be reutilized for that year only.

The following payment determination, which is for calendar year 2026, we will go back to using all four quarters, but they will be aligned with the calendar year, as seen on this slide. There are additional tables available in the proposed rule. We do look forward to your feedback on this proposed alignment.

Our next proposal is the targeting criteria for validation. We are proposing to add a new criterion to the four already established targeting criteria used to select the 50 additional hospitals, beginning with validations affecting the calendar year 2023 reporting period/calendar year 2025 payment determination. We are proposing that a hospital with a less than four quarters of data due to receiving an ECE for one or more quarters and with a two-tailed confidence interval that is less than 75 percent would be targeted the following year. We are also proposing to add the criterion for targeting the additional 50 hospitals for validation to the CFR, which would state: "Any hospital with two-tailed confidence interval that is less than 75 percent and that had less than four quarters of data due to receiving an ECE for one or more quarters." Our proposal would allow us to appropriately address instances in which hospitals that submit fewer than four quarters of data due to receiving an ECE for one or more quarters might face payment reduction under the current validation policies. We believe that, for a hospital that has less than four quarters of data available for validation, the validation results could be considered inconclusive for a payment determination. We do look forward to your feedback on our proposals.

That concludes my summary of the proposed rule as it relates to the Hospital OQR Program. Let me hand things over to Anita to review the Rural Emergency Hospital Quality Reporting Program. Anita?

Anita Bhatia: Thank you, Shaili. Our network program lineup now features the new Rural Emergency Hospital Quality Reporting Program. Proposals for administrative requirements, as well as requests for comment on potential measures and additional topics, are here for your viewing.

Rural Emergency Hospitals are a new Medicare provider type established under the Consolidated Appropriations Act of 2021. Rural Emergency Hospitals, or REHs, are defined as a facility that was a critical access hospital [CAH] or a subsection (d) hospital with not more than 50 beds located in a county in a rural area. A subsection (d) hospital is basically a short-term acute care hospital, with the subsection (d) referring to a specific section of the Social Security Act. Among other requirements, an REH must apply for enrollment in the Medicare program, provide emergency department services and observation care, and, at the election of the REH, provide services furnished on an outpatient basis, and does not provide any acute care inpatient services.

Here is the statutory reference. This section also calls for the establishment of quality measurement reporting requirements for REHs, which may include the use of a small number of claims-based measures or patient experience surveys. An REH must submit quality measure data, and these data are to be made available to the public on a CMS website.

For the REH Quality Reporting program, we seek to adopt a concise set of important, impactful, reliable, accurate, and clinically relevant measures for Rural Emergency Hospitals that would inform consumer decision-making regarding care and further quality improvement efforts in the Rural Emergency Hospital setting. We intend to adopt measures that are tailored to be useful for REHs for their quality improvement efforts, but it is vital that measure information be of sufficient volume to meet case thresholds for facility level public reporting. In general, we prefer to adopt measures that have been endorsed by an entity like the National Quality Forum, or NQF, as it is a national multi-stakeholder organization with a well-documented and rigorous approach to consensus development. However, due to lack of an endorsed measure for a given facility setting, procedure, or other aspect of care, the requirement that measures reflect consensus among affected parties can be achieved in other ways, including through the measure development process, through broad acceptance, use of such measures, and through public comment.

We recognize Rural Emergency Hospitals will be smaller hospitals that have limited resources compared with larger hospitals. Certain measures, particularly those that are chart-abstracted, may be more burdensome than other measures to report. For the REH Quality Reporting Program, we intend to seek balance between the costs associated with reporting data and the benefits of ensuring safety and quality of care through measurement and public reporting which may necessitate limiting the number of quality measures in use for the REH Quality Reporting Program to facilitate success.

There are several avenues we can consider for limiting burden including the use of Medicare claims-based measures, the use of digital quality measures in place of chart-abstraction and, to the extent possible, aligning measures across different payers including Medicare and Medicaid. In the selection of measures, we believe it important that having sufficient case volume to ensure that the performance rates for such measures are reliable and of sufficient number to meet minimum numbers to allow public reporting of the data. We continue our rulemaking program by requesting comment on potential measures for use in a Rural Emergency Hospital Quality Reporting Program.

The National Advisory Committee on Rural Health and Human Services recommended measures for REH quality reporting, and we drew measures from this report, focusing on measures that are currently being reported or were recently reported under our Hospital Outpatient Quality Reporting Program. We focus on measures from this program because hospitals both short-term acute care and critical access hospitals that are eligible to convert to REH status can and are reporting data under the Hospital Outpatient Quality Reporting Program. Thus, we have some current data to begin our program planning. We request comment on a selection of measures from this report as we review measures for potential future inclusion in the REH Quality Reporting Program.

The chart-abstracted measures we are seeking comment on are OP-2, OP-3, OP-4, and OP-18. We seek to better understand how these measures may help achieve our goal of selecting measures for the REH Quality Reporting Program that focus on Rural Emergency Hospital areas of care, especially emergency department care. Measures with an OP designation represent current or past Hospital Outpatient Quality Reporting Program measures; measure specifications for these measures are contained in program specification manuals with current and past manuals back to calendar year 2013, available on the QualityNet website.

Currently, the majority of critical access hospitals and small rural hospitals report on these measures. Note, in last year's final rule, OP-2 and OP-3 were finalized for removal from the Hospital Outpatient Quality Reporting Program and are to be replaced in that program with OP-40, the STEMI eCQM, beginning with the calendar year 2023 reporting period and calendar year 2025 payment determination. We are interested in your feedback on the future adoption of OP-2 and OP-3 as well as its replacement, the STEMI eCQM, with the other measures noted here.

We also request comment on one web-based measure, OP-22, and two claims-based measures, OP-10 and OP-32. The Hospital Outpatient Quality Reporting Program has several established measures that are claims-based measures that could be applicable to Rural Emergency Hospitals. At this time, we focus on these current measures that have publicly reported data available for small rural hospitals and critical access hospitals and focus on services expected to be provided by hospitals eligible for REH conversion.

The OP-22 measure is a structural measure currently part of the [Hospital] OQR Program and data for this measure are reported annually. As claims-based measures, data for OP-10 and 32 are collected via paid Medicare claims, not by manual abstraction, which minimizes burden and provides valuable information regarding Medicare beneficiary service utilization and care provision.

CMS has an important partner in regard to quality reporting for hospitals eligible to convert to REH status, the Health Resources and Services Administration, or HRSA, and a program this agency oversees, the Medicare Beneficiary Quality Improvement Project.

The Emergency Department Transfer Communications measure is a core measure in the Medicare Beneficiary Quality Improvement Project that is for critical access hospitals. This measure was included in those measures recommended by the National Advisory Committee on Rural Health and Human Services for use for REHs in the report previously referenced. This measure assesses how well key patient information is communicated from an ED to any health care facility. Thus, we include this measure as having potential use for REH quality reporting and request comment on such.

In addition to the requests for comment on the measures we just covered, we are also interested in your feedback on additional topics and measures. We request comment on the topics seen here and request suggestions for specific measures to assess the patient experience, outcome, and processes related to these topics. All of these topics arose from public comments received from our request for information in last year's calendar year 2022 OPPS/ASC [payment system] rulemaking. Yes, public comments are read and considered.

First on this list is Telehealth, which has become much more prevalent. Rural Emergency Hospitals could utilize telehealth and other remote service capacities in serving rural communities in their vicinity. Flexibilities that were implemented due to the COVID-19 pandemic can facilitate the use of telehealth for 151 days after the expiration of the declared public health emergency. Maternal Health is also an important topic, especially in rural communities. Rural Emergency Hospitals could provide valuable emergency care and other outpatient services for preserving and improving maternal health in rural areas, such as providing outpatient OB services in areas where these services are not readily available.

REHs could also leverage remote patient monitoring. REHs could possibly fill gaps in the maternity care continuum or play a critical role in a patient's emergency plan by being identified as their closest medical facility equipped to handle a maternal health emergency.

Third on our list, Mental Health, is another important topic of interest. With high rates of mental health and substance use issues, compounded by lack of access to treatment, the need for an array of behavioral health crisis services in rural areas is essential. REHs could fill this need by providing valuable emergency care and other outpatient services for patients experiencing mental health and substance use crises and possibly bridging the gaps in the continuum of care.

Fourth, emergency department services are definitely another area we are interested in your feedback. Emergency departments and the services provided in this setting are expected to be a focus of Rural Emergency Hospitals. We discussed several measures earlier that could relate aspects of emergency department care. ED utilization and unplanned ED returns are additional important aspects of ED care and quality.

Additionally, we would like feedback on concerns regarding small case numbers. Earlier in this presentation, we expressed our concerns about this issue, and, in this section, we are asking for your feedback regarding this issue. This topic was also included in the National Advisory Committee on Rural Health and Human Services report referenced earlier in this presentation.

Finally, on this list, we have healthcare equity. This is also an area of interest for rural areas and the hospitals that serve them. We discussed this topic in last year's rulemaking cycle, and CMS had cross-program Requests for Information this year in the Inpatient Prospective Payment System proposed rule, as Shaili discussed at the beginning of this presentation.

We seek public comment on these important topics and potential future quality measures for REH quality reporting.

Our final program on this channel will discuss administrative requirements.

As stated earlier, the establishment of the Rural Emergency Hospital as a new Medicare provider type also included establishing quality measure reporting requirements. We currently use the *Hospital Quality Reporting*, or HQR, *Secure Portal* to host our CMS online data submission tool. In order to submit quality measure data in the HQR System, a hospital must establish a secure account through the QualityNet website and designate a Security Official. This system is used for the hospital outpatient and inpatient quality reporting programs, is familiar to those hospitals reporting under those programs, and would include hospitals that are eligible to convert to REH status.

This year, we are proposing foundational administrative requirements for the collection of measure data from Rural Emergency Hospitals participating in the Rural Emergency Hospital Quality Reporting Program. We propose that, for an REH to participate in the REH Quality Reporting Program, they must have a current account for the purpose of submitting data to the HQR System. If an REH already has an account for a CMS hospital quality reporting program, the REH can fulfill this requirement by updating its existing account with its new Rural Emergency Hospital CMS Certification Number, or CCN.

If an REH does not have an account, we are proposing that it must register a new account. Once an REH has an account, it must then have a Security Official, or SO. Since hospitals in the REH Quality Reporting Program will have new REH CCNs, these hospitals will have to request Security Official access for the new CCN following the standard instructions posted on the QualityNet website. While a Security Official is initially required to enable a hospital's QualityNet account for data submission and an SO allows the set-up of basic user accounts with capabilities including data submission, it will not be necessary or required to maintain a Security Official.

We highly recommend that hospitals have and maintain a Security Official, but, we reiterate, a Security Official will not be required on an ongoing basis. We invite public comment on this proposal.

This concludes my discussion on the REH Quality Reporting Program. I do encourage you to read the rule for a more in-depth discussion of our proposals and our requests for comment and information.

We are now going to change networks again. On our public access network, we will be discussing the commenting process. As both Shaili and I have stated throughout this presentation, we are looking forward to your comments and feedback. This is your opportunity to provide your thoughts and insights toward shaping decisions for this brand new quality reporting program. Please provide us with your comments. For details on how to comment, let me turn things back over to Karen.

Karen VanBourgondien: Thank you, Anita. Our program line up is discussing the comment period, locating the rule, and how to submit comments to CMS.

So, first, we are going to learn about how to comment and access the rule. To be assured consideration, comments must be submitted no later than September 13, 2022. CMS cannot accept comments by fax transmission and does encourage submission of comment by electronic means. You may also submit comment via regular mail, or express mail, or overnight mail. These do however have separate addresses, and you can resource those specific addresses in the proposed rule. Please allow sufficient time for any mailed comments to be received before the close of the comment period. The proposed rule again can be found in the *Federal Register*, we do have the direct link here on the slide. The Hospital OQR Program specifically begins on page 226 of the PDF version. The REHQR Program begins on page 254 of the PDF version. Addenda to the rule are also available by accessing the link here on the slide.

So, how do you comment? Well, actually it's a pretty easy process. So, let me show you.

When you access that *Federal Register* link we provided, it will direct you to the exact location for this rule in the *Federal Register*. To begin the commenting process, you're just going to select the green Submit a Formal Comment box. It's right there at the top. It's in that red box.

This will redirect you to the regulations.gov website. This is where you're actually going to be submitting your comment.

Here on the slide, you see the top part of that page. You would enter your comment in that Comment field and you can add a file, if you wish. You can just scroll down that page.

You will fill in the rest of the information in the designated fields. Fill in the necessary information and make sure that you click on "I read and understand the statement above." The Submit Comment box will not turn green unless that box is selected. Once complete, you will simply click on the Submit Comment button. That's it. That's all there is to submitting your comment. So, once again, please comment. CMS does look forward to hearing from you about their proposals discussed here today.

Okay, our last network, Classic Rewind, and we're just gonna review the [Hospital] OQR Program a little bit.

We're gonna discuss the measure set for the program and talk about some upcoming measures because, remember, there were some finalized proposals last rulemaking cycle that we'll need to talk about. Lastly, we will talk about some upcoming deadlines.

Here on the slide are the current measures for the program, and this would be for payment year 2024. You see OP-2 and OP-3 are listed as they are part of the current program requirements. Remember though that those two measures are being replaced with the OP-40 STEMI eCQM beginning with the 2025 payment determination.

So, when we look at the following payment year, which is the 2025 payment determination, you see OP-2 and OP-3 are now not part of the program as the OP-40 measure replaced them. Additionally, you now have, in this payment year, the OP-37 measures. Those are the survey measures, but let's take a look at that in a little bit more detail.

The survey measures were recently finalized to have a voluntary period beginning with the calendar year 2023 reporting period. Of course, that would be for the 2025 payment determination. The mandatory reporting will begin with the 2024 reporting period and that would be for the 2026 payment determination. During the voluntary period, you can report data voluntarily, or not. However, the following year, you must start collecting data to report.

The new STEMI eCQM also starts off with voluntary reporting for one quarter for the calendar year 2023 reporting period and mandatory reporting begins the following year. The calendar year 2024 reporting period, of course, is for the 2026 payment determination year.

We will be bringing you more information on the new measures as time for submission draws a little closer, but what do you have coming in the immediate future? Let's talk about that.

Here on the slide, we have a summary of what you will need to report through November of 2022. The next clinical quarterly submission will be for Quarter 2 data, and the data submission deadline is November 1, 2022. You will report for OP-2, OP-3, OP-18, and OP-23. Now, as we just discussed, OP-2 and OP-3 are going to be removed, but you will be reporting on those two measures through Quarter 1 2023. That due date is August 1, 2023. So, you still have some time that you're going to be reporting those two measures, but Quarter 1 will be the last quarter. Quarter 1 2023 will be the last quarter you're gonna submit for those two measures.

If the proposal to align the encounter quarters, as Shaili discussed earlier in the presentation, then Quarter 1 2023 data for chart-abstracted measures will not be used for payment determination. So, stay tuned, we'll have to see what happens with that in the final rule.

The OP-38 measure, the COVID-19 vaccination measure that's reported through NHSN, is reported quarterly. Don't forget that's one self-selected week per month of every quarter. The next quarterly deadline for that measure is November 15, 2022.

So, this slide summarizes what you have due in the immediate future.

So, there you have it. The proposed rule in summary and a very brief overview of some deadlines. Please access the rule yourselves and comment.

As always, if you have any program-related questions or you need assistance, call our help desk. We're always glad to hear from you and always happy to help. Our number is there on the slide. Of course, you can enter your question in the question-and-answer tool. The link is provided here as well. For any NHSN-specific issues, you can reach out to the NHSN at their email here. You can also choose to call us with regard to that, as well.

That's all the time we have today. Thank you, Shaili and Anita, again for your time. It is always really nice to have CMS here with us to go over these important proposals and requests for information and comment.

Thank you to all of you for joining us. We'll see you the next time!