Outpatient Quality Program Systems and Stakeholder Support Team

The Calendar Year 2024 Final Rule: Discussing the Impacts for the Hospital Outpatient Quality Reporting and Rural Emergency Hospital Quality Reporting Programs

Presentation Transcript

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Karen VanBourgondien: Hello everyone. My name is Karen VanBourgondien and thank you for accessing this webinar. In this event, CMS will be discussing the finalized proposals and the impacts for both the OQR and REH Quality Reporting Programs.

Our speakers today are Nicole Hilton and Dr. Anita Bhatia. Nicole is the acting CMS Program Lead for the Hospital Outpatient Quality Reporting Program. She received her Master of Arts in Geography from the University of North Carolina at Charlotte and her Bachelor of Science in Communication from the University of North Florida. Anita is the CMS Program Lead for the Rural Emergency Hospital Quality Reporting Program. Dr. Bhatia plays a crucial role in development of the proposed and final rulings. Her contributions to the rulings are essential to the continuing success of these programs. We are very fortunate to have Dr. Bhatia's commitment.

The objectives for today are here on the slide. We will show how where to locate the Final Rule in the Federal Register. Nicole will discuss finalized proposals as they relate to the Hospital OQR Program, and Anita will discuss the REHQR Program finalized proposals and how they all relate to each program, deadlines, etc. There will also be discussion on the requests for comments put forth by CMS in this year's rulemaking cycle. Although this event is not our typical live event, if you have a question about any of the topics discussed today, please feel free to enter your question into the QualityNet Q&A tool.

The published version of the final rule is in the Federal Register, and you can access that by the direct link. That very first live link. Also, we have a direct link to the PDF version if you prefer that. The OQR-specific begins on page 81961 and for the REH Program begins that section begins on page 82046. We have also placed the link to the correction notice published with regard to these programs for your review.

So, without any further delay, let me turn things over to our first speaker, Nicole, to discuss the rule and the finalized proposals as it relates to the Hospital OQR Program. Nicole?

Nicole Hilton: Thank you, Karen, and welcome everyone; we appreciate you joining us. As Karen mentioned, I will be providing a broad overview of the Hospital OQR Program CY 2024 OPPS/ASC final rule proposal decisions and requests for comment. I recommend reading the final rule for more details.

To begin, I will cover the proposal decisions related to our existing program measures.

First, we proposed to remove the Left Without Being Seen measure from the measure-set beginning with the CY 2024 reporting period and CY 2026 payment determination, as the measure does not provide enough evidence to promote quality of care and improved patient outcomes to justify retaining the measure in the program. We received many comments in response to this proposal, including several which emphasized the importance of quality measurement for the ED care setting, and some which noted the benefits of retaining the measure in order to identify and inform quality improvement efforts or beneficiary care decision-making. We also noted that since publication of the CY 2024 OPPS/ASC proposed rule we had received new data indicating an increase or worsening in measure rates. After reviewing all the responses, and considering the concerns raised by commenters as well as our identification of measure value increases, we did not finalize our proposal to remove the Left Without Being Seen measure.

Next, we proposed to modify three previously adopted measures: the COVID-19 Vaccination Among Healthcare Personnel, or HCP, measure, the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients, or the Colonoscopy Follow-Up Interval measure, and the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery, or Cataract Visual Function measure, starting

with the CY 2024 reporting period and the CY 2026 payment determination.

For the COVID-19 Vaccination Among HCP measure, we proposed to modify the term "up to date" in the HCP vaccination definition. The term "up to date" is defined as meeting the Center for Disease Control and Prevention's, or CDC's, set of criteria on the first day of the applicable reporting quarter. We also proposed to update the numerator to specify the timeframes within which an HCP is considered "up to date" with CDC recommended COVID-19 vaccines, including updated vaccine doses. As we publicly report each quarterly COVID-19 HCP vaccination coverage rate as calculated by the CDC, we further proposed that public reporting of the modified version of the COVID-19 Vaccination Coverage Among HCP measure would begin with the fall 2024 Care Compare refresh, or as soon as technically feasible. After consideration of the public comments we received, we are finalizing our proposal as proposed.

Another measure we proposed to modify is the Colonoscopy Follow-Up Interval measure. Under this proposal, the measure denominator would be modified from "all patients aged 50 years" to be "all patients aged 45 years". More specifically, the measure would now read "all patients aged 45 years to 75 years receiving screening colonoscopy without biopsy or polypectomy" in alignment with current clinical guidelines, and the modification adopted into the Merit-based Incentive Payment System (MIPS) program. After consideration of the public comments we received, we are finalizing our proposal as proposed. This update will be included in the program specifications manual.

Our third measure modification proposal was to limit the use of survey collection instruments for the voluntary Cataracts Visual Functioning measure to the NEI VFQ-25, the VF-14, and the VF-8R in response to interested parties requesting additional guidance regarding measure specifications and survey instruments. These three survey instruments are readily available for hospitals to access and use. We believe that the value of the information the measure provides to consumers about quality of

care justifies the potential administrative burden for facilities reporting on it. As some facilities have been voluntarily reporting this measure successfully, we believe this indicates the measure is not overly burdensome, and that standardizing the allowable survey instruments will further improve its usability and reliability in this setting. We also emphasize that all three surveys demonstrate adequate reliability and validity, which indicates that they are dependable survey instruments for measuring cataract outcomes. After consideration of the public comments we received, we are finalizing our proposal as proposed.

Finally, we also proposed to modify our public reporting of the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients (or Median Time for Discharged ED Patients) measure on Care Compare and in the downloadable files to include two additional strata - Transfer Patients and the Overall Rate - beginning with the CY 2024 reporting period. We currently publicly report on two other strata, which are the Reported Rate and Psychiatric Patients. We believe displaying all strata will highlight and prioritize various issues in the health care system, specifically behavioral health, and continuum of care. After consideration of the public comments we received, we are finalizing our proposal as proposed.

Next, I will cover our proposal decisions for new program measures.

To begin, we proposed to re-adopt with modification one new measure, and adopt two new measures into the Hospital OQR Program, including the Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures or HOPD Procedure Volume measure, the Risk-Standardized Patient-Reported Outcome-Based Performance Measure Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty in the Hospital Outpatient Department Setting or THA/TKA PRO–PM, and the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults or Excessive Radiation eCQM.

More specifically, we proposed to re-adopt with modification the HOPD Procedure Volume measure, which is similar to the measure that was previously part of the program measure-set but removed in CY 2018 OPPS/ASC final rule with comment period. We proposed that, if re-adopted, the measure would collect data on the aggregate count of selected surgical procedures, and that the most frequent within eight categories would be publicly reported. As stated in our proposed rule, we believe there is significant evidence linking volume to quality of care, and that volume serves as an indicator of which facilities have experience with certain outpatient procedures and can assist patients in making informed decisions about where they receive care. However, based on comments received, we are not finalizing our proposal to re-adopt the HOPD Procedure Volume with modification. We are re-assessing the measure's methodology and reconsidering how the data may be publicly displayed. We would also like to investigate procedural frequency trends which may mirror that of non-Medicare populations by conducting analysis that includes Fee-For-Service and Medicare Advantage data when evaluating categories and the most frequently performed procedures.

Secondly, we proposed the THA/TKA PRO–PM measure beginning with voluntary CYs 2025 and 2026 reporting periods followed by mandatory reporting beginning with the CY 2027 reporting period and CY 2030 payment determination. We note that because this proposed measure requires collection of data that could include as early as a three-month pre-operative period as well as a greater than one-year post-operative period, there is significant time between when an elective THA/TKA procedure is preformed, when the results would be reported under the Hospital OQR Program, and when payment determinations would occur. Therefore, we proposed a three-year reporting period for this measure.

The goal of this measure is to capture the patient's self-assessment of their pain and function and measure their improvement following their THA/TKA procedure. Clinical improvement is measured by the pre-defined score on one of two joint-specific PRO instruments—the HOOS,

JR for completion by THA recipients and the KOOS, JR for completion by TKA recipients.

Improvement is more specifically measured from pre-operative assessment data which will be collected 90 to 0 days before surgery to post-operative assessment data which will be collected 300 to 425 days following surgery. Improvement scores are risk-adjusted to account for differences in patient case-mix. The measure, as proposed, accounts for potential non-response bias in measure scores through inverse probability weighting based on likelihood of response. We also proposed that hospitals would be required to submit 50 percent of eligible, complete pre-operative data with matching eligible, complete post-operative data as a minimum amount of data for mandatory reporting in the Hospital OQR Program.

The THA/TKA PRO–PM uses four sources of data for the calculation of the measure: PRO data; claims data; Medicare enrollment and beneficiary data; and U.S. Census Bureau survey data. The measure uses PRO data directly reported by the patient regarding their health, quality of life, or functional status associated with their health care or treatment. This patient reported-data are collected by facilities pre-operatively and post-operatively, and limited patient-level risk factor data are collected with PRO data and identified in claims. For risk-adjustment by pre-operative mental health score, hospitals would submit one of two additional PRO instruments, all the items in either the Patient Reported Outcomes Measurement Information System (PROMIS)-Global Mental Health subscale; or the Veterans RAND 12-Item Health Survey (VR–12) Mental Health subscale. You can access details on measure methodology on the CMS.gov website. After considering the comments received, we are finalizing the adoption of the THA/TKA PRO–PM with modification.

In response to interested party feedback, we are delaying implementation of mandatory reporting by one year, such that voluntary reporting would begin with the CY 2025 reporting period and continue through the CY 2027 reporting period, and mandatory reporting would begin with the CY

2028 reporting period for CY 2031 payment determination. The additional year of voluntary reporting would allow time to monitor implementation progress with regards to data collection burden and response rates, as well as time for rulemaking should any improvements for mandatory reporting need to be made.

This slide provides a snapshot of our finalized Reporting Dates. We intend to provide hospitals with confidential feedback reports during the voluntary reporting period, and their results in CY 2031 before publicly reporting results on the Care Compare website.

Our last measure we proposed for adoption was the Excessive Radiation eCQM based on the evidence of harm from excessive radiation and evidence that radiation doses could be lowered in many patients' situations without deteriorating image diagnostic utility to the point of rendering exams unacceptable. We believe it is important to promote patient safety by ensuring that patients are exposed to the lowest possible level of radiation while preserving image quality. We proposed to adopt the measure beginning with a voluntary CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period and CY 2028 payment determination.

The measure calculates the percentage of eligible CT scans that are out-of-range based on having either excessive radiation dose or inadequate image quality, relative to evidence-based thresholds based on the clinical indication for the exam. The measure numerator is diagnostic CT scans that have a size-adjusted radiation dose greater than the threshold defined for the specific CT category. The threshold is determined by the body region being imaged and the reason for the exam, which affects the radiation dose and image quality required for that exam. The measure denominator is all diagnostic CT scans performed on patients ages 18 and older during the one-year measurement period which have an assigned CT category, a size-adjusted radiation dose value, and a global noise value. The Excessive Radiation eCQM uses hospitals' electronic health record (EHR) data and radiology electronic clinical data systems during the one-

year measurement period. Hospitals may choose to use any available software that performs the necessary functions to comply with measure requirements. Measure specifications are available on the eCQI website.

After considering commenter's feedback, we are finalizing our proposal to adopt the Excessive Radiation eCQM with modification to extend the voluntary reporting period by an additional year. With this modification, voluntary reporting would begin with the CY 2025 reporting period, and mandatory reporting would begin one year later than proposed with the CY 2027 reporting period and CY 2029 payment determination. The additional year of voluntary reporting would allow time to monitor implementation progress with regards to data collection burden and response rates.

This slide is an overview of the reporting deadlines as finalized. You will have two years of voluntary reporting for CYs 2025 and 2026 reporting periods. During this voluntary reporting period, hospitals can voluntarily submit any quarter of data and submit them by May 15th of the applicable year. The first year of mandatory reporting would begin with CY 2027 reporting period for the CY 2029 payment determination. At that point, hospitals must report two self-selected quarters of data and would be required to submit eCQM data by May 15, 2028. The following year, hospitals would then report all four quarters of data and submit by May 15, 2029.

In addition to our proposals, we also requested comment on several topic areas; I will only be noting the subjects here. The final rule with comment period provides extensive detail on the public comments we received.

With our requests for comments, we are seeking input on innovative measurement approaches and data sources for use in quality measurement to inform our work and, more specifically, the focus of measure development within the Hospital OQR Program. We also sought public comment to address quality measurement gaps in the HOPD setting, including the ED; changes in outpatient care (such as shifts in volume,

technology use, and case complexity); growth of concerns around workforce and patient safety; the transition to digital quality measurement; and interest in patient-reported outcomes. We were particularly interested in feedback on quality measurement topics that include promoting Safety (Patient and Workforce); Behavioral Health; and Telehealth. Again, for full discussion, details, and comments, please refer to the final rule.

That wraps up my summary of the finalized proposals for the Hospital OQR Program. Let me now turn things over to my colleague, Anita Bhatia for discussion on the Rural Emergency Hospital Quality Reporting Finalized Proposals.

Anita Bhatia: Thank you, Nicole. We have a lot to cover for the REHQR Program. Today, I will be summarizing our finalized proposals and do encourage you to access the final rule for a more comprehensive overview. The Rural Emergency Hospital Quality Reporting Program's overarching goals are to improve the quality of care provided to Medicare beneficiaries, facilitate public transparency, ensure accountability, and safeguard the accessibility of facilities in rural settings. Congress established Rural Emergency Hospitals as a new Medicare provider type in the Consolidated Appropriations Act of 2021.

As we stated in the Calendar Year 2023 OPPS/ASC final rule, we sought 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 drive further quality improvement efforts in the Rural Emergency Hospital setting. We focused on the considerations of service and patient volume, care accountability and quality, rurality, and care setting relevance, as well as health equity.

In the CY 2024 OPPS/ASC proposed rule, we proposed to adopt four measures for the Rural Emergency Hospital Quality Reporting Program measure set. All of these measures are currently active in the Hospital Outpatient Quality Reporting Program: Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients;

The Abdomen Computed Tomography (CT) - Use of Contrast Material; Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy; and Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery. The first measure is a chart-abstracted measure, and the other three are claims-based. Claims-based measures do not require manual reporting on the part of the hospital.

We proposed to adopt the Median Time for Discharged ED Patients for the Rural Emergency Hospital Quality Reporting Program beginning with the calendar year 2024 reporting period. As stated, this is a chart-abstracted measure that evaluates the time between the arrival to and departure from the emergency department, also known as ED throughput time. The measure calculates the median time in minutes from ED arrival to time of departure from the ED for discharged patients. Data are stratified into four separate calculations listed here on the slide. Results are calculated using chart-abstracted data on a rolling quarterly basis and all stratified data would be publicly reported in aggregate for one calendar year. This proposal was finalized to adopt the Median Time from ED Arrival to ED Departure for Discharged ED Patients measure, beginning with the calendar year 2024 reporting period as proposed.

Next is our proposal to adopt the Abdomen CT measure into the Rural Emergency Hospital Quality Reporting Program measure set beginning with the calendar year 2024 reporting period. This measure provides the percentage of CT abdomen and abdominopelvic studies that are performed with and without contrast out of all CT abdomen studies performed (those with contrast, those without contrast, and those with both) to assess potential overuse of contrast material. As typically, both types of scans are not necessary. This measure is calculated using a 12-month window using Medicare Fee-For-Service final action claims and enrollment data for hospital services paid through the Outpatient Prospective Payment System for abdomen CT studies performed in the Rural Emergency Hospital setting. This measure does not include Medicare managed care beneficiaries, non-Medicare patients, or beneficiaries who were admitted to the hospital as inpatients. This proposal to adopt the Abdomen

Computed Tomography (CT) - Use of Contrast Material Measure, beginning with the calendar year 2024 reporting period was finalized as proposed.

Our next measure for today is the Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery measure, which we proposed for adoption beginning with the calendar year 2024 reporting period. This measure defines any unplanned hospital visits within seven days of an outpatient surgical procedure and is calculated from Part A and Part B Medicare administrative claims data for beneficiaries with an outpatient same day surgical procedure. There are exclusions to the procedures included for this measure, such as eye procedures and colonoscopies. Colonoscopy procedures are included in the next measure to be discussed and additional details for the measure are included in the program specifications manual. The performance period for the measure is one year, that is, the measure calculation includes eligible outpatient same day surgeries occurring within a one-year timeframe. The proposal to adopt this measure beginning with the calendar year 2024 reporting period was finalized as proposed.

As promised, here we have the Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy measure. This measure defines the outcome as any (one or more) unplanned hospital visits within 7 days of an outpatient colonoscopy procedure and again is calculated using Medicare Fee-For-Service claims and enrollment data. We proposed to adopt this measure in the Rural Emergency Hospital Quality Reporting Program beginning with the calendar year 2024 reporting period. In alignment with the reporting period for this measure as used in the Hospital Outpatient Quality Reporting Program, we proposed the initial reporting period to be a three-year period beginning with patient encounters from January 1, 2024, through December 31, 2026, with annual updates on a rolling basis. This proposal was finalized as proposed.

To have a quality reporting program, it is also necessary to have policies regarding program processes and procedures. And these need to be made

readily available. As the Rural Emergency Hospital Quality Reporting Program is new, we have a bunch of establishing proposals.

Summarized here on this slide, you can see the submission deadlines for the adopted measures. At the top is the clinical chart-abstracted measure which will be submitted through the Hospital Quality Reporting system, and the outcome claims-based measures are listed below the first.

In the CY 2024 OPPS/ASC rulemaking cycle, we proposed to align the policies regarding submission of program data for the Rural Emergency Hospital Quality Reporting Program with those from the Hospital OQR Program. Rural Emergency Hospitals sharing the same CCN must combine data collection and submission across their multiple campuses for all clinical measures for public reporting purposes. Beginning with the calendar year 2024 reporting period, the applicable patient encounter quarters for chart-abstracted data will be submitted quarterly. Submission deadlines by measure and by data type will be posted on a CMS website. We proposed and finalized that all deadlines occurring on a Saturday, Sunday, or legal holiday, or on any other day–all or part of which is declared to be a non-workday for federal employees by statute or executive order–would be extended to the first day thereafter which is not declared to be a non-workday. This lengthy description is to be in alignment with other statutory language.

We proposed and finalized to adopt the review and corrections policy, in alignment with what is currently in place for the Hospital OQR Program. Hospitals are encouraged to submit data early in the submission schedule so that they can identify errors and resubmit data before submission deadlines. Hospitals can continue to review, correct, and change submitted data up until the close of each submission deadline. With this policy Rural Emergency Hospitals have a review and corrections period for all quality data submitted, which runs concurrently with the data submission period, when they would be able to enter, review, and correct data submitted prior to the submission deadline. Note that after the submission deadline, these data cannot be changed.

For submitted data, we proposed and finalized how data will be publicly reported under the Rural Emergency Hospital Quality Reporting Program. Data will be displayed by CMS Certification Number, or CCN, on our Care Compare website and in downloadable data files found at the data.cms.gov website after providing the REH an opportunity to review the data to be made public. CMS will publicly display Rural Emergency Hospital data by the CCN that the data were submitted under. Similar to the Hospital OQR and Hospital IQR Programs, we would announce the timeframes for the preview period starting with the measure data submitted relevant to services provided in calendar year 2024 on our CMS-designated website, such as *QualityNet*, or on applicable listservs. This preview process aligns with that of the Hospital OQR Program.

Also, to align with the Hospital OQR Program, we proposed and finalized an Extraordinary Circumstances Exceptions, also known as ECE, process for Rural Emergency Hospitals. Under this process Rural Emergency Hospitals can request CMS to grant extensions or waivers with respect to the reporting of required quality data when there are extraordinary circumstances beyond the control of the Rural Emergency Hospital. CMS may grant an exception to one or more data submission deadlines and requirements in the event of extraordinary circumstances such as when an act of nature affects an entire region or locale or a systemic problem with one of CMS' data collection systems. CMS may grant exceptions at its own discretion, without an accompanying request from an affected Rural Emergency Hospital, when CMS determines that an extraordinary circumstance has occurred.

Again, the Rural Emergency Hospital Quality Reporting Program is new, so we had initial regulations. To begin, we proposed and finalized to codify the statutory authority for the Rural Emergency Hospital Quality Reporting Program to implement a quality reporting program requiring Rural Emergency Hospitals to submit data on quality measures. Rural Emergency Hospital policies are codified in the Code of Federal Regulations. In last year's rule cycle, we finalized foundational administrative requirements for Rural Emergency Hospitals participating

in the Rural Emergency Hospital Quality Reporting Program. This was also codified. In that rule last year, we stated that Rural Emergency Hospitals must register on a CMS website before beginning to report data and identify and register a security official as part of that registration process. We would also require Rural Emergency Hospitals to submit data on all quality measures to CMS.

In this rulemaking cycle, we also proposed and finalized that, once adopted into the Rural Emergency Hospital Quality Reporting Program measure set, each measure would be retained for use, except when such measures are removed, suspended, or replaced under our policies for measure removal, suspension, or replacement. This policy was also codified.

Here we have an immediate removal policy. When there is reason to believe that the continued collection of a measure raises potential patient safety concerns, we believe it would be appropriate for us to take immediate action to remove the measure from the program. This immediate measure removal policy allows us to promptly notify Rural Emergency Hospitals and the public of the decision to remove the measure through standard hospital communication channels. We also proposed and finalized to confirm the removal of the measure in the next appropriate rulemaking, typically an Outpatient Prospective Payment System rulemaking cycle, and this language was also codified.

We received public comment on our initial proposal that our policy reduced consumer voice in decision making and diminished transparency. Therefore, we finalized a modified version of the proposed immediate measure removal policy which affected the final codified language. When a measure raises potential patient safety concerns, instead of immediately removing the measure, we will suspend the measure's use until the removal can be proposed and finalized through rulemaking.

In addition to our removal and retention policies, we proposed and finalized to adopt and codify a set of removal factors for the Rural

Emergency Hospital Quality Reporting Program in alignment with the Hospital Outpatient Quality Reporting and ASC Quality Reporting Programs. Specifically, eight factors to determine conditions for measure removal from the Rural Emergency Hospital Quality Reporting Program were adopted. Additionally, we proposed and finalized to adopt the criteria to determine topped-out measures and to assess the benefits of removing a measure from the program on a case-by-case basis.

The finalized removal factors are listed here on the slide.

Continuing with establishing policies, we proposed and finalized a policy to use a sub-regulatory process to make non-substantive updates to measures adopted for the Rural Emergency Hospital Quality Reporting Program. Specifically, when there is an update to a program measure that we believe does not substantially change the nature of the measure, we would use a sub regulatory process to incorporate those updates to the measure and we will use rulemaking to adopt substantive updates to measures previously adopted under the Rural Emergency Hospital Quality Reporting Program. We believe that this adequately balances the need to incorporate updates while also preserving the public's ability to comment on updates that significantly change a measure.

We intend to maintain technical specifications for adopted program measures and we proposed and finalized to adopt a policy for maintaining the measure specifications of program measures that aligns with the Hospital Outpatient Quality Reporting Program's policy. This includes that we would update the specifications manual for the program. The manuals containing specifications for previously adopted measures can be found on the QualityNet website.

In addition to our proposals in the proposed rule, we requested comment on potential future considerations for the Rural Emergency Hospital Quality Reporting Program. The final rule provides enormous details as well as CMS feedback to the public comments received.

Here is a listing of the Requests for Comments. We asked for feedback on the inclusion of eCQMs for Reporting Quality Data under the Rural Emergency Hospital Quality Reporting Program. For example, the Excessive Radiation eCQM, which was finalized for the Hospital Outpatient Quality Reporting Program. Another area of interest for us is Care Coordination Measures including telehealth. We received a great deal of feedback also on a Tiered Approach Framework for reporting under the program. This approach could be phased-in with Tier 1 having required measures for all Rural Emergency Hospitals and focus on required ED and observation services. Tier 2 would apply only to Rural Emergency Hospitals that choose to provide additional outpatient services, such as imaging. Again, please resource the final rule for details and discussion of comments that were received.

Thank you. I can now return the presentation over to Karen.

Karen VanBourgondien: Thank you, Nicole and Anita, for sharing time with us today and going over the finalized proposals. We do have some program resources here listed on the slide. Again, if you have any questions, please put them in that QualityNet Q&A tool. We have that listed right here on the slide. We appreciate you joining us today and accessing this webinar. We hope it was helpful.