Centers for Medicare & Medicaid Services
Hospital Open Door Forum
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*Webinar recording: https://cms.zoomgov.com/rec/share/pvqNbhtKXpjvv8rPq-ys3NuVQfGcLhuZ3ltp0qAhW5FBa7zVYZEa10kp5f70K-jh.m3JtD_ShODC1XKkh?startTime=1699383642000 Passcode: Qa*35ht=*

Jill Darling: Hi, everyone. Welcome to the Hospital Open Door Forum. We will give it a few more minutes. Thank you for your patience.

Would you please press "record"?
[Recording in progress]

Great. Thank you so much. Hello and welcome, everyone. My name is Jill Darling, and I am in the CMS (Centers for Medicare & Medicaid Services) Office of Communications here at CMS. Welcome to today's Hospital Open Door Forum. As always, we appreciate your patience in letting more attendees into the webinar today. Before we begin, I do have a few announcements. This webinar is being recorded. The recording and transcript will be available on our CMS Open Door Forum podcast and transcript webpage. That link was on the agenda that was sent out. If you are a member of the press, you may listen in, but please refrain from asking questions during the webinar. If you do have any questions, please email press@cms.hhs.gov. All participants are muted. For those who need closed captioning, a link will be provided right now in the chat function of the webinar.

We will be taking questions at the end of the agenda today. And for today's webinar, the agenda slide, and a resource slide will be the only slides for today. During—I'm sorry—when the Q&A does begin, you may use the raise hand feature at the bottom of the screen, and we will call on you to ask your question and one follow-up question. We will do our best to get to all your questions today. Now, I will turn it over to our chair, Joe Brooks.

Joe Brooks: Thank you, Jill. I appreciate that. Hi, everyone. As Jill said, I'm Joe Brooks. Thank you all very much for joining us today. During this Open Door Forum, we will be providing an overview of final policies issued in the calendar year 2024 Outpatient Prospective Payment System (OPPS) final rule, which was displayed in the Federal Register on November 2. And after that overview, as Jill said, we will be reserving some time for questions on the issues presented. So, we have quite a few topics to discuss today, so we should probably get right to it. And with that, I'll turn it right over to Ted Oja to get us started. Thank you.

Ted Oja: Thank you, Joe. In the proposed rule, CMS put forth a request for comment regarding separate payment under the Inpatient Prospective Payment System (IPPS), for establishing and maintaining access to a buffer stock of one or more of 86 essential medicines to foster more

reliable, resilient supply of these medicines. CMS received many thoughtful comments on this request for comment, and we appreciate the broad consensus among commenters regarding the need to curtail shortages of essential medicines. While we are not adopting a policy regarding payment for buffer stocks of essential medicines in this final rule, we look forward to continuing to engage with the public on this critical issue in future rulemaking. I'll now turn things over to Emily Yoder and Susan Janeczko.

Emily Yoder: Thank you so much. So first, we'll be covering policies in the OPP—the CY 2024 OPPS final rule. So, beginning with the annual update, we are finalizing an increase to OPPS payment rates for hospitals and ASCs (Ambulatory Surgical Centers) that meet the applicable quality reporting requirement—requirements of 3.1%. This update is based on the projected hospital market basket percentage increase of 3.3% produced by a 0.2 percentage point for the productivity adjustment.

Moving along to our policies for mental health services. As a reminder, last year we finalized creation of coding to describe mental health services furnished by hospital staff to beneficiaries in their homes, through communications technology. For this year, we are finalizing technical changes to reflect additional information provided by assisted parties regarding how these services are furnished, including the creation of new—a new untimed code describing group psychotherapy, and these policies are intended to reduce administrative burden and increase access to care. With that, I'll turn it over to Susan Janeczko.

Susan Janeczko: All right. The next issue is our biosimilar packaging policy. Current OPPS policy packages all drugs, including biosimilars that are below the packaging threshold. And I'll note that the Calendar Year 2023 packaging threshold is $135. However, we believe that the packaging of biosimilars, but not the reference biologic product, may create an incentive for providers to select the more expensive reference biologic or other separately paid biosimilars. So, for Calendar Year 2024, we are finalizing the policy to accept biosimilars from the OPPS threshold packaging policy when their reference biologicals are separately paid.

Next up is our comment solicitation on our packaging policy for diagnostic radiopharmaceuticals. In the proposed rule, we solicited comment on how the OPPS packaging policy for diagnostic radiopharmaceuticals may have affected beneficiary access. We also solicited comment on five potential approaches for payment of diagnostic radio pharmaceuticals that would allow for enhanced beneficiary access while also maintaining the principles of the Outpatient Prospective Payment System. We received considerable interest in this comment solicitation, with commenters providing a wide variety of insights and potential policy changes, and we intend to consider these points for future notice and common rulemaking.

Next up, the OPPS dental payment policies. for 2024 calendar year, CMS is finalizing Medicare payment rates under the OPPS for over 240 dental codes to align with the dental payment provisions in the Calendar Year 2023 Physician Fee Schedule final rule by assigning them to

clinical APCs (Ambulatory Payment Classifications). Assigning additional dental codes to clinical APCs will result in greater consistency and Medicare payment for different sites of service and help ensure patient access to dental services performed in the hospital outpatient setting when payment and coverage requirements are met.

Now, I'll start us off on our ASC payment updates and policies. And as Emily noted above in the annual update, in accordance with Medicare law, CMS is finalizing payment rates for ASCs that meet applicable quality reporting requirements by 3.1%, and this update is based on projected hospital market basket percentage increase of 3.3%, reduced by 0.2 percentage points for the productivity adjustment. And then, the extension of the hospital market basket update. So, in Calendar Year 2019, we finalized a policy to apply the productivity adjusted hospital market basket update to ASC payment system rates for an interim period of five years—those calendar years, 2019 through 2023, during which time we would assess whether there was a migration in the performance of procedures from the hospital setting to the ASC setting. However, as we all know the impact of the COVID-19 PHE (Public Health Emergency) on health care utilization, especially for elective surgeries, was profound. Therefore, for this final rule, we are finalizing extending the five-year interim period an additional two years through Calendar Year 2025. We hope this will enable us to gather additional claims data to more accurately analyze whether the application of the hospital market basket update to the ASC payment system has an effect on the migration of services from the hospital setting to the ASC setting.

Next up is our opioid alternatives policy. For Calendar Year 2024, CMS is continuing its current policy, implementing Section 682 of the Support Act to provide for separate payment for non-opioid pain management drugs and biologicals that function as supplies in the ASC setting. When those products are: one, FDA approved, two, have an FDA approved indication for pain management or as an analgesic, and three, have a per day cost above the OPPS drug packaging threshold. CMS is finalizing separate payment in the ASC setting for four non-opioid pain management drugs that function as surgical supplies, including certain local anesthetics and ocular drugs that must meet these—that meet these criteria.

And finally, for me, the comment solicitation on access to non-opioid treatments for pain relief. Section 4135 of the Consolidated Appropriations Act (CAA) of 2023 provides for temporary additional payments for non-opioid treatments for pain relief in both the OPPS and the ASC payment system. Addressing the opioid misuse epidemic and its impact on communities is a top priority for CMS, and we're committed to a comprehensive and multi-pronged strategy to combat this Public Health Emergency. As the additional payments are required to begin on January 1, 2025, we plan to include our proposals to implement Section 4135 amendments in the calendar year 2025 proposed rule. And now, I'll turn it back to—to Emily Yoder.

Emily Yoder: Thank you, Susan. So next, we'll be covering the Ambulatory Surgical Center's Cover Procedures List, or CPL. In response to public comments, we are adding 11 additional surgical procedures to the ASC's CPL, including codes describing total shoulder arthroplasty.

We're also finalizing our proposal to add 26 separately payable dental surgical procedures to the ASC CPL, and 78 ancillary dental services to the—to the covered list of ancillary covered procedures. The full list of procedures included in this policy can be found in the CY 2024 ASC addendum, AA, and BB. Next, I will actually be covering the REH (Rural Emergency Hospital) and IHS (Indian Health Service) policies. So, in this rule, we are implementing a policy where IHS and tribal facilities that convert to the Rural Emergency Hospital provider type will be paid for hospital outpatient services under the same all-inclusive rates that would otherwise apply if these services were performed by an IHS or tribal hospital that is not an REH. We are also finalizing a policy where IHS and tribal facilities that convert to REHs would receive the REH monthly facility payment consistent with how this payment is applied to REHs that are not tribally or IHS operated. We also sought comments in this rule, on payment for high-cost drugs provided by IHS and tribal facilities. Under current regulations, IHS hospitals are excluded from payment under the OPPS, and are instead paid under the AIR (All-Inclusive Rate) for each encounter that provides outpatient services. We got comments on whether Medicare should pay separately for high-cost drugs provided by IHS and tribal facilities and any additional payment approaches that would enhance our ability to provide equitable payment for these high-cost drugs and services when provided by these facilities. We received many thoughtful comments, and while we're not finalizing any changes, we will consider the comments received for future rulemaking. And with that, I will hand it over to David for PHP (Partial Hospitalization Program), IOP (Intensive Outpatient Program), and CMHC (Community Mental Health Center).

David Pope: Thank you, Emily. In the Calendar Year 2024 OPPS final rule, we are expanding access to behavioral health care services under Medicare by establishing Intensive Outpatient Program payment in accordance with Section 4124 of the CAA of 2023. IOP is a level of care that is more intensive than individual outpatient behavioral health services and less intensive than partial hospitalization, which Medicare currently covers. This final rule sets forth the scope of benefits, physician certification requirements, coding and billing, and payment rates under the IOP benefit.

We are finalizing a consolidated list of service codes to be included in IOP that have been and are paid for by Medicare, either as part of PHP benefit, or under the OPPS more generally. In addition, we are adding service codes to recognize activities related to care coordination and discharge planning as well as to recognize the role of caregivers and peer support specialists in PHPs and IOPs. These final policies will allow IOP services to be furnished in hospital outpatient departments, community mental health centers (CMHCs), Federally Qualified Health Centers, and rural health clinics. For hospital-based outpatient departments and CMHCs, we are finalizing our proposal to establish two IOP ambulatory payment classifications for each provider type—one for days with three services per day and one for days with four or more services per day.

We are also finalizing our proposal to establish consistent payment between PHP and IOP in each setting, which will align with the consistent set of services that we are recognizing under

both benefits. That is, we are also establishing PHP APCs (Ambulatory Payment Classifications) for days with three services per day and four or more services per day. As we've already discussed, the CAA of 2023 added intensive outpatient services to the allowable services provided by CMHCs. In this rule, we are finalizing the proposed changes throughout the CMHC Conditions of Participation (CoPs) to include IOP with one modification to the practitioners who can lead the interdisciplinary team. Based on comments received, we have modified the requirements of Section 485.916 treatment team, person-centered active treatment plan and coordination of services at A1 to specifically identify MFTs (Marriage and Family Therapists) and MHCs (Mental Health Counselors) as potential members that may lead the CMHC interdisciplinary team. In addition, we are finalizing the requirements for Mental Health Counselor and adding the citation for Marriage and Family Therapists into the CoP to reflect the requirements being finalized in the 2024 Physician Fee Schedule rule. Finalized update for MHC and the addition of MFT to the CoPs is consistent with the payment requirements being finalized for these providers. I will now hand it over to Nicole Hilton.

Nicole Hilton: Thank you, David. There are three outpatient quality reporting programs covered in this final rule, including the hospital outpatient Ambulatory Surgical Center and the Rural Emergency Hospital quality reporting programs, or Hospital OQR (Outpatient Quality Reporting), ASCQR (Ambulatory Surgical Center Quality Reporting) or REHQR (Rural Emergency Hospital Quality Reporting), respectively, which collect and report on quality measured data to reflect the care rendered in the respective settings and to support consumer decision-making. For the Hospital OQR and ASCQR programs, we finalized four shared proposals, including three modifications to existing program measures and the adoption of one new measure for each program. More specifically, we finalized modifications to, first, the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure, to align with the Centers for Disease Control and Prevention's (CDC) definition of "up to date." Second, the Appropriate Follow-Up Interval for a Normal Colonoscopy in Average Risk Patients, to update the measure denominator from all patients aged 50 to 75 years, to aged 45-75 years. And lastly, the voluntary Cataracts: Improvement in Patient's Visual Functioning Within 90 Days Following Cataract Surgery measure, to limit survey collection instruments, all beginning with the CY 2024 reporting period. We also have finalized the adoption of the Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty measure, with modification in response to commenter feedback, and that the measure will have one additional year of voluntary reporting, beginning with the CY 2025 reporting period and with mandatory reporting, now beginning with the CY 2028 reporting period. Additionally, while we continue to believe there is significant evidence linking volume to quality of care, after considering comments received, we did not finalize our proposals to adopt the Hospital Outpatient Department or ASC Facility Volume Data on Selected Outpatient or ASC Surgical Procedures measures so that we may—so that way, we may reassess the measure's methodology and reconsider how the data may be publicly displayed. For the Hospital OQR program alone, in response to commenter feedback, we finalized with modification the adoption of the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in

Adults eCQM (electronic Clinical Quality Measure), so that it includes an additional year of voluntary reporting, so that the voluntary reporting would begin with the CY 2025 reporting period, and mandatory reporting would now begin with the CY 2027 reporting period.

Furthermore, we finalized our proposal to publicly report both the overall rate and the transfer of patient rate of the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients measure. However, we are not finalizing our proposal to remove the Left Without Being Seen (LWBS) measure after considering the concerns raised by some commenters, and to further investigate recent rate increases and measure values. Finally, we requested comments on patient safety and sepsis, behavioral health—including suicide prevention and telehealth for this setting.

For the REHQR program, we finalized the adoption of four measures beginning with the CY 2024 reporting period, including three claims-based and one chart-abstracted measure. The claims-based measure is the Abdomen Computed Tomography—Use of Contrast Material measure, the Facility Seven Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure, and the Risk-Standardized Hospital Visits Within Seven Days After Hospital Outpatient Surgery measure. The chart-abstracted measure is the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients measure, which we finalized to be displayed by all four strata. In addition, except for one, we finalized the adoption and codification of a set of standard quality program policies as proposed. However, in response to commenter feedback, we did modify our immediate measure removal policy to replace the word "removal" with "suspension" to clarify that a quality measure considered by CMS to have potential patient safety concerns will be immediately suspended from the program and then addressed in the next appropriate rulemaking cycle. Finally, we requested comment on the use of eCQMs care coordination measures and a tiered approach for the collection of measures in this program. I will now pass it along to Terri for hospital price transparency.

Terri Postma: Thanks, Nicole. Just by way of background, Section 2718(e) of the Public Health Service Act requires hospitals to make public the standard charges that the hospital has established. Consistent with that law, the regulation instructs the Secretary, how to tell—or to tell hospitals how to make public, the standard charges that the hospital has established. As a result, the hospital price transparency regulations require hospitals to make their standard charges public in two ways. First, as a single machine-readable file (MRF) that displays five types of standard charges, including payer-specific negotiated charges the hospital has established for the items and services provided by the hospital and second, as a consumer-friendly display of some standard charges for 300 shoppable services. Hospitals may meet the second consumer-friendly display requirement by offering an online price estimator tool. CMS's hospital price transparency regulations lay the foundation for a patient-driven health care system by making hospital standard charge data available to the public and support President Biden's Executive Order on Promoting Competition. To strengthen hospital compliance and improve the public's understanding and automated use of hospital standard charge information, CMS is finalizing in

the CY 2024 OPPS ASC final rule, modifications to the machine-readable file display requirements and its enforcement policies. Specifically, CMS is finalizing the following: first, that each hospital must make a good faith effort to ensure that the standard charge information encoded in the machine-readable file is true, accurate, and complete as of the date indicated in the machine-readable file, and to facilitate automated access to machine-readable files, hospitals must ensure that the public website it selects to host the machine-readable file establishes and maintains in the form and manner specified by CMS, a .txt file in the root folder that includes the hospital name and source page URL that hosts the machine-readable file, and a link in the footer of the hospital's website that links directly to the publicly available web page that hosts the machine-readable file link. Beginning July 1, 2024, the hospital's machine-readable file must conform to a CMS template layout, data specifications, and data dictionary for purposes of making public, the standard charge information as applicable. This includes the following: a statement affirming that, to the best of its knowledge and belief, the hospital has included all applicable required standard charge information in the machine-readable file and that the information encoded in it is true, accurate, and complete as of the date indicated in the file, general information about the hospital and the machine-readable file such as the version number and the date of the information, each type of standard charge—this includes payer-specific negotiated charges by payer and plan.

For payer-specific negotiated charges, the hospital must include the method used to establish the standard charge and whether the payer-specific negotiated charge should be interpreted by users of the file as a dollar amount, a percentage, or an algorithm. If the hospital has established a standard charge as a dollar amount or algorithm, the hospital must also calculate and display an estimated allowed amount in dollars. Also, information about the item or service that corresponds to the standard charge the hospital has established, including billing and coding information.

CMS is also finalizing in this rule, policies to improve and streamline its enforcement capabilities. These include additional methods that CMS may use to assess hospital compliance, requiring that hospitals acknowledge receipt of a warning notice, and the ability to notify health system leadership when CMS has determined that one or more of the system's hospitals is out of compliance. CMS is also finalizing an increase in the transparency of its enforcement activities by—and processes by making public on the CMS website, information related to CMS's assessment of a hospital's compliance. Also, making public any compliance action taken against a hospital, the status of such compliance action and the outcome of such compliance action. And CMS may also make public, notification sent to health system leadership. Finally, because disclosure of hospital standard charges is necessary but not sufficient for individuals to obtain a personalized cost estimate in advance of receiving a health care item or service, and because the consumer-friendly requirements under hospital price transparency were before additional price transparency regulations and authorities such as those through the transparency and coverage and the No Surprises Act, have allowed for more comprehensive and specific consumer-friendly pricing information for patients, CMS sought in this rule, comment from the public on the future

evolution of the hospital price transparency consumer-friendly display requirements. We appreciated the comments that we received, and we intend to take them into consideration in future rulemaking. And with that, I'll hand it back to Jill.

Jill Darling: Great. Thank you, Terri, and thank you to all of our speakers today. We will now go into the Q&A. So, a reminder, please use the raise hand feature at the bottom to get in line and we will call on you for your question and one follow-up question. So, we'll just give it one moment.

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Moderator Jackie: All right. So, I saw the first hand was Valerie. Valerie, you're able to unmute yourself.

Valerie Rinkle: Yes. Can you hear me?

Moderator Jackie: Yes, I can. Thank you.

Valerie Rinkle: Thank you. So, my question is concerning the principal illness navigation, community health integration, and social determinants of health assessment. The only discussion in the IPPS rule was in the context of intensive outpatient and partial hospitalization program. Will other hospitals be able to bill this for cancer and other patient types for OPPS payment?

Emily Yoder: Hi, Valerie. So, those codes are payable under the OPPS as well, it's not just for IOP.

Valerie Rinkle: All right. So how does that coordinate with the statements in the physician rule about these codes that they are "incident to" only?

Emily Yoder: So that part of it, we're still looking into, and we have your emails, and we'll follow up.

Valerie Rinkle: Okay, but right now, they are billable under OPPS for cancer and all other types of care for payment beginning January 1?

Emily Yoder: Yes, that's my understanding.

Valerie Rinkle: Okay. And then caregiver training services, they have status Indicator A. Can you describe that?

Emily Yoder: No, we will need to follow up. Since that—is that part of the emails that you sent to myself and some of the other teams here? Or if you need to reach out again with that question, that's fine. Thank you.

Valerie Rinkle: Okay.

Moderator Jackie: All right. Um, so the next person that I see is Jugna Shah. I think it's how I pronounce it? Jugna, you're able to unmute yourself.

Jugna Shah: Hi, can you hear me?

Moderator Jackie: Yes, I can.

Jugna Shah: Okay. Hi there, guys. This is Jugna Shah. Thank you for the update. My question has to do with Comprehensive APCs (C-APCs) and on page 82, CMS described that commenters had requested that CMS unpackage and pay separately for all status Indicator K drugs—that they unpackaged that from C-APCs. And the response from CMS was that they will take this item into consideration for future rulemaking. I have two questions. The first is, I did not notice, and I may have missed it, but I didn't notice the HOP Panel (Advisory Panel on Hospital Outpatient Payment) recommendation make its way into this section. And I recall in the past, you guys have either kept the HOP Panel recommendations together, or I think now, you weave them in through the different discussions. So, the HOP Panel had recommended that CMS unpackage, and I didn't see that. Would you guys be including that in the correction notice or if I have missed it, can you let me know?

Susan Janeczko: We can look into that.

Jugna Shah: Okay. All right, great. I just think it's—if it's possible, it's so helpful, I think, for people that look at the final rule to be able to track that instead of going to them separately to pull the HOP Panel recommendations. And then, my follow-up question is just—as you guys are looking into this for future rulemaking, is—is it appropriate for folks to reach out to the agency to provide more guidance or discussion around this topic, and if so, what is the best timing to reach out to you guys?

Susan Janeczko: Sure. We are certainly willing to take a meeting to discuss the matter. And, you know, you can—you can reach out at your convenience, and we can discuss timing.

Jugna Shah: Okay. Fantastic. Thank you so much.

Moderator Jackie: All right. Next up, I see Kim. Kim, you're able to unmute yourself.

Kim Droboniku: Hi. I'm Kim Droboniku with Johns Hopkins Health System. We have been trying to figure out, for Maryland hospitals, the inpatient only list—if there are services that we are providing that like—we generally try to follow the inpatient-only list and only provide—you know, have those patients as inpatients. We were doing an audit and we realized that the Medicare system is paying for their services, and inadvertently, they are provided on the

outpatient basis. So, are Maryland hospitals subject to those—the status Indicator C procedures and like—should we refund those or like—we are just trying to figure out the right thing to do with these. And we've like—submitted questions to different folks but have never heard back.

Emily Yoder: Yeah. So, I think that you have probably submitted a question to us, and this is one that we are still looking into as well. So, we really appreciate your patience as we try to chase down a response on this one.

Kim Droboniku: Okay. I'm sorry. Who was this?

Emily Yoder: This is Emily—Emily Yoder. I think on this topic, I don't know if it's from you or not, but if you haven't, then you can also email me again.

Kim Droboniku: Terrific. Thank you so much.

Moderator Jackie: All right. The next hand I'm seeing is Tim. Tim, you are able to unmute yourself.

Tim Wolters: Thank you. Can you hear me?

Moderator Jackie: Yes, I can.

Tim Wolters: Okay. I work for two different PPS hospitals in Missouri, and since October 1, each hospital has had several million dollars in Medicare part A claims held. [DOH says it's due to a quarterly audit by CMS, but they know no other details about it. The Missouri Hospital Association contacted the Kansas City Regional Office, and they were unaware of it. DOH PS says 90% of calls they are getting are complaining about this. But can you help explain what has happened, what's going on, and why there's no advance notice of this significant crippling loss of cash flow we've had for the past month? I understand finally, the claims may be released later this month, but it has just been a crippling loss of cash that we've been experiencing.

Donald Thompson: Doesn't sound like anyone on the call is familiar with the issue. Maybe if you can send that to the—with the hospitals' names, and the MACs (Medicare Administrative Contractors), and the contacts, and the history to the Hospital Open Door Forum mailbox, we can have someone look at it.

Tim Wolters: Okay. I will do that.

Donald Thompson: You said that you contacted the regional office, and you haven't heard back from them?

Tim Wolters: No, the regional office told the Missouri Hospital Association they knew nothing about it. So, they were going to try to check with central office and—but that was just as of the last 24 hours. I'm not sure they have heard back but I've tried to search everywhere I can. I can't find any explanation for it so—but I'll send it into the Hospital Open Door Forum mailbox.

Donald Thompson: And who you are working with in the RO (regional office) would be helpful as well if they said they were going to get back to you, and it's only been 24 hours. I suspect they will get back to you, but I want to make sure we are working collaboratively with them.

Tim Wolters: Okay. Thank you. Okay.

Donald Thompson: If they're working on it.

Tim Wolters: Okay.

Moderator Jackie: All right. And then the next hand I'm seeing—hmm. Actually, I don't see any other hands right now at the moment.

Jill Darling: Okay. We will give it just a few more seconds in case anybody does have a question. Okay. I haven't seen any raised hands. So, we will conclude today's Hospital Open Door Forum. Again, we have these helpful emails and links up and the Open Door Forum email was sent through the chat. I can send it out again for questions and comments. And I will pass it over to Joe Brooks for any closing remarks.

Joe Brooks: Thanks, Jill. Great. Thank you, Jill and thank you, Jackie. And thank you for all of the questions from all the participants today. If you didn't get a chance to ask your question or if you think of one later, as Jill said, please make sure you reach out and email us at Hospital_ODF@cms.hhs.gov. Again, thank you to everyone for joining us and have a great afternoon.

Jill Darling: Thanks, everyone. That concludes today's call. Have a great day.