Hospital Inpatient Quality Reporting (IQR) Program

Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor

Overall Hospital Quality Star Ratings: July 2024 Refresh Presentation Transcript

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Candace Jackson: Hello, and welcome to today's event: *Overall Hospital Quality Star Ratings: July 2024 Refresh*. My name is Candace Jackson. I am with the Hospital Inpatient Quality Reporting Program support contractor. I will be the moderator for today's event. Before we begin, I would like to make a few announcements. This program is being recorded. A transcript of the presentation, along with a question-and-answer summary, will be posted to the Quality Reporting Center website in the upcoming weeks. That website is www.QualityReportingCenter.com. If you registered for this event, a link to the slides was sent out a few hours ago. If you did not receive that email, you can download the slides from the Quality Reporting Center website. This webinar has been approved for one continuing education credit. Please stand by after the event. We will display a link for the survey in the chat box. You will need to complete this survey in order to obtain continuing education credit. The survey link will not be available if you leave the event early. So, if you do need to leave prior to the conclusion of the event, use the survey link that will be sent to you in the summary email within one or two business days after the webinar. This email will contain a link to the survey, along with the information about how to obtain continuing education credit. If you did not register for the event, you may obtain that email from someone who did register. If you have questions as we move through the webinar, please type the question into the Ask A Question window. Be sure to include the associated slide number, if applicable. We will answer questions as time allows after the event.

Our speakers today are Michelle Schreiber, MD, Deputy Director, Center for Clinical Standards and Quality, Director, Quality Measures and Value-based Incentives Group, for the Centers for Medicare & Medicaid Services; Arjun Venkatesh, MD, MBA, MHS, Project Director, Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation; Cameron Gettel, MD, MHS, Project Lead, Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation; Kyle Bagshaw, MPH, Project Lead, Yale New Haven Health

Services Corporation/Center for Outcomes Research and Evaluation; and Dawn Beard, LPN, Clinical Analyst II, Star Ratings Lead for Lantana Consulting Group.

This slide shows the members of the star ratings team.

The agenda for today's event is as follows: the introduction, overall star ratings background, 2024 star ratings, frequently asked questions, and 2024 implementation.

This slide is a reference to the acronyms and abbreviations that may be used during today's event.

I will now turn the presentation over to Dr. Michelle Schreiber. Dr. Schreiber, the floor is yours.

Michelle Schreiber: Hello, welcome to the Overall Hospital Quality Star Ratings [event]. I'm Dr. Michelle Schreiber, the Deputy Director of the Center for Clinical Standards and Quality at CMS, and we're delighted to welcome you to today's session. The overall star ratings methodology has been applied successfully for the third time since the onset of the COVID-19 pandemic. This demonstrates the resilience of the approach in our changing world. CMS continues active surveillance to understand the impact of COVID-19 and looking at future changes as well. Last year, we were so pleased that the 2023 overall star rating marked a successful incorporation of information from the Veterans Health Administration Hospitals and their eligibility to receive star ratings. CMS anticipates continued stakeholder engagement through multiple channels, such as this webinar, to provide hospitals and other stakeholders meaningful opportunities to contribute to the ongoing evolution of star ratings. Again, thank you for attending today.

Cameron Gettel: All right. Thanks, Michelle. My name is Cameron Gettel. I am a Project Lead for the Star Ratings Team at CORE. I'm excited to be here and talk with each of you today about the star ratings background and 2024 results.

Those of you who have been part of the National Provider Calls in past years, you'll recall that the objective for the star ratings team is overall to develop a methodology that summarizes the quality measure information that's published on Care Compare on the Medicare.gov website. We hope that's in a way that's useful to interpret for patients and caregivers to compare healthcare facilities. History dates back eight to nine years, when star ratings started with a dry run. It's undergone iterations up until recently, with the most recent version being 4.1, which we'll talk about in the coming slides.

Our guiding principles over those eight years have remained the same. Over that time, we've used methods that are scientifically valid. We have a team of statisticians and analysts that are continually doing updates and analyses on the star ratings to ensure its accuracy and representativeness. Also, we ensure that those methods are inclusive of hospitals and the measure information, as well as a heterogeneity of those available measures that are present on the Care Compare tool on Medicare. gov. We also aim to accommodate the changes in the underlying measures that comprise the star ratings results. We aim to be aligned with the Care Compare tool on Medicare.gov and other CMS programs, as well as being transparent with our methods. We do this through release of methodologies annually, as well as our code for our SAS packs. We are responsive to stakeholder input as well, as we'll see in the coming slide.

This slide is a little bit busy, but it shows the historical timeline of the star ratings program and that stakeholder input that I mentioned on the prior slide. You can see that over the eight to nine years, we've had several Technical Expert Panels. We've had several public comment periods as well, as well as over a dozen workgroups, including provider workgroups and patient and family engagement workgroups. On the bottom of the slide, you can see the National Provider Calls that we held in past years. At the bottom right, you can see that, in the past year, 2023 was the first inclusion of hospitals within the VHA network.

Before I share the 2024 results for star ratings, I'd like to get everybody on a common ground on the same page and remind everybody of the star ratings methodology briefly.

The slide here is Version 4.1 of the star ratings methodology. We're going to walk you through each of the seven steps. On the left is Step 1. That's the first step, and that's the Selection of Measures. In the 2024 star ratings, there are 46 measures that will comprise the star ratings. Those measures are selected from stakeholder input, from prioritization and ensuring that at least 100 hospitals report and are scored on each of those measures. Each hospital is scored on that measure, and their scores are ultimately standardized. For some measures, a higher score may be better, and other measures, a lower score may be better. So, we ensure standardization before we move forward with other steps. The 46 measures are grouped into five groups that you see in purple for Step 2. Mortality, the Safety of Care, and Re-admission groups comprise our outcome measures. Patient Experience and Timely & Effective Care comprise the process measures. Mortality, for example, has seven measures. Safety of Care has eight measures that comprised those groups. In Step 3, we then calculate a group score. For example, if a hospital has all seven measures reported and scored on, then, for Step 3, the group score for Mortality is simply the average of those seven individual standardized measure scores. In Step 4, we then generate a summary score. A hospital summary score is the policy-based weighted average of those available hospital group scores. For example, the Timely & Effective Care group contributes 12% weight to that summary score, and the other four groups each contribute 22% to comprise the full 100% hospital summary score. If, for example, a hospital has no measures within the Patient Experience group score, then the other group scores are proportionately upweighted to result in the full 100% contributing to the hospital summary score. In Step 5, we then apply reporting thresholds. So, hospitals must report at least three measures, in at least three groups, to obtain a star rating. One of those groups must be Mortality or Safety, importantly. In Step 6, we apply peer grouping. The goal of this step is to ensure that hospitals are compared to like hospitals.

The hospital's peer group is determined by how many groups they have at least three measures reported on and scored. So, if a hospital has two measures in the Re-admission group, the maximum peer group that they could be in is peer group 4, if they have at least three measures in all other groups. The vast majority of hospitals within the 2024 star ratings are within the bottom, peer group 5. In Step 7, we then calculate star ratings, using k-means clustering, which again, compares hospitals within individual peer groups amongst their peers. The summary scores have been categorized into the five star ratings, one being the lowest and five being the highest.

The following slides show you briefly the 2024 star ratings.

Before we touch on the results of the 2024 star ratings, I want to remind everybody of another important consideration that you may recall from last year called the Extraordinary Circumstances Exception, or the ECE. The ECE period was a time period from January 1 to June 30 of 2020, where no quality measure data contribute to the star ratings. The numbers in the table show the percent of data months that are beyond that or after June 30 of 2020. You can see in light blue in 2023, Patient Experience and Timely & Effective Care, 100% of those data months were after June 30, 2020. Similarly, 42%, 53%, and 79% respectively for Mortality, Re-admission, and Safety of Care were after that ECE period. As we've progressed a year in 2024, with the dark blue on the right, you can see that almost 100%, in fact, about 89% to 90% of the data months within these five measure groups are after that period.

This slide and the next slide are the graphical depictions of that table. Again, you can see, this is the measure data availability in 2023. You can see on the bottom that all groups, approximately 68%, of the data were after the ECE period.

In 2024, the number increases up to about 89%. We anticipate by 2025, this number to continue to rise, if not be fully after the ECE period.

Now, shifting to the 2024 star ratings, in 2024, there will be 2847 hospitals that will receive a 2024 star rating. This is compared to 3076 hospitals that received a star rating in 2023. It's a net 229 fewer hospitals in comparison; 265 hospitals no longer met criteria to have a star rating, and 36 hospitals newly met criteria for a star rating that they did not in 2023. Of the 265 hospitals that no longer met criteria to have a star rating, 27 of those no longer were included in the dataset, potentially as a result of hospital closure or consolidation, and 238 hospitals have some quality data on Care Compare on Medicare.gov, but they no longer meet the star rating criteria threshold that I've shared on the prior slides. We'll dig into those hospitals in the coming slides as well.

This slide is meant to show the difference between 2023 and 2024 in regard to the peer group. I mentioned that peer group stat is meant to compare hospitals with like hospitals, based on the measure reporting data availability within star ratings. On the left, in light blue, you can see the 2023 information. In peer group 3, about 6.3% were within peer group 3, compared about 78.7% within peer group 5. As I mentioned on the prior slides, peer group 5 is the largest peer group, with the vast majority of hospitals in that peer group. You can see on the numbers on the right, in the dark blue, that has remained consistent this year in comparison to last.

As we look at the peer groups, I want to look at the most important outcome that you're probably interested in today, the overall star ratings distribution. You can see, on the whole, the distribution of star ratings is rather similar across all hospitals from 2023 to 2024. Forty to 41% received either four or five stars in 2023. That's approximately what we saw in 2024, as you can see from this table.

This slide shows two stratifications, and it combines those last two slides that we shared. It combines the peer grouping, and it combines star ratings. On he top left, you can see the light blue is the 2023 star ratings. In the row below that, you can see the split of peer groups, 194 hospitals in peer group 3, to 462 hospitals in peer group 4, and 2420 hospitals in peer group 5. On the right, again, you can see the 2024 star rating splits.

Going down, row by row, you can see the one to five stars that were received by the hospitals within those peer groups. Again, you can see quite similar distributions, particularly for the two, three, and four stars that are highlighted. One notable difference, maybe, is that, in 2024 star ratings, the small number of hospitals in peer group 3 maybe had a greater likelihood, as you can see, to get four stars. That difference is slightly greater.

So, one of the questions I think that naturally comes out of some of the slides that I presented earlier is why did hospitals drop out of star ratings? I think we show 238 hospitals had a star rating in 2023, but they didn't have a star rating in the 2024 data. The big picture, the big reason, is that they were less likely to report at least three measures in those critical measure groups of Safety of Care and Mortality that I mentioned. The table at the bottom shows the number of measures by measure group, or a hospital, both with star ratings in 2023 and not in 2024, so, those 238 hospitals. So, if you look at the first row of Mortality, you can see that over 75% of those hospitals reported at least three measures of Mortality in 2023, but, moving to the right, we can see that over 75% did not report at least three measures in 2024. Similar for Safety, we can see a little over 25, at least 25%, reported three measures of Safety in the Safety measure group, yet less than less than 25% of this population reported at least three measures in Safety. So, without those measure groups having at least three measures, likely that that's the primary reason that those hospitals dropped out of 2024 star ratings.

Looking a little bit more granular, that was previously at the measure-group level, you are now digging into the individual measures: What measures are not being reported? We can see that the primary reason is within the Mortality measure group. There's significantly lower reporting of the COPD and heart failure Mortality measures as likely the cause. These graphs are inclusive of those 238 hospitals that received a 2023 star rating but did not receive a 2024 star rating. We can see that over 200 hospitals in the 2023 star ratings in that light blue bar for COPD Mortality dropping well below 50 hospitals reporting that.

You can imagine a hospital that had three Mortality measures reported in 2023, suddenly did not report and were not scored upon that measure, now, not meeting those criteria for star ratings eligibility. We saw similar, but not quite as pronounced, findings for the heart failure Mortality and pneumonia Mortality measures as well.

This slide shows a similar drop from 2023 to 2024 for the Safety measures. We can see considerably less, but not as pronounced, as Mortality measures decrease from 2023 to 2024 star ratings.

This slide shows a reclassification table of peer grouping between 2023 and 2024 star ratings. We fully anticipate hospitals to have some degree of changes within their peer group, year to year, based on who they're being compared to, if they're fellow peer group hospitals did better, did worse. It may alter their peer group and it may alter their star rating that will show the following slide. However, 93% of hospitals remained in the same group in 2024, compared to 2023. That can be shown by the diagonal purple line, the diagonal purple cells. A small amount also went down one peer group, shown in pink. A small amount also went up one peer group from, say, peer group 4 to peer group 5, shown in light blue. We mentioned the orange group that no longer receives a star rating, 265, and then also those newly receiving star rating hospitals shown in the bright yellow.

Having shown peer grouping, reclassification, on the prior slide, this slide is meant to show a reclassification of how star ratings changed. So, for example, one hospital that in 2023 received two stars, and, for example, in 2024, received one star, that hospital would be included in the pink cell with 117 hospitals. It would be one of those 117 hospitals. The big picture, at 51% kept the exact same star rating, 22% increased by a star, and 27% decreased by one star, again, shown respectively by the pink and the light blue.

In summary, the large majority of data used in the 2024 star ratings is post COVID-19 ECE waiver period that I shared, approximately 89% to 90%.

A net of 229 fewer hospitals received a star rating in 2024, and that continues a trend observed of fewer hospitals reporting sufficient measure information to be eligible for star rating. More specifically, the measures that are forcing hospitals to drop out and/or shift peer groups seem to be the COPD/heart failure Mortality measures and also some of the Safety measures as well. Peer grouping assignment and star ratings remained fairly stable for 2023 to 2024, as we showed in the re-classification tables.

I will hand it over to Kyle Bagshaw to talk about the frequently asked questions regarding star ratings. Thank you.

Kyle Bagshaw: Thank you, Dr. Gettel. We'd like to now take this opportunity to address a few frequently asked questions regarding the overall star ratings and the methodology and hopefully provide some clarification to aspects of the methodology that we commonly receive questions about.

The first frequently asked question we'd like to address is why the star ratings may not always be refreshed in the same quarterly refresh.

CMS considers and selects refresh criteria for each year within the bounds of rulemaking, as codified in the 2021 of OPPS rule and clarified in 2023. Specifically, the star rating is to be refreshed once each year, using data from a quarter within the previous 12 months. The goal, when selecting a refresh period, is to maximize the available information consistent with the guiding principles of the star rating project. In 2024, we sought to maximize the number of hospitals eligible, minimize the impact of pre COVID-19 data and the waiver period data when possible, and also accommodate individual measure updates and recalculations. Most pertinent for 2024 was the PSI measures including PSI 4 and PSI 90 for which the annual refresh was delayed from October 2023 to January 2024. Using the January 2024 data allows CMS to include the most up to date PSI info. Publishing the star ratings in July allows hospitals the opportunity to see the measure data before they are included in the star rating.

The second question we'd like to address is why the star ratings peer group hospitals based on the number of measure groups, with at least three measures, rather than any other hospital characteristics.

Peer grouping was introduced in 2021 with the goal of making the star rating comparisons on a more like-to-like basis. This approach was codified in the 2021 OPPS rule and focuses on the compatibility of measure information, acknowledging that there are many factors that could contribute to differences in reporting. This also allows flexibility as hospitals change, for example, seamlessly incorporating the VHA hospitals in 2023. As I'll show in an upcoming slide, while peer grouping is driven by the data, these groups do have relationships to different hospital characteristics that are either static, such as critical access designation, or unstable over time. This also includes size, volume, case and service mixes. While most rated hospitals have enough information to be in the five measure peer group, close to 80% as shown on this slide, hospitals with less available information due to factors, such as smaller volume or different services offered, can be in the three and four measure peer groups.

This slide is showing the differences in measure group reporting for hospitals in each peer group. At the bottom, you'll see that hospitals in the five measure group peer group have a measure group score for each measure group. This is by definition, as noted earlier, because these hospitals have to have at least three measures in each group. Hospitals in the four measure group peer group generally still have Re-admission, Timely & Effective Care, and Patient Experience groups, but they tend to be less likely to have measures in Safety of Care, in particular, or in Mortality. Then, in the three measure group peer group, almost all hospitals still have the Timely & Effective Care group, in addition to fewer hospitals with Mortality and Safety of Care measures. There are now also fewer hospitals with Re-admission and Patient Experience measures.

Like we discussed before, hospitals in different peer groups do have some relationship with different hospital characteristics.

In particular, on this table, you can see some distinctions between the different measure groups and hospital characteristics, including critical access designation, safety net designation, DSH payment eligibility, and teaching status. In particular, the five measure group peer group hospitals are much more likely to be noncritical access, non-safety net, DSH payment eligible, and teaching hospitals compared to those in the three and four measure group peer groups.

The third frequently asked question we'd like to address: Is it possible to influence their star ratings by choosing which measures to report?

Hospitals participating in CMS programs are required to collect data for the measures that are reported on Care Compare on Medicare.gov. Each underlying individual measure has established thresholds, such as a minimum case count, for a hospital score to be publicly reported in order to ensure reliable measurement. If the hospital does not meet such a threshold for a measure, that score is not reported publicly, and its performance does not factor into the star ratings. However, in general, hospitals do not have a choice in measures for which their data is collected. In other words, in the context of star ratings, measure reporting refers not to hospitals reporting their underlying data to CMS, but rather to the measure scores that CMS reports to the public for each hospital.

Finally, we'd like to address the question of why a hospital's star rating might change each year.

As you can see in the reclassification tables back on slide 25, many hospitals in 2024, it was 51%, got the same star rating in 2024 as 2023. More than 90% of all hospitals remained within one star in 2023. There are several factors that can contribute to a hospital's shift in ratings. The star rating can change when a hospital's performance on underlying measures shifts relative to its peers, and this can be accomplished in a few ways. The hospital itself may have performed better or worse than the prior year. A hospital may have performed similarly but its peers collectively performed better or worse.

We'll note, also, that the measures and groups in which performance shifts will have bearing on particular shifts in groups and measures that carry a weight and would be more likely to result in a star rating change. Second, hospitals that are initially closer to a cut off between ratings may be more susceptible to shift. For example, a hospital that's just on the border between three and four stars, may be more likely to shift than a hospital that's firmly in the middle of three-star hospitals. Finally, change in peer group assignment results in comparison to different peers. This can affect the hospital's star rating, even if the underlying performance is similar.

To elaborate a bit further on the changes in peer grouping, we observe that most hospitals remain in the same peer group as last year. In 2024, 93% of hospitals remained in the same peer group. While 7% shifted to a higher or lower peer group. In large part, this is because the available information is linked to hospital characteristics that are static or fairly stable. So, peer group assignment tends to remain consistent over time. We also observed this in testing prior to implementation of this peer group and methodology. Looking back at the time period between prior refreshes, we observed a similarly high correlation in peer group between time periods. When a hospital does shift to a different peer group, it is usually based on the reporting of individual measures. In particular, if a hospital meets or does not meet the measure-level requirements, such as case count or minimum sample size, like we discussed in a previous FAQ. So, for example, we look at a hypothetical hospital here that has three measures in all groups, except for Safety of Care. In this example, this hospital had only two Safety measures reported in 2023. This could be because, for example, one of the hospital-acquired [healthcare-associated] infection measures did not have a sufficient volume. If the volume in 2024 for the hospital was slightly higher in 2024, and it was sufficient for them to then receive a score in that measure, this would bump their count of Safety measures up to three. So, this hospital would move up from peer group 4 to peer group 5, on the basis of this change. We will also note that similar considerations can result in hospitals either becoming eligible for a star rating or no longer receiving a star rating if a hospital meets or now fails to meet the criteria to receive a peer group 3 designation.

Overall, the star rating is designed to be flexible as the universe of hospitals and quality information evolves. So, some change over time would be expected due to changes in hospitals. Yet, as shown here, in general, the peer group assignment is fairly stable and related to other hospital characteristics.

I'd now like to hand the presentation over to Dawn Beard of Lantana Consulting Group to discuss the implementation of the 2024 star rating.

Dawn Beard: Thank you, Kyle. I'll be highlighting the implementation dates for the 2024 overall star rating publication.

On May 3, CMS intends to have the July 2024 Hospital-Specific Report, also known as the HSR, available. Like last year, the HSRs can be accessed directly from the Hospital Quality Reporting System and will not be sent out by the Managed File Transfer application. If needed, the instructions on how to access the HSR can be found on the QualityNet Star Ratings Hospital-Specific Report web page, as well as will be included in the HSR announcement that will be sent out when the HSRs are available. The preview period will begin on May 6 through midnight June 4. As a reminder, the intention of the preview period is for providers to review their star ratings data, prior to being publicly reported on Care Compare on Medicare.gov. The preview report is not a review and correction period, where providers can send in corrected data, as this data has already been publicly reported in January of 2024. CMS intends to publish the 2024 overall star ratings on July 31. Please note, release dates are subject to change at CMS discretion.

This slide provides links for resources for providers. CMS provides resource documents such as the Comprehensive Methodology 4.1, the Quarterly Updates and Specification Report, a mock HSR, the HSR User Guide, and Frequently Asked Questions. These documents can be found on QualityNet Overall Star Rating web pages. Any questions concerning the overall star ratings can be submitted to the team by using the QualityNet Question and Answer Tool.

Once in there, under the Program drop-down, please select the Overall Hospitals Star Ratings. Then, choose your specific topic. This will ensure that your questions are sent directly to our star ratings team. Thank you for joining today's presentation, and I will turn it back to Candace for the question-and-answer portion of our call.

Candace Jackson: Thank you, Dawn. Thank you to the team for providing such useful information to us today. We do have time for a short Q&A session. As we stated earlier, all the Q&As that have been submitted today will be responded to and posted at a later date. So, we will go ahead and get started with our Q&As. The first one is: Is it possible to know which hospitals are in a specific peer group?

Dawn Beard: Hi, Candace. This is Dawn from Lantana. The hospitals receive their HSRs and the hospital's peer group is in the HSRs only. This information is not publicly reported.

Candace Jackson: Thank you, Dawn. So, going on that, the next question is: How can we identify our peer groups?

Dawn Beard: Again, a hospital can identify their peer groups within their HSRs. However, we do not publicly report all the hospitals that are in the peer group. So, that information is not available to know what hospitals are in the peer group of your hospital.

Candace Jackson: Thank you, Dawn. Our next question relates to some earlier slides, slides 14 through 16, and it asks: Were the various measure time periods adjusted to account for the excluded COVID-19 ECEs, or were the periods simply narrowed related to the excluded COVID-19 ECE.

Cameron Gettel: Thank you. This is Cameron here. Data from within the ECE period were removed from measure score calculation, and the measure score is then calculated based on the remaining data. So, as an example, measures that use or include 12 quarters of data now just include data from 10 quarters.

Candace Jackson: Thank you. Just for everybody's knowledge, just in case they don't know, the ECE is an Extraordinary Circumstance Exception.

CMS has an opportunity for hospitals to request an exception from submitting data if there is some kind of an extraordinary circumstance, such as a natural disaster or a system error that occurred, that prevented the hospital from submitting the required data.

Our next question is: Will you release the cut points for star ratings, in advance, a report release?

Dawn Beard: Again, this is Dawn from Lantana. The cut points, also known as summary scores, are found on the quarterly update and specifications report. That will be posted on the QualityNet star ratings page when the HSRs are available on May 3. So, it will not be released prior to that.

Candace Jackson: Thank you, Dawn. Our next question is: Are there any plans for a critical access hospital specific star rating, the current methodology, a peer grouping, based on number of measures reported? Does it feel like an accurate grouping appears for the CAHs that have a robust, quality improvement program?

Arjun Venkatesh: It's Arjun here from Yale. That is a good question. It's one that we've sort of received in the past, as well. You know, as it's currently designed, CMS solicited a lot of feedback in earlier stages of work from the Technical Expert Panels, public comment workgroups, around various options for peer grouping. At the time, critical access hospital designation was considered for this. Based on the feedback from a variety of different stakeholders, CMS moved forward with peer grouping by measuring information, because, in some ways, this captures some of those differences with most critical access hospitals in the three measure group and four measure group peer group. This also preserves the intent and the principal around star ratings to ensure accessibility and simplicity of information so that all hospitals are peer grouped within sort of one star rating system and there are not multiple parallel star ratings published at the same time.

Candace Jackson: Thank you, Arjun. That concludes our Q&A session for today.

Again, all questions that have been submitted will be responded to and posted at a later date. This presentation has been approved for one continuing education unit. You will need to complete a survey at the end of the presentation to be able to obtain your credit, your continuing education units.

Again, we thank you for joining our webinar today. We hope you have a great day.