Quality Reporting Program

Support Contractor

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

Presentation Transcript

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Karen VanBourgondien: Hello everyone. Welcome to the Hospital OQR Program webinar. Thanks for joining us today. My name is Karen VanBourgondien, the Education Lead for the Hospital OQR Program. If you have not yet downloaded today's handouts, you can get them from our website at www.qualityreportingcenter.com. Just click on today's event, and you should be able to download and print out the handouts. They were also attached to the invite you received for this presentation.

Our speaker today is Dr. Anita Bhatia. Dr. Bhatia is the Program Lead for both the Hospital OQR Program, as well as, the Ambulatory Surgical Center Quality Reporting Program. She received her PhD from the University of Massachusetts Amherst and her Master's in Public Health from John Hopkins University. Dr. Bhatia plays a crucial role in the development of the Proposed Rule and Final Rule. Her contributions to the rulings are essential to the continuing success of this program. We are very fortunate to have Dr. Bhatia's commitment to this program and ultimately to patient care outcomes.

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

Just to mention, before we get started, as a standard disclaimer for our Proposed Rule, CMS can only address procedural questions and comments submission and

cannot address any rule-related questions. CMS does look forward to your comments as this is your opportunity to provide input on these proposals. So, without any further ado, I'd like to turn things over to Dr. Anita Bhatia. Anita?

Dr. Anita Bhatia: Welcome everyone. Today we are discussing proposals for Hospital Outpatient Quality Reporting Program requirements contained within the Calendar Year 2019 OPPS/ASC Proposed Rule. For those of you who are new to the Hospital Outpatient Quality Reporting Program or OQR Program, here is a very simplified version of the rule process. On or around July 1 after months of evaluation, research, and writing, proposals for the OPPS/ASC payment rule are placed on display and subsequently published. From the Proposed Rule display date there is a 60-day public comment period where you can submit comments regarding proposals. Then, by a scheduled date of November 1, after reviewing and considering all comments, the Final Rule for this payment rule is placed on display. Your comments are extremely important to CMS and the rule-making process. Every comment is reviewed, considered, and receives a response in the Final Rule. At the end of this webinar we will go over how to submit comments.

Let's walk through the process of finding the publicly posted Proposed Rule.

The Proposed Rule is published annually in the *Federal Register*. To find this rule, as there are many rules published in the *Federal Register*, I put the direct link on the slide. When this link opens, you would use your "find" feature and enter the number 37175. This is the page number where the Hospital Outpatient Quality Reporting Program portion begins. You can also find the Hospital Outpatient Quality Reporting section from the "home" page of the *Federal Register*.

The "home" page of the *Federal Register* can be found at www.federalregister.gov, and you can see the web address at the top of this screen shot. Now on the screen shot in the red box you can see the volume number 83 entered, FR for *Federal Register*, and then the page number of interest which is 37175. Once this information is entered on the screen, just click the "enter" key on your computer.

That search brings up the link to the Proposed Rule. You can see the Proposed Rule here in blue. So, when you click the title, which is the area in blue, this is the page you will see next.

So, let me just point out a couple of things here. This is the Hospital Outpatient Ambulatory Surgical Center document in the *Federal Register*. This starts on Page 37046, but the Hospital Outpatient Quality Reporting Program requirements begin on Page 37175 with the Roman Numeral 13, or XIII. Now, you can just scroll down through the many pages of this very long document until you reach

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Page 37175 or you can view this document as a PDF document. Just click on the PDF icon circled here in red. You would then use your "find" feature and enter the page number of interest, again 37175. On that version you will still have to scroll down a little on the page to see Section XIII.

CMS has developed the Meaningful Measures Initiative in minimizing program costs. Efforts with this aim as seen here on this slide will include the facility information collection burden and related costs and burden associated with the submitting and reporting of quality measures to CMS, the facility costs associated with complying with other quality program requirements, the facility costs associated with participating in multiple quality programs, and tracking multiple similar or duplicative measures within or across those programs, and the cost to CMS associated with program oversight including measure maintenance and public display, and lastly, the facility costs associated with compliance with other Federal and/or State regulations.

These proposals also reflect our efforts to improve the usefulness of the data that we publicly report. Our goal is to improve the usefulness and usability of CMS quality program data by streamlining how facilities are reporting and accessing data while maintaining or improving consumer understanding of the data publicly reported on the Compare website. This framework will allow hospitals and patients, as well as other consumers, to continue to obtain meaningful information about facility performance and incentivize quality improvement while also streamlining the measure sets to reduce duplicative measures and program complexity so that the costs associated with participating in this program do not outweigh the benefits of improving beneficiary care.

CMS works with stakeholders to define measures of quality across multiple settings in an effort to align measures within these programs. These measures provide useful information that can be utilized for improvement in care quality and patient outcome. Currently, the measures listed here are aligned with the Hospital Outpatient Quality Reporting Program and the Ambulatory Surgical Center Quality Reporting Program.

Last year we noted that the National Quality Forum or NQF undertook a two-year trial period in which certain new measures and measures undergoing maintenance review be assessed to determine if risk adjustment for social risk factors is appropriate for the Hospital Outpatient Quality Reporting Program. That trial period ended in April 2017, and the web link for this report is posted on this slide. This report concluded that measures with a conceptual basis for adjustment generally did not demonstrate an empirical relationship between social risk factors and the outcome measures. The report noted also that this discrepancy could be explained in part by the methods used for adjustment and the limited availability

of robust data on social risk factors. So, the National Quality Forum or NQF, is now undertaking an extension of the socioeconomic status trial which is allowing further examination of social risk factors in outcome measures. During this time CMS will continue to consider options to address equity and disparities in our value-based purchasing programs while working with the public and other key stakeholders to identify policy solutions that achieve the goals of obtaining health equity for all beneficiaries and minimizing unintended consequences.

Next, we have proposals to update Measure Removal Factors.

We are proposing to codify our policies for measure removal. We previously adopted a policy to retain measures from a previous year's Hospital Outpatient Quality Reporting Program measure set for subsequent years' measure sets. Thus, quality measures adopted in a previous year's rule-making are retained in the Hospital Outpatient Quality Reporting Program for use in subsequent years unless otherwise specified. We previously finalized a process for immediate retirement, a term later changed to removal, of a Hospital Outpatient Quality Reporting Program measure based on evidence that continued use of the measure as specified raise patient safety concern. In other circumstances where we do not believe that continued use of a measure raises specific patient safety concern we stated that we intend to use the regular rule-making process to remove a measure. The benefits of removing a measure from the Hospital Outpatient Quality Reporting Program are assessed on a case-by-case basis. Under this case-by-case approach a measure will not be removed solely on the basis of meeting any specific factor. We are not proposing any changes to these policies. However, we are proposing to codify our policies and are inviting comment on our proposed regulatory text.

The current or existing factors for determining whether to remove measures are listed on this and the next slide. The first, listed here, addresses when measure performance among hospitals is so high and unvarying that meaningful distinction and improvement in performance can no longer be made. These are known as "topped out" measures. The second addresses when performance or improvement on a measure does not result in better patient outcomes. The third, here on this slide, addresses when a measure does not align with current clinical guidelines or practice. And fourth, addresses when a more broadly applicable measure for the topic across settings, populations, or conditions is available.

Continuing, the fifth factor relates to the availability of a measure that is more proximal in time to desired patient outcomes for a particular topic. Sixth, a measure that is more strongly associated with the desired patient outcomes for that particular topic is available. And seventh, the collection or public reporting of a measure leads to negative unintended consequences such as patient harm. The

Ambulatory Surgical Center Quality Reporting Program, which is our other program for the outpatient surgical setting, has similar Measure Removal Factors.

In this Proposed Rule we are proposing to modify Removal Factor 7 to read "collection or public reporting of a measure leads to negative unintended consequences other than patient harm" such that it align with measure Removal Factor 7 in the Ambulatory Surgical Center Quality Reporting Program. We believe the wording in the Ambulatory Surgical Center Quality Reporting Program is more appropriate because measures causing patient harm would be removed from the program immediately outside of rule-making in accordance with our previously finalized policies to immediately remove measures as a result of patient safety concerns. We are proposing to adopt an additional factor to consider when evaluating measures for removal, and that would be Measure Removal Factor 8. This factor reads "the costs associated with a measure outweighs the benefit of its continued use in the program." We believe that adding this Measure Removal Factor serves our Meaningful Measures Initiative efforts to reduce cost and burden while ensuring that the Hospital Outpatient Quality Reporting Program measure sets continues to promote improved health outcomes for beneficiaries while minimizing the overall costs associated with the program.

In this Proposed Rule we are clarifying our process for calculating the truncated coefficient of variation, referred to as the TCOV, in determining "topped-out" status for those measures which assess the rate of rare events for which a lower rate is desired. Specifically, in this rule-making, this relates to two measures, OP-11 and OP-14. We are proposing to codify these changes in the Removal Factor and seek these changes beginning with the effective date of the Calendar Year 2019 OPPS/ASC Final Rule with comment period and for subsequent years.

If the proposed changes to the Removal Factors are finalized, they will be as they appear on the next two slides. Factor 1: Measure performance among hospitals is so high and unvarying that meaningful distinction and improvement in performance can no longer be made or "topped-out measures." Factor 2: Performance or improvement on a measure does not result in better patient outcomes. Factor 3: A measure does not align with current clinical guidelines or practice. Factor 4: The availability of a more broadly applicable across settings, populations, or conditions measure for the topic. Factor 5: The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic. Factor 6: The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic. Factor 7: Collection or public reporting of a measure leads to negative unintended consequences other than patient harm, and Factor 8: The costs associated with a measure outweigh the benefit of its continued use in the program. We note that we have proposed the same Removal Factor for the Ambulatory Surgical Center.

Quality Reporting Program, other quality reporting programs, as well as, value-based purchasing programs for Fiscal Year 2019 including the Hospital VBP Program, the Hospital Inpatient Quality Reporting Program, and the PCHQR program, and others.

In weighing the costs against the benefits, we evaluate the benefits of the measure as a whole. But, in particular, we assess the benefits through the framework of our Meaningful Measures Initiative as we discussed. One key aspect of patient benefit is assessing the improved beneficiary health outcome if a measure is retained in our measure set. We believe that these benefits are multi-faceted and are illustrated through the Meaningful Measures framework's six domains and nineteen areas. This diagram depicts this vision. When these costs outweigh the evidence supporting the benefit to patients with the continued use of a measure in a program, we believe that it may be appropriate to remove the measure from the program.

Our goal is to move the program forward in the least burdensome manner possible while maintaining a parsimonious set of meaningful quality measures and continuing to incentivize improvement in the quality of care provided to patients. Now, let's take a look at the measures that we have proposed for removal.

We are proposing to remove OP-27: Influenza Vaccination Coverage among Healthcare Personnel beginning with the Calendar Year 2020 Payment Determination under our proposed Measure Removal Factor 8 because we have concluded that the costs associated with this measure outweigh the benefits of its continued use in the Hospital Outpatient Quality Reporting Program. We know that if proposed Measure Removal Factor 8 is not finalized, removal of this measure would also not be finalized. We have also proposed removal of this measure from the Ambulatory Surgical Center Quality Reporting Program. This measure does still propose some information collection burden on facilities due to the requirement to identify personnel who have been vaccinated against influenza and the reason that unvaccinated personnel have not been vaccinated. It may be costly for healthcare providers to maintain general administrative knowledge to report this measure. Hospital outpatient departments are only required to participate and the system that collects this information, NHSN, to submit data for this one measure. The incremental costs of this measure over the other measures in the program measure sets are significant due to separate data reporting requirements through the NHSN web portal. In addition, CMS must expand the resources in maintaining information collection systems, analyzing reported data, and providing public reporting of the collected information. We wish to minimize the level of cost of our program for participating facilities as discussed under the Meaningful Measures Initiative. Our assessment concluded that while the OP-27 measure continues to provide benefits these benefits are diminished by other factors and are outweighed by the significant cost of reporting this measure. As

this measure is included in the MIPS Program, we also expect that a portion of MIPS eligible clinicians nationwide will continue to report data on this measure. This measure is also included in the Hospital Inpatient Quality Reporting Program.

Our next measure proposed for removal is OP-5: Median Time to ECG beginning with the Calendar Year 2021 Payment Determination. We are proposing to remove this measure under our proposed Measure Removal Factor 8, "the cost of the measure outweighs the benefit of its continued use in the program." We believe OP-5 no longer meaningfully supports the program objective of informing beneficiary choice given that the variation in measure performance between hospitals is minimal with a difference in median time to ECG of less than two minutes between the 75th and the 90th percentile. This minimal variation in hospital performance does not help beneficiaries to make informed care decisions since it is difficult to distinguish meaningful differences in hospital performance on this measure. We believe that any cost to both facilities and CMS such as program oversight, measure maintenance, and public display associated with retaining this measure for use in making decisions about care outweigh the limited benefit associated with the measure's continued use in the program. Additionally, chart-abstracted measures are potentially more challenging for providers due to the need to access and interpret patient records, and we believe by removing this measure it would reduce program complexity.

In this proposed rule we are proposing to remove OP-29: Endoscopy/Polyp Surveillance: Follow-up Interval for Normal Colonoscopy in Average Risk Patients and OP-30: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use. Removal will begin with the Calendar Year 2021 and for subsequent years under Measure Removal Factor 8, the cost associated with a measure outweigh the benefits of its continued use in the program. The cost of collection and submission of chart-abstracted measure data is burdensome for facilities when taking into consideration the availability of another colonoscopy-related measure required in the program that does not require chart abstraction. The OP-32 measure is a claims-based measure and does not require chart abstraction methods. It similarly contributes data on quality of care related to colonoscopy procedures although the measure does not specifically track processes such as follow-up interval. We believe that by capturing only OP-32 facilities can avoid the burdens and costs associated with chart abstraction when reporting on measures for the same procedure. The potential effects of removing this measure are mitigated by the existence of the same measure for gastroenterologists in the Merit-Based Incentive Payment System or MIPS for the 2019 performance period in the QPP. The availability of this measure in other programs demonstrates CMS's continued commitment to this measure area. Beneficiaries may find it confusing as well to see public reporting on the same measure for different

programs. Furthermore, we seek to align our quality reporting work with the patients-over-paperwork and Meaningful Measures Initiative. The purpose of this effort is to ensure that CMS holds providers accountable for only the measures that are most important to patients and clinicians and those measures that are focused on patient outcomes in particular because outcome measures evaluate the actual results of care.

We are proposing to remove OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery beginning with the Calendar Year 2021 Payment Determination under our proposed Measure Removal Factor 8. We have come to believe that this measure is operationally difficult for facilities to collect and report. Specifically, we are concerned that the results of the survey used to assess the pre-operative and post-operative visual function of the patient may not be shared across clinicians and facilities making it difficult for facilities to have knowledge of the visual function of the patient before and after surgery. We are also concerned about the surveys used to assess visual function. The measure allows for the use of any validated survey, and results may be inconsistent should clinicians use different surveys. The high administrative costs of the technical tracking of this information presents an undo facility information collection burden, as well as, there is burden associated with submission and reporting of these data to CMS. When reviewing this measure, we became aware that it is overly burdensome for facilities to report this measure due to the difficulty of tracking care that occurs outside of the hospital outpatient department setting, and since making the measure voluntary, there were a low number of facilities reporting, comprising only 1.2 percent of facilities. As such, we have been unable to uniformly offer pertinent information to beneficiaries on how the measure assesses facility performance.

We are proposing the removal of OP-9: Mammography Follow-up Rates under measure Removal Factor 3, "a measure does not align with current clinical guidelines or practice" beginning with the 2021 Payment Determination. After review of the OP-9 measure specification against current clinical practice, we have found recent changes in clinical practice not incorporated into the measure calculation. These changes in clinical guidelines are due to the advancements in imaging technology and clinical practice. So, we are proposing to remove this measure under Measure Removal Factor 3 that the measure does not align with current clinical guidelines or practice. We intend to investigate re-specification of this measure and to consider it for adoption to the program through future rule-making, and we will consider ways to capture a broader more comprehensive spectrum of mammography services.

We are proposing removal of OP-11: Thorax CT – Use of Contrast Material and OP-14: Simultaneous Use of Brain Computed Tomography and Sinus CT beginning with the Calendar Year 2021 Payment Determination under Removal Factor 1, "measure performance among providers is so high and unvarying that

meaningful distinctions and improvements in performance can no longer be made." There is a statistically indistinguishable difference in hospital performance between the 75th and 90th percentile for both of these measures. We believe that removal is appropriate as there is little room for improvement, and removal of this measure would alleviate the maintenance costs and administrative burden to providers associated with retaining these measures. As such, we believe the burden associated with reporting these measures outweighs the benefits of keeping them in the program.

We are proposing the removal of OP-12 beginning for the Calendar Year 2021 Payment Determination under our Measure Removal Factor 2, "performance or improvement on a measure does not result in better patient outcomes." OP-12 is a structural measure that tracks the transmittal of data but does not directly assess quality or patient outcomes. Commenters have expressed concern that the measure only assesses HIT functionality and does not assess the quality of care provided. Therefore, we believe that provider performance in the measure is not an indicator for patient outcomes as one of the goals for the Meaningful Measures Initiative is to utilize measures that are outcome-based where possible. We do not believe OP-12 adds to these goals.

We are proposing to remove OP-17. If this measure removal is finalized, this would begin with the Calendar Year 2021 Payment Determination under our Measure Removal Factor 2, "performance or improvement on a measure does not result in better patient outcomes." OP-17 is a structural measure that tabulates only the ability for transmittal of data but does not directly assess quality or patient outcomes. Commenters expressed concern that the measure only assesses HIT functionality and does not assess the quality of care provided. Therefore, we believe that provider performance in the measure does not improve patient outcomes. Thus, like OP-12, we believe OP-17 does not meet the goals of the Meaningful Measures Initiative.

Measures and topics for future consideration: We seek to develop a comprehensive set of quality measures to be available for wide spread use for informed decision making and quality improvement in the hospital outpatient setting. Through future rule-making, we intend to propose new measures that help us further our goal of achieving better healthcare and improve health for Medicare beneficiaries who receive healthcare in hospital outpatient settings while aligning quality measures across the Medicare program to the extent possible.

We seek to develop a develop a comprehensive set of quality measures to be available for wide spread use for informed decision making and quality improvement in the hospital outpatient setting. Through current rule-making we are moving toward greater use of outcome measures and away from use of clinical process measures across our Medicare quality reporting and value-based

purchasing programs. We are inviting public comments on possible measure topics for future consideration in the Hospital Outpatient Quality Reporting Program. We are specifically requesting comment on any outcome measures that would be useful to add to the Hospital Outpatient Quality Reporting Program, as well as, any clinical process measures that should be eliminated from this program.

Now, let's move to review administrative requirements update.

In this proposed rule we are proposing to update our requirements related to the Notice of Participation or NOP form. Currently, participation in the Hospital Outpatient Quality Reporting Program requires that hospitals register on the QualityNet website before beginning to report data, identify and register a QualityNet Security Administrator, and to complete and submit an online participation form, the Notice of Participation or NOP form. In this proposed rule beginning with the Calendar Year 2020 Payment Determination we are proposing to remove the Notice of Participation as a requirement for the program. This form does not provide CMS with any necessary or unique information, and therefore, we believe it is unnecessary for hospitals to complete and submit it. We note that in place of the NOP form we are proposing that submission of program data would indicate a hospital status as a participate in the program. If our proposal is finalized as proposed, hospitals would no longer be required to submit this form according to previously finalized deadline.

In this proposed rule we are proposing to update the frequency with which we release program specifications manuals, such that, instead of every 6 months we would release specifications manuals every 6 to 12 months beginning with the Calendar Year 2019 Payment Determination and for subsequent years. We believe it can be confusing for participants if we unnecessarily release a manual more than once per year on a regular basis. Under this proposal we would release a specifications manual one to two times per calendar year depending on the need for an updated release and ensuring alignment with our policy to provide at least 6 months' notice for substantive changes.

In the Calendar Year 2015 OPPS/ASC Final Rule with a comment period, we finalized the adoption of OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy with public display to begin on or after December 1, 2017. We finalized a one-year reporting period believing it adequately balanced competing interest of measure reliability and timeliness for payment determination purposes, and we noted that we would continue to assess the length of the reporting period. However, after our dry run, CMS adopted the measure with separate calculations for hospital outpatient departments and ASCs. Under the dry run they were calculated together. During subsequent analyses of the one-year time period of July 2013 through June 2014 we confirmed that a one-

year reporting period with separate calculations for hospital outpatient departments and ASCs was sufficient, but it did result in lower reliability and decreased precision compared to these measures calculated from longer reporting periods. These results indicate that a larger portion of included facilities have scores measured with good reliability when 3 years of data are used rather than 1 year of data. We are proposing to change the reporting period for OP-32 from 1 year to 3 years beginning with the Calendar Year 2020 Payment Determination. This change would initially use claims data from January 1, 2016 through December 31, 2018. Under this proposal the annual reporting requirements for hospitals would not change because this is a claims-based measure. However, with a 3-year reporting period the most current year of data would be supplemented by the addition of 2 prior years.

To summarize these proposals, listed here are the claims-based measures for this program. We are proposing removal of OP-9, -11, and -14 all beginning with the Calendar Year 2021 Payment Determination.

On this slide we have the web-based measures listed. We are proposing to remove OP-12, -17, -27, -29, -30, and -31. All but one measure are proposed for removal beginning with the Calendar Year 2021 Payment Determination. OP-27, as noted here, is proposed to be removed beginning with the Calendar Year 2020 Payment Determination.

With respect to the clinical chart-abstracted measures, OP-5 is being proposed for removal beginning with the Calendar Year 2021 Payment Determination. So now, we've gone through and talked about all of our proposals in this rule-making for the Hospital Outpatient Quality Reporting Program. Let's discuss how you can be involved in this decision-making process.

Your feedback commenting is very important. We want to know what you think about these proposals. The comment process provides the opportunity to be involved in the program development process. Next, I will show you how to submit your comments to CMS.

Comments can be submitted using various methods including electronic, regular mail, express or overnight mail, as well as, by hand or courier. The deadline for all comments to be received is no later than the times listed for each submission venue on September 24, 2018. Please refer to the Proposed Rule for the necessary addresses, and keep in mind that you must send in your comments so that your comments are received by the deadline. We encourage the electronic submission of comments using regulations.gov. Responses to comments will be published in the Final Rule which is scheduled for display on or before November 1, 2018, and I do have a direct link on this slide to the comment page. If you were to enter this link, you will be able to submit your comments to CMS. And that's all I have for you today regarding our Proposed Rule for the Hospital Outpatient Quality

Reporting Program contained in the Calendar Year 2019 OPPS/ASC Proposed Rule. I will now turn things back over to Karen.

Thank you, Anita, for all that great information that you provided to us today. Again, we do have quick links here on the Proposed Rule, as well as, the direct link to the comment area. Let me just mention that if you want to use this direct link, you have to either download the document or put this address in your web browser.

Karen VanBourgondien: Anita, we have just a few minutes, and I've seen a trend that there are a few questions that we have gotten from several people, so I wonder if you wouldn't mind answering some questions in these last few minutes that we have?

Anita Bhatia: That would be great.

Karen VanBourgondien: Okay, the first question is about OP-5, and the person is wanting to know if OP-5 is finalized for removal, when would we stop reporting that?

Anita Bhatia: That's a great question. OP-5: Median Time to ECG**,** if finalized, would be removed beginning with the Calendar Year 2021 Payment Determination. You would continue to abstract and submit data quarterly through the end of Quarter 1 2019 which has the submission deadline of August 1, 2019. You would report this quarter because it is the last quarter for chart-abstracted data required for the Calendar Year 2021 Payment Determination.

Karen VanBourgondien: Thank you Anita, appreciate that clarification. Also, a number of people are inquiring about the colonoscopy measures, and they want to know why these measures are being proposed for removal?

Anita Bhatia: Well, this is another good question. We have proposed removing these colonoscopy measures as this program has another measure, OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy, which we believe is able to reduce adverse patient outcomes associated with colonoscopies. Removing the OP-29 and OP-30 colonoscopy measures would reduce burden and cost to facilities associated with the collection of information and reporting on their performance associated with the measure. Additionally, some of the benefits of keeping these measures in the program are mitigated by the existence of the same measure being reported in another CMS quality reporting program, the Merit-Based Incentive Payment System or MIPS for clinicians.

Karen VanBourgondien: Thank you Anita. And probably another popular question is, since the Notice of Participation may no longer be required, how will we let CMS know that we are participating in the program?

Anita Bhatia: Well, Karen, I can see why hospitals might be concerned about this. If the Notice of Participation form is no longer required, hospitals would let us know if they are participating in the program by submitting any Hospital Outpatient Quality Reporting Program data, even a single data element. Hospitals will need to register on the QualityNet website, designate and register a Security Administrator, and submit data. This change would begin with the Calendar Year 2020 Payment Determination if finalized, and, to be clear, this change primarily affects new hospitals. Those hospitals already enrolled remain enrolled.

Karen VanBourgondien: Thank you Anita very much. I think that's all the time we have. Thank you very much for taking the time to go over some questions and presenting all of this information. As a reminder, if your question did not get answered for some reason in the chat box, we do post all the questions and the answers on our website at qualityreportingcenter.com. We appreciate everybody joining us today.