Outpatient Quality Program Systems and Stakeholder Support Team

Making the Case: The CY 2024 Hospital OPPS/ASC Proposed Rule

Presentation Transcript

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Karen VanBourgondien: Hi everyone. My name is Karen VanBourgondien. Thanks for joining us today. CMS will be discussing the proposed rule and the impacts on both the Hospital Outpatient Quality Reporting Program as well as the Rural Emergency Hospital Quality Reporting Program.

Our speakers today are Kimberly Go and Anita Bhatia. Kimberly Go is the Hospital OQR Program Lead and joined CMS' Clinical Standards and Quality in late 2022, where she served as Task Lead for the Electronic Prescribing for Controlled Substances Program and the Quality Measure Index. She previously worked in the Center for Medicare where she gained experience in rulemaking and policy development for the Inpatient Prospective Payment System. Anita is the CMS Program Lead for the Rural Emergency Hospital Quality Reporting Program. She received her PhD from the University of Massachusetts Amherst and her Masters in Public Health from Johns Hopkins University. Dr. Bhatia plays a crucial role in the development of the OPPS/ASC proposed and final rulings. Her contributions to these rulings are essential to the continuing success of these programs. We are fortunate to have Dr. Bhatia's commitment. So, before we get started, let me just cover a couple of housekeeping items here.

The objectives today are here on the slide. We will again cover proposals as they relate to the Hospital OQR Program as well as the REHQR Program. We also are going to talk about any requests for comments that were put forth and we are going to discuss how to comment. If you need the slides, you can just click on the paper icon that's located on your screen. We'll also have the slides posted on QualityReportingCenter.com. And we will put the link in the chat box as well.

I'd like to make certain that the content covered on today's call should not be considered official guidance. This webinar is only intended to provide information regarding program requirements. Please refer to the proposed rule, located in the *Federal Register*, to clarify and provide a more complete understanding of the modifications and proposals for the program which CMS will be discussing today. We have placed the direct link to this document here on the slide and we will put it in the chat box as well. So, without any further delay, let me hand things over to our first speaker, Kimberly Go. Kim?

Kimberly Go: Thank you, Karen. Today I will be covering our proposals for calendar year 2024 as they relate to the Hospital OQR Program. I will be summarizing these proposals and it is highly recommended that you read the proposed rule as referenced in the previous slide for additional details.

In the first section, we will cover proposals for measures that were previously adopted into the OQR Program.

In this proposed rule, we have proposals for four measures currently part of the Hospital OQR Program which are seen here on the slide. We are proposing to modify four previously adopted measures; the COVID-19 measure; the cataract measure; the colonoscopy measure; and the Median Time for Discharged ED Patients. We are also proposing to remove the Left Without Being Seen measure which we will discuss later on.

First is the COVID-19 measure. We are proposing to modify the term "up to date" in the HCP vaccination definition beginning with the calendar year 2024 reporting period for calendar year 2026 payment determination. We propose to adopt the same modification to versions of the measure that we have adopted for other quality reporting programs. Additionally, we are proposing that public reporting of the modified version of the measure would begin with the fall 2024 refresh, or as soon as technically feasible. The term "up to date" is defined as meeting the CDC's set of criteria on the first day of the applicable reporting quarter. We are proposing to update the numerator to specify the time frames within which an HCP is considered up to date with CDC recommended COVID-19 vaccines, including booster doses. You can find the guidance on "up to date" on the NHSN website.

Next is the OP-29 measure, Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients. We are proposing a modification to align with current clinical guidelines beginning with the calendar year 2024 reporting period for calendar year 2026 payment determination.

Based on the recent changes in clinical guidelines to begin CRC screening at age 45 instead of age 50, we are proposing to modify the measure's denominator language by replacing the phrase "aged 50 years" with the phrase "aged 45 years."

The measure denominator would be modified to "all patients aged 45 years to 75 years receiving screening colonoscopy without biopsy or polypectomy." We are not proposing any changes to the measure numerator, other measure specifications, exclusions, or data collection for the Colonoscopy Follow-Up Interval measure.

Last is our modification related to Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery. We have considered comments we have received on this measure, and we agree that survey instruments for the assessment of visual function pre- and post-cataract surgery should be clarified in order to standardize acceptable survey instruments while minimizing collecting and reporting burden and to improve measure reliability. As a result, we are proposing a modification to the specific survey instruments to be used for the assessment of visual function pre- and post- cataract surgery beginning with the calendar year 2024 reporting period for calendar year 2026 payment determination. As a reminder, this measure is still a voluntary measure for this program. The allowable survey instruments are seen here on the slide. We recommend the patient's physician or optometrist administer, collect, and report the survey results, and the survey instruments required for this measure can be administered by the hospital itself via phone, by the patient via regular or electronic mail, or during clinician follow-up. Scientific literature supports that self-administered survey instruments produce statistically reliable results. The inclusion of both options ensures that patients will be able to respond to survey instruments in their preferred format.

Additionally, we are proposing to modify public reporting processes for Median Time from ED Arrival to ED Departure. This is a chart-abstracted measure that evaluates the time between the arrival to and departure from the ED, also known as ED throughput time. The Median Time for Discharged ED Patients measure is calculated in stratified subsections for certain types of patients. Currently, measure data for the Overall Rate are not reported publicly on the Care Compare site. We believe displaying all strata will highlight and prioritize various issues in the healthcare system, specifically behavioral health and continuum of care. We propose to make data publicly available on our Care Compare website and in downloadable data files found at data.cms.gov for the measure strata: Median Time for Discharged ED Patients-Transfer Patients and the Median Time for Discharged ED Patients-Overall Rate which contains data for all patients beginning with calendar year 2024.

Finally, we are proposing to remove the existing measure, Left Without Being Seen. Over the last few years, through our routine measure monitoring and evaluation, we believe the Left Without Being Seen measure does not provide enough evidence to promote quality of care and improved patient outcomes to justify retaining the measure in the Hospital OQR Program. Based on these findings, we are proposing to remove this measure beginning with the CY 2024 reporting period for the CY 2026 payment determination under measure removal Factor 2, which is

performance or improvement on a measure does not result in better patient outcomes.

Let us move on to our next section which covers proposals to add new measures to the OQR Program.

We are proposing to re-adopt, with modification, the original Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures, as well as proposing to adopt the THA/TKA PRO–PM and Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults measure. Before we move on, let me provide some background. Hospital care has been gradually shifting from inpatient to outpatient settings. Research indicates that volume of services performed in hospital outpatient departments will continue to grow. In light of these trends in facility volume and more recent studies finding that volume is an indicator of quality, it is now especially important to track volume within hospital outpatient departments, as it could provide valuable insight into the quality of hospital outpatient department services for CMS and patients. Elective THA and TKA are most commonly performed for degenerative joint disease or osteoarthritis, which affects more than 30 million Americans. However, not all patients experience benefit from these procedures. Many patients note that their pre-operative expectations for functional improvement have not been met. Regarding our proposal for the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults electronic clinical quality measure there is a large body of research that suggests that exposure to ionizing radiation within the same range that is routinely delivered by CT scans increases a person's risk of developing cancer.

So, as discussed previously, we are proposing to re-adopt with modification the Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures measure with voluntary reporting in the calendar year 2025 reporting period followed by mandatory reporting beginning with the calendar year 2026 reporting period for calendar year 2028 payment determination. A volume measure was a part of the Hospital OQR Program, previously. At that time, hospitals would report all-patient volume data with respect to six categories: Gastrointestinal, Eye, Nervous System, Musculoskeletal, Skin, and Genitourinary. This proposed re-adoption will have two modifications.

The first modification in this proposal is that the measure data collection will cover eight categories: Cardiovascular, Eye, Gastrointestinal, Genitourinary, Musculoskeletal, Nervous System, Respiratory, and Skin.

The data publicly displayed will be from the top five most frequently performed procedures within each category. The second modification to this measure is that instead of collecting and publicly displaying data surrounding these eight broad categories, we would collect and publicly display data reported for the top five most frequently performed procedures among hospitals within each category. We propose that hospitals submit these data to CMS during the time period of January 1st to May 15th in the year prior to the affected payment determination year via the Hospital Quality Reporting system. Data received through the HQR system would then be publicly displayed on the Care Compare website or another CMS website after a 30-day preview period. We would assess and update the top five procedures in each category on an annual basis, as needed.

Next, as previously discussed, we are proposing to adopt the THA/TKA PRO-PM with voluntary reporting beginning with the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2027 reporting period for CY 2030 payment determination. As seen on the table here, the mandatory reporting will use eligible elective outpatient procedures occurring between January 1, 2027, through December 31, 2027, for payment determination covering CY 2030 and subsequent years. Because this proposed measure requires collection of data during the three-month pre-operative period and the greater than one-year post-operative period, there is a delay between when the elective THA/TKA procedures actually occur and when the results would be reported under the OQR Program, and when payment determinations occur. Therefore, we are proposing a three-year gap between the reporting period and the payment determination. Let me go over these specifics in a little more detail.

The THA/TKA PRO-PM measure reports the facility-level risk-standardized improvement rate in PROs following elective primary THA/TKA. It will include Medicare Fee-for-Service beneficiaries aged 65 years and older who were enrolled in Medicare Fee-for-Service Part A and B for the 12 months prior to the date of the procedure and in Medicare Fee-for-Service Part A and B during the procedure. The measure includes only elective primary outpatient THA/TKA procedure. That is, patients with fractures and revisions are not included. The measure excludes patients with staged procedures that occur during the measurement period and excludes discontinued procedures that is, procedures that were started but not completed.

The THA/TKA PRO–PM uses four sources of data for the calculation of the measure: PRO data; claims data; Medicare enrollment and beneficiary data; and U.S. Census Bureau survey data.

The measure uses PRO data directly reported by the patient regarding their health, quality of life, or functional status associated with their healthcare or treatment. This patient reported-data are collected by facilities pre-operatively and post-operatively, and limited patient-level risk factor data are collected with PRO data and identified in claims. For risk-adjustment by pre-operative mental health score, hospitals would submit one of two additional PRO instruments, all the items in either the Patient Reported Outcomes Measurement Information System, Global Mental Health subscale; or the Veterans RAND 12-Item Health Survey Mental Health subscale. The goal is to capture the patient's self-assessment of their pain and function and measure their improvement following their THA/TKA. This will use patient voice in the measure outcome and directly captures the results of their THA/TKA. You can access additional specifications at CMS Quality Initiatives sites.

For this measure, clinical improvement is measured by a pre-defined score on one of two joint-specific PRO instruments—the HOOS, JR for completion by THA recipients and the KOOS, JR for completion by TKA recipients. Improvement is measured from the pre-operative assessment and data will be collected 90 to 0 days before surgery to the post-operative assessment when data will be collected 300 to 425 days following surgery. Improvement scores are risk-adjusted to account for differences in patient case-mix. The measure, as proposed, accounts for potential non-response bias in measure scores through inverse probability weighting based on likelihood of response. We propose that hospitals would be required to submit 50 percent of eligible, complete pre-operative data with matching eligible, complete post-operative data as a minimum amount of data for mandatory reporting in the Hospital OQR Program.

While we do not propose to publicly report the data we receive during the voluntary reporting periods, we are proposing to publicly report which facilities choose to participate in voluntary reporting and the percent of pre-operative data submitted by participating facilities for the first voluntary reporting period, as well as their percent of pre-operative and post-operative matched PRO data submitted for subsequent voluntary reporting periods. We intend to provide hospitals with their results in calendar year 2030 before publicly reporting results on the Compare website. We would provide confidential feedback reports during the voluntary period.

Lastly, we are proposing the Excessive Radiation eCQM, beginning with the voluntary calendar year 2025 reporting period where hospitals submit up to all four quarter(s) of data.

Mandatory reporting will begin with the calendar year 2026 reporting period for calendar year 2028 payment determination where hospitals report two self-selected calendar quarters of data for the Excessive Radiation eCQM. What this means is, beginning with the calendar year 2027 reporting period for calendar year 2029 payment determination, we propose to require hospitals to report all four calendar quarters, that is one calendar year of data. We will take a closer look at this in just a moment. We believe that aligning the schedule with the new STEMI eCQM measure will allow for a seamless transition from voluntary to mandatory reporting of all calendar quarters.

You can see on the slide here, the reporting requirements beginning with the voluntary reporting period at the top. For the calendar year 2026 reporting period for calendar year 2028 payment determination, hospitals must report two self-selected quarters of data and would be required to submit eCQM data by May 15, 2027. Hospitals would then report all four quarters the following year. We believe that a phased implementation approach would allow facilities the ability to make the necessary adjustments for data submission over time and would produce more comprehensive and reliable quality measure data for patients and providers. We also propose to require Excessive Radiation eCQM data submission by May 15 in the year prior to the affected payment determination year.

The measure numerator of the Excessive Radiation eCQM is diagnostic CT scans that have a size-adjusted radiation dose greater than the threshold defined for the specific CT category. The threshold is determined by the body region being imaged and the reason for the exam, which affects the radiation dose and image quality required for that exam. The numerator also includes CT scans with a noise value greater than a threshold specific to the CT category. The measure denominator is all diagnostic CT scans performed on patients ages 18 and older during the one-year measurement period which have an assigned CT category, a size adjusted radiation dose value and a global noise value. The measure excludes CT scans that cannot be categorized by the area of the body being imaged or reason for imaging. These include scans that are simultaneous exams of multiple body regions outside of four commonly performed multiple region exams defined by the measure, or scans that cannot be classified based on diagnosis and procedure codes. Measure specifications can be found at the web address here on the slide.

The Excessive Radiation eCQM uses hospitals' electronic health record data and radiology electronic clinical data systems, including the Radiology Information System, or RIS, and the Picture Archiving and Communication System, or PACS.

Hospitals may choose to use any available software which performs the necessary functions to comply with measure requirements. Hospitals and their vendors would be able to use the data elements created by this software to calculate the eCQM and to submit results to the Hospital OQR Program via Quality Reporting Document Architecture Category I files as they do for all other eCQMs.

We have one administrative proposal, and that is to replace "QualityNet" with "CMS-designated information system" or "CMS website." This is to accommodate recent and future systems requirements and mitigate confusion for program participants.

In addition to our proposals, we also seek public comment on potential measurement topic areas for the Hospital OQR Program.

This request for comment seeks input on innovative measurement approaches and data sources for use in quality measurement to inform our work and, more specifically, the focus of measure development within the Hospital OQR Program. We identified three potential priority areas and encourage the public to review and provide comment. We are also seeking public comment to address quality measurement gaps in the hospital outpatient department setting, including the emergency department; changes in outpatient care (such as shifts in volume, technology use, and case complexity); growth of concerns around workforce and patient safety; the transition to digital quality measurement; and interest in patient-reported outcomes. Specifically, we seek comment on quality measurement topics for the Hospital OQR Program that include promoting Safety (Patient and Workforce); Behavioral Health; and Telehealth.

With respect to workplace safety. We are particularly interested in sepsis care for potential future inclusion in the Hospital OQR Program as a patient safety measure. Preventing, diagnosing, and treating sepsis effectively has been a focus of patient safety in recent years. We also believe quality measures should align, to the extent possible, across CMS programs to minimize reporting burden. For instance, as the inpatient program adopted a Sepsis measure, we are requesting comment on whether this measure would be appropriate and feasible for use in the Hospital OQR Program, as well as whether CMS should consider adopting an alternative measure that assesses the quality of sepsis care in the hospital outpatient setting. We are also requesting comment on additional topics such as safety outcome priorities specific to settings, services, transitions and transfers, and access to care; general cross-outpatient setting outcomes; individual harms, including methodological approaches to patient identification and data collection, technological-derived harm,

and use of electronic resources to mitigate potential for harm; and, of course, workforce safety.

Regarding technological-derived harm, as new technology becomes available and is used more widely, such as artificial intelligence for diagnoses, robotic surgery, and electronic health records, there is a potential for these technologies or their application to cause harm to patients.

We are also requesting comment on behavioral healthcare in the outpatient setting, which comprises a vast array of services for patients with a wide range of conditions. We are particularly interested in measuring suicide screening in the hospital outpatient setting to improve early risk detection and facilitate appropriate behavioral health treatment.

We also seek broad input on behavioral health as a measurement topic area of priorities for measuring outcomes of outpatient behavioral health services, particularly by setting.

Lastly is Telehealth. Telemedicine has the potential to improve patient experience, outcomes, and access to healthcare. It is also associated with cost-savings for both patients and healthcare systems. Utilization expanded greatly in the outpatient setting during the early months of the pandemic. The number of outpatient visits conducted via telehealth has since declined but remains higher than pre-pandemic levels. There are also known disparities in the effectiveness of telehealth and its impact on outcomes as certain populations lack access to internet and digital devices, or lack familiarity with technology. For the Hospital OQR Program, we are considering a measure focused on telehealth. We seek input from interested parties on the following topics: inclusion and prioritization of areas of telehealth-related care, and in particular, those priority topic areas discussed addressing quality gaps in outpatient telehealth-related care, including across hospital outpatient department settings and services; capturing utilization, disparities resulting from utilization of telehealth-related care for outpatient settings and services; and understanding patient experience with outpatient telehealth services.

That completes my review of these proposals. Let me turn things back over to my colleague, Anita, to discuss the REHQR Program.

Anita Bhatia: Thank you, Kim. Rural Emergency Hospitals are a new Medicare provider type. In general, small rural hospitals with 50 or fewer beds and Critical Access Hospitals can convert to REH status. Here, we are only going to discuss proposals regarding the implementation of the new quality reporting program for Rural Emergency Hospitals.

The Rural Emergency Hospital Quality Reporting Program's overarching goals are to improve the quality of care provided to Medicare beneficiaries, facilitate public transparency, ensure accountability, and safeguard the accessibility of facilities in rural settings. We are continuing foundational work in this proposed rule through the proposal of policies that align with our other outpatient quality reporting programs, the hospital outpatient and the ASC quality reporting programs. Importantly, we are also proposing initial quality measures for this program. We will be looking at an overview of this program's proposals. Let's begin our discussion with proposed codifications for the program.

So why are we talking about something called codification? To establish the program in the Code of Federal Regulations, we must codify program requirements. This supplies legal basis and requirements for the program in Federal Regulation text. So, what is being proposed? Here on this slide is a listing of measure-related policies being proposed, all in alignment with our other outpatient quality reporting programs. First, we are proposing to codify the statutory authority for the Rural Emergency Hospital Quality Reporting Program to implement a quality reporting program requiring Rural Emergency Hospitals to submit data on measures to the Secretary, as is specified in the authorizing statute. Second, we propose to codify a measure retention and removal policy, which has a few parts. Quality measures would be adopted into the Rural Emergency Hospital Quality Reporting Program measure set until such time that such measures are proposed for removal, suspension, or replacement. When there is reason to believe that the continued collection of a measure raises potential patient safety concerns, we believe it would be appropriate for us to take immediate action to remove the measure from the Rural Emergency Hospital Quality Reporting Program outside of rulemaking. Therefore, we propose to adopt an immediate measure removal policy that would allow us to promptly remove such a measure and notify Rural Emergency Hospitals and the public of the decision to remove the measure through standard hospital communication channels. We also propose to confirm the removal of the measure in the next appropriate rulemaking, typically an Outpatient Prospective Payment System, or OPPS, rulemaking cycle. If there is no immediate cause for concern, we would use rulemaking to remove, suspend, or replace quality measures in the Rural Emergency Hospital Quality Reporting Program using the measure removal, suspension, or replacement through the rulemaking process. We propose to adopt eight factors to determine conditions for measure removal from the program.

Measure removal factors are noted here on the slide. For Factor 1, this simply relates to when measures are considered topped out. That is, that measure performance is high and does not vary much. This Factor would

be used when the difference between the 75th and 90th percentiles for a Rural Emergency Hospital measure is within two times the standard error of all measure data reported for all Rural Emergency Hospitals. Additional Factors 2-8 for measure removal are listed here. We also propose to assess the benefits of removing a measure from the Rural Emergency Hospital Quality Reporting Program on a case-by-case basis. A Rural Emergency Hospital Quality Reporting Program measure would not be removed solely based on meeting any specific factor.

Let's talk a little more about sub-regulatory and non-substantive and how it relates to our measure update policy. To set the stage, these changes are ultimately incorporated into something familiar to many of you. A specifications manual. So, we propose a policy under which we would use a sub-regulatory process to make non-substantive updates to measures adopted for the Rural Emergency Hospital Quality Reporting Program. We propose that when there is an update to a measure that we believe does not substantially change the nature of the measure, we would use a sub-regulatory process to incorporate those updates to the measure specifications that we apply to the program. So, when we say sub-regulatory, we mean will not be going through rulemaking. Examples of non-substantive changes to measures might include updated diagnoses or procedure codes, such as annual CPT updates. Substantive are those where the changes are so significant that the measure is no longer the same measure. An example being the age range change for the colonoscopy measure that Kim discussed. We also proposed that we would utilize rulemaking, i.e., regulatory processes to adopt substantive updates to measures previously adopted under the Rural Emergency Hospital Quality Reporting Program. With respect to what constitutes substantive versus non-substantive changes, we expect to make this determination on a case-by-case basis.

We would revise the specifications manual to clearly identify any updates and would provide sufficient lead time for Rural Emergency Hospitals to implement the revisions where changes to the data collection systems would be necessary. We would also provide notification of the measure specification updates on a designated website, currently the *QualityNet* website.

In case you have been looking, we will develop a specifications manual that will provide the complete and current technical specifications and abstraction information for quality measures utilized in the Rural Emergency Hospital Quality Reporting Program.

Now that we have talked about some program basics, let's move our focus to the measures for the program. As we stated in the calendar year 2023

OPPS/ASC final rule, we seek to adopt a concise set of important, impactful, reliable, accurate, and clinically relevant measures for Rural Emergency Hospitals that would inform consumer decision-making regarding care and drive further quality improvement efforts in the Rural Emergency Hospital setting.

We recognize Rural Emergency Hospitals will be smaller hospitals that will likely have limited resources compared with larger hospitals in metropolitan areas. For the Rural Emergency Hospital Quality Reporting Program, we intend to seek balance between the costs associated with reporting data and the benefits of ensuring safety and quality of care through measurement and public reporting.

We propose to adopt four measures in this proposed rule that are currently adopted and part of the Hospital Outpatient Quality Reporting Program for the Rural Emergency Hospital Quality Reporting Program: (1) Abdomen Computed Tomography, or CT - Use of Contrast Material; (2)) Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery; (3) Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy; and (4) Median Time from ED Arrival to ED Departure for Discharged ED Patients for the Rural Emergency Hospital Quality Reporting Program measure set. And, again, all of these measures are currently part of the Hospital OQR Program. As these are all current Hospital OQR measures, you may already know a lot about them. But a review of them, and why we selected them for potential adoption for the REH Quality Reporting Program may be helpful.

One important consideration is that, based on data analysis of the January 2023 Care Compare refresh, we saw that a relatively high percentage of the hospitals eligible to convert to Rural Emergency Hospital status have reported aggregated measure data in sufficient number for public reporting. We view public reporting of Rural Emergency Hospital data to be very important in selecting measures for the program. Let’s discuss each of these proposed measures.

Beginning with Abdomen CT - Use of Contrast Material. A CT study performed with and without contrast increases the radiation dose to patients, exposing them to the potential harmful side effects of the contrast material itself and it is often unnecessary. We believe that the Abdomen CT measure is relevant for REH quality reporting. This measure is fully calculated from Medicare Fee-for-Service claims and enrollment data, so there is no data collection burden for Rural Emergency Hospitals for this measure.

We are proposing adoption beginning with the calendar year 2024 reporting period as this measure is claims-based and Rural Emergency Hospitals likely are already familiar with this measure. The measure would be calculated based on a 12-month window of claims data. For this measure, lower scores indicate less usage of CT scanning as scans, which means a high-performing facility reports a value nearer to zero, whereas facilities that may be performing too many combined CT abdomen studies, their score would be closer to 100 percent. This measure provides the percentage of CT abdomen and abdominopelvic studies performed with and without contrast out of all CT abdomen studies performed, those without contrast, those with contrast, and those with both.

We also propose to adopt the Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy Measure beginning with the calendar year 2024 reporting period, also a claims-based measure that is a current Hospital OQR Program measure. In alignment with the reporting period for this measure as used in the Hospital OQR Program, the initial reporting period is a three-year period. We believe this could be an important measure for those Rural Emergency Hospitals that elect to provide outpatient services and for patients seeking information regarding complications following this procedure.

Next is our proposal for the Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery measure. Another current Hospital OQR measure that is claims-based. This measure does not include colonoscopy–those procedures are considered in the measure just discussed–or, eye procedures. We are proposing reporting will begin with the calendar year 2024 reporting period. This measure calculation includes eligible outpatient same-day surgeries occurring within a 1-year time frame. We also considered increasing the data collection time period, to account for low case volume, moving to a two- or three-year data collection time period. This measure would make unplanned patient hospital visits, which includes ED visits, observation stays, or unplanned inpatient admissions, after outpatient surgery more visible to providers and patients through publicly reporting scores. It could also encourage providers to engage in quality improvement activities to reduce these visits by providing feedback to facilities and physicians.

Next is for the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients measure, which we are proposing to adopt again beginning with the calendar year 2024 reporting period. Unlike the other measures discussed, this is a chart-abstracted measure. This measure evaluates the time between the arrival to and departure from the ED, also known as ED throughput time. Reducing the time patients remain in the emergency department can improve access to

treatment and increase quality of care. And this metric is of interest to patients and other stakeholders.

With regard to public reporting for the proposed Median Time from ED Arrival to ED Departure for Discharged ED Patients measure; currently, for the Hospital OQR Program, only data for two out of the four strata for this measure are reported publicly. Kim discussed this earlier during the Hospital Outpatient Quality Reporting section of this presentation. However, we believe publicly reporting measure data for more of the strata are important for the Rural Emergency Hospital Quality Reporting Program. Thus, we are proposing to make publicly available data received from Rural Emergency Hospitals and calculate the following measure strata for the Median Time for Discharged ED Patients measure. And these are listed on the slide and are contained in the current measure specifications under the Hospital OQR Program. To clarify, the Median Time for Discharged Patients reporting measure includes patients excluding those that are in strata 3 and 4.

We are proposing that data for this measure would be submitted via the HQR system as is done for the Hospital Outpatient Quality Reporting Program. In developing this proposal, we also considered proposing that Rural Emergency Hospitals submit data for this measure on an annual, rather than quarterly, basis to help reduce burden for Rural Emergency Hospitals participating in the Program. However, we note that Rural Emergency Hospitals would have been reporting this measure on a quarterly basis under the Hospital Outpatient Quality Reporting Program and would, thus, be acclimated to this reporting frequency. Therefore, to enhance alignment between programs, we propose a similar data submission frequency that is on a quarterly basis. Our proposed dates of deadlines for submitting chart-abstracted measure data for this measure for the Rural Emergency Hospital Quality Reporting Program are seen here on the slide.

So, to continue with some codification, in last year's rule cycle, we finalized foundational administrative requirements for Rural Emergency Hospitals participating in the Rural Emergency Hospital Quality Reporting Program. In that rule, we finalized to require Rural Emergency Hospital to register on a CMS website before beginning to report data and to identify and register a Security Official as part of that registration process. We also finalized to require Rural Emergency Hospitals to submit data on all quality measures to CMS. We now propose to codify these participation requirements.

While we are talking about data, we can discuss some details of the public display of the data. Again, these proposals are in alignment with current

policies under our outpatient quality reporting programs. We propose to make publicly reported data under the Rural Emergency Hospital Quality Reporting Program available to the public, both on our Care Compare website and in downloadable data files, beginning with measure data submitted relevant to services provided in calendar year 2024. We also propose that participating Rural Emergency Hospitals would be granted the opportunity to review their data before the information is published during a 30-day review and corrections period. As in other programs, we would announce the time frames for the preview period. Additionally, we propose that data Rural Emergency Hospitals submits would be made publicly available by a CMS Certification Number, or CCN, for that Rural Emergency Hospital on a CMS website in an easily understandable format after providing the Rural Emergency Hospital an opportunity to review the data to be made public. We also propose that submission deadlines by measure and by data type will be posted on a CMS website.

So, regarding the review and corrections period, if a Rural Emergency Hospital submits data for a measure, and later discovers or suspects the data provided were not accurate, the Rural Emergency Hospital may need to submit corrected data. To address this need, we propose to adopt the same review and corrections policies currently in place for the Hospital Outpatient Quality Reporting Program. Under the Hospital Outpatient Quality Reporting Program, hospitals submit chart-abstracted data to CMS on a quarterly basis. These data are typically due approximately four months after the quarter has ended. A Rural Emergency Hospital may review and submit corrections to measure data submitted for a period of four months after the reporting quarter has ended. We also propose to codify this policy. Hospitals are encouraged to submit data early in the submission schedule so that they can identify errors and resubmit data before submission deadlines. Hospitals can continue to review, correct, and change these data up until the close of each submission deadline. However, after the submission deadline, hospitals would not be allowed to change these data. Under the Hospital OQR Program, we generally provide rates to hospitals for the measures that have been submitted for chart-abstracted, patient-level data 24 to 48 hours following submission deadline.

Extraordinary Circumstances Exceptions, or ECE process. In our experience, there have been times when facilities have been unable to submit information to meet program requirements due to extraordinary circumstances that are not within their control. It is our goal not to penalize hospitals for such circumstances and we do not want to unduly increase their burden during these times.

As with our other outpatient quality reporting programs, we propose an Extraordinary Circumstances Exceptions (ECE) process for Rural Emergency Hospitals to request and for CMS to grant extensions or waivers with respect to the reporting of required quality data when there are extraordinary circumstances beyond the control of the Rural Emergency Hospital. Under this proposed process, CMS may grant an exception to one or more data submission deadlines and requirements in the event of extraordinary circumstances beyond the control of the Rural Emergency Hospitals, such as when an act of nature or a systemic problem with one of CMS' data collection systems. We propose that CMS may grant an extension or waiver upon request by an REH, pursuant to specific requirements for submission of a request for an extension or waiver. In addition, we propose that CMS may grant waivers or extensions at its own discretion, without an accompanying request from an affected Rural Emergency Hospital, when CMS determines that an extraordinary circumstance has occurred.

We have several requests for comment on Rural Emergency Hospital Quality Reporting Program Measures and Topics for Future Consideration.

To begin, we requested comment on electronic clinical quality measures, or eCQMs. We believe that certain eCQMs, if adopted into the Rural Emergency Hospital Quality Reporting Program, could provide insightful quality measure data for monitoring REHs and potentially lower provider burden. For example, the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults eCQM, referred to as the Excessive Radiation eCQM, could be adopted to improve patient outcomes and patient safety. We proposed adoption of the Excessive Radiation eCQM for the Hospital Outpatient Quality Reporting Program which we discussed earlier in the presentation. Additionally, as part of future rulemaking, we may consider adding measures to the Rural Emergency Hospital Quality Reporting Program measure set that are relevant to the coordination of care between Rural Emergency Hospitals and other kinds of healthcare providers. Rural Emergency Hospitals encounter challenges in coordinating care that are specific to rural settings. We invite public comment on the use of care coordination measures including telehealth measures and any specific measures that we should consider for inclusion in the Rural Emergency Hospital Quality Reporting Program measure set regarding care coordination, and any considerations or criteria we should use in determining which, if any, coordination of care measures to propose for future inclusion.

Additionally, we are requesting comment on a tiered approach framework, to provide Rural Emergency Hospitals an ability to select measures for reporting.

In the calendar year 2022 OPPS/ASC proposed rule, we included a request for information, and we received more than 50 comments in response, including one suggestion to implement a multi-tiered approach for quality measures and reporting requirements to incentivize Rural Emergency Hospital reporting. Within such a tiered framework, Tier 1 could include a set of measures that would be required for all Rural Emergency Hospitals and would focus on measures applicable for the required ED and observation services at Rural Emergency Hospitals. Tier 2 could apply only to Rural Emergency Hospitals that choose to provide additional outpatient services; the measures in that set would be related to the optional services provided. We invite public comment on all of these proposals and requests. This concludes my discussion on the proposals and requests for comment on the Rural Emergency Hospital Quality Reporting Program.

Comments. Public comments are essential to the rulemaking process. We truly want your feedback and comments on our proposals.

For details on how to comment, I will now turn things back over to Karen.

Karen VanBourgondien: Thank you, Anita.

To be assured consideration, comments must be submitted no later than September 11th. CMS cannot accept comments by fax and does encourage submission of comment by electronic means. You can also submit comment via regular mail, express mail, things like that; however, there are separate addresses for those types of mail-in responses. You will have to resource the specified addresses which are found in the proposed rule. Please allow time for any mailed comments to be received before the close of the comment period.

Again, the proposed rule can be found in the *Federal Register*, and we have the direct link here on the slide if you have them downloaded. We will also put the link in the chat box. If you prefer a PDF copy, we also have a link for that version. The Hospital OQR Program specifically begins on page 222 of the PDF version. The REHQR Program begins on page 274.

So, when you access the *Federal Register* link, you will be directed to the exact location of the rule in the *Federal Register* and your page will look

like this. To begin the commenting process, select the green **Submit a Formal Comment** box.

This will direct you to where you are going to actually be submitting your comment and here you see the top part of that page you can enter your comment in the **Comment** field, and you can even add a file, if you wish to do so. If you continue to scroll down that same page, you're going to enter your information in the designated fields. Fill in the necessary information, but make sure you click on the "**I read and understand the statement above**" box. The **Submit Comment** box will not turn green unless that box is selected. So, once you have completed that, you will simply click the **Summit Comment** button. That's it. That is all there is to submitting a comment. So, again, please comment. CMS does look forward to hearing from you about the proposals that were discussed today.

That's all the time we have today, we appreciate you joining us. We hope it was helpful in your understanding the proposals and the requests for comment that CMS put forth. We appreciate, again, CMS, Kimberly Go and Dr. Anita Bhatia for joining us and walking us through all these proposals. We do have some resources here for your convenience; and don't for get to comment! Thanks everyone. See you next time.