The CMS Universe: Exploring the CY 2022 OPPS/ASC Proposed Rule

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Proposed Changes to the Hospital OQR Program Measures

Changes To the Hospital OQR Program Galaxy

Proposed Removal of Two Measures

Removing Two Stars From the Hospital OQR Program Galaxy

Proposal: Removal of Two Measures

- Beginning with CY 2023 reporting period/CY 2025 payment determination and subsequent years.
- OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
- OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention

Rationale

- Removal Factor 4, the availability of a more broadly applicable measure.
- Reduces provider burden

Proposed Adoption of Three New Measures

The Emerging of New Stars Into the Hospital OQR Program Galaxy


ST-Segment Elevation Myocardial Infarction (STEMI) Electronic Clinical Quality Measure (eCQM)

Proposal: Adopt STEMI eCQM

This eCQM measure would:

- Replace the OP-2 and OP-3 measures.
- Begin voluntary reporting with CY 2023 reporting period.
- Begin mandatory reporting with CY 2024 reporting period/2026 payment determination and subsequent years.

We invite public comment on our proposal.

Rationale

- Aligns with Meaningful Measures priority of effective prevention and treatment of chronic disease
- Includes patients who present to and receive primary percutaneous coronary intervention (PCI) at a PCI-capable facility
- Supports compliance and guidelines for STEMI management
- Encourages timely, effective and appropriate treatment using clinical data available in Certified EHR Technology (CEHRT)
  - Eliminates the need for manual chart-abstraction
  - Uses data collected through the EHR using patient-level data

Measure Specifics

- The measure assesses the percentage of ED patients aged 18 years or older with a diagnosis of STEMI who received appropriate treatment.
- Denominator: All ED patients 18 years or older diagnosed with STEMI who do not have contraindications to fibrinolytic, antithrombotic, and anticoagulation therapies.
- Numerator: ED-based STEMI patient:
  - Whose time from ED arrival to fibrinolytic therapy is 30 minutes or fewer.
  - Who received PCI at a PCI-capable hospital within 90 minutes of arrival and are non-transfer.
  - Who were transferred to a PCI-capable hospital within 45 minutes of ED arrival at a non-PCI-capable hospital.

Reporting Periods

CY 2023 payment determination and subsequent years

Calendar Year Period	Calendar Quarters of Reporting
CY 2023 Reporting Period/ CY 2025 Payment Determination	Any quarter(s)*
CY 2024 Reporting Period/ CY 2026 Payment Determination	One self-selected quarter
CY 2025 Reporting Period/ CY 2027 Payment Determination	Two self-selected quarters
CY 2026 Reporting Period/ CY 2028 Payment Determination	Three self-selected quarters
CY 2027 Reporting Period/ CY 2029 Payment Determination	Four quarters (one calendar year)

*In this proposed rule, CMS is proposing a voluntary reporting period for eCQMs for the CY 2023 reporting period/CY 2025 payment determination.

Proposal: Submission Requirements

- Utilize certified technology updated consistent with the 2015 Edition Cures Update
- Submit eCQM data via the Quality Reporting Data Architecture (QRDA) Category I file format
- Use third parties to submit QRDA I files on their behalf if they choose

Proposal: Case Threshold

Propose to align case threshold exemption from the Medicare Promoting Interoperability Program which aligns with the IQR Program:

- CMS proposes the ability to declare a case threshold exemption if the hospital has five or fewer applicable discharges.
  - Hospitals could report those individual cases if they chose to do so.
- CMS proposes a zero-denominator declaration.
  - Hospitals would submit a zero for the denominator.
- This would begin with the CY 2023 reporting period/ CY 2025 payment determination.

Proposal: Review and Corrections

Propose a review and corrections period for hospitals for eCQM data:

- The period runs concurrently with the data submission period (from the time the submission period opens through the submission deadline).
- This encourages early testing.
- No correction is possible after the submission period closes.

We invite public comment on our proposals related to eCQMs.

COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) Measure

Proposal: Adopt COVID-19 Vaccination Coverage Among HCP

This measure would:

- Begin with CY 2022 reporting period/CY 2024 payment determination
- Assess the proportion of a hospital's healthcare workforce that has been vaccinated

Rationale

- Through the Meaningful Measures area of Preventive Care, the measure addresses the quality priority of "Promote Effect Prevention and Treatment of Chronic Disease."
- Vaccination is critical in countering the spread of COVID-19.
- Would allow vaccination rate information to be publicly available to assist consumers with healthcare choices.

Measure Specifics

- Measure developed by the Centers for Disease Control and Prevention (CDC) to track COVID-19 vaccination coverage among HCP.
- Denominator: Number of HCP eligible to work in the hospital for at least one day during the reporting period, excluding persons with any contraindications.
- Numerator: Number of HCP eligible to work in the hospital for at least one day during the reporting period and who received a complete vaccination course against COVID-19 using a Food and Drug Administration (FDA)-authorized vaccine.

Measure Specifics (cont.)

- Vaccination coverage is defined as the estimated percentage of HCP eligible to work at the hospital for at least one day who received a COVID-19 vaccine.
- Facilities would count HCP working in all inpatient and outpatient:
  - Units that are physically attached to the inpatient acute care facility site and share the same CMS Certification Number (CCN).
  - Departments that are affiliated with the facility regardless of distance from the acute facility but share the same CCN.
- Specifications are available on the CDC website: https://www.cdc.gov/nhsn/nqf/index.html

Reporting Specifics

- The reporting would be through the CDC National Healthcare Safety Network (NHSN) web-based surveillance system.
- Hospitals would collect the numerator and denominator for at least one, self-selected week during each month of the reporting quarter and submit the data before the quarterly deadline.
- The CDC would calculate a single quarterly rate for each hospital, by taking the average from the three submission periods by the hospital for that quarter.

We invite public comment on our proposal.

Breast Screening Recall Rates 1ST Measure

Proposal: Adopt the Breast Screening Recall Rates Measure

This claims-based measure would:

- Begin with the CY 2023 payment determination
- Focus on imaging efficiency
- Use a 12-month data collection period of July 1 to June 30

Rationale

- Fills the gap in women's health and oncology care
- Provides facility information to use in examining their own imaging practices for improvement
- Addresses the Meaningful Measure priority area of "Making Care Safer" by:
  - Promoting appropriate use of breast cancer screening and diagnostic imaging by encouraging facilities to aim for a performance score within the target recall range
  - Reducing the harms associated with too many recalls, which can lead to unnecessary radiation exposure
  - Addressing the issue of inappropriately low recall rates, which may lead to delayed diagnoses or undetected cases of breast cancer

Measure Specifics

- Facility-level claims-based process measure that calculates the percentage of Medicare fee-for-service (FFS) beneficiaries for receiving traditional mammography or digital breast tomosynthesis (DBT) screening that was followed by a diagnostic mammography, DBT, ultrasound of the breast, or magnetic resonance imaging (MRI) of the breast in an outpatient or office setting on the same day or within 45 days of the index image

Measure Specifics (cont.)

- Denominator: Medicare FFS beneficiaries who received a screening mammography or DBT study at a facility reimbursed through the OPPS.
- Numerator: Individuals from the denominator who had a diagnostic mammography study, DBT, ultrasound of the breast, or MRI of the breast following a screening mammography or DBT study on the same day or within 45 days of the screening study.

We invite public comment on our proposal.

Proposed Modifications to Previously Adopted Measures

Bringing the Planets Into the Galaxy

Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-Based Measures

ST

Proposal: OAS CAHPS Survey-Based Measure

Propose to resume reporting for the OP-37a-e OAS CAHPS Survey-Based Measure

- Previous voluntary reporting to the National OAS CAHPS is independent of the Hospital OQR Program.
- Voluntary reporting begins with the CY 2023 Reporting Period.
- Mandatory reporting begins with the CY 2024 reporting period/CY 2026 payment determination.

Rationale

- Assesses important aspects of care where the patient is the best or only source of the information
- Benefits of the measure outweigh the burdens
- Implementation will enable objective comparisons between hospital outpatient departments and patient experience ratings

Modes of Administration

Following are the additional proposed administrative modes:

- Mail-only
- Telephone-only
- Mixed Mode (mail with telephone follow-ups)
- Web with mail follow-up
- Web with a telephone follow-up

Vendor Requirements

Hospitals would require a CMS-approved survey vendor to administer the survey.

- Hospitals would authorize and register CMS-approved vendor on the survey website https://oascahps.org.
- Vendors would need to submit data by the specified submission deadlines.

Data Collection

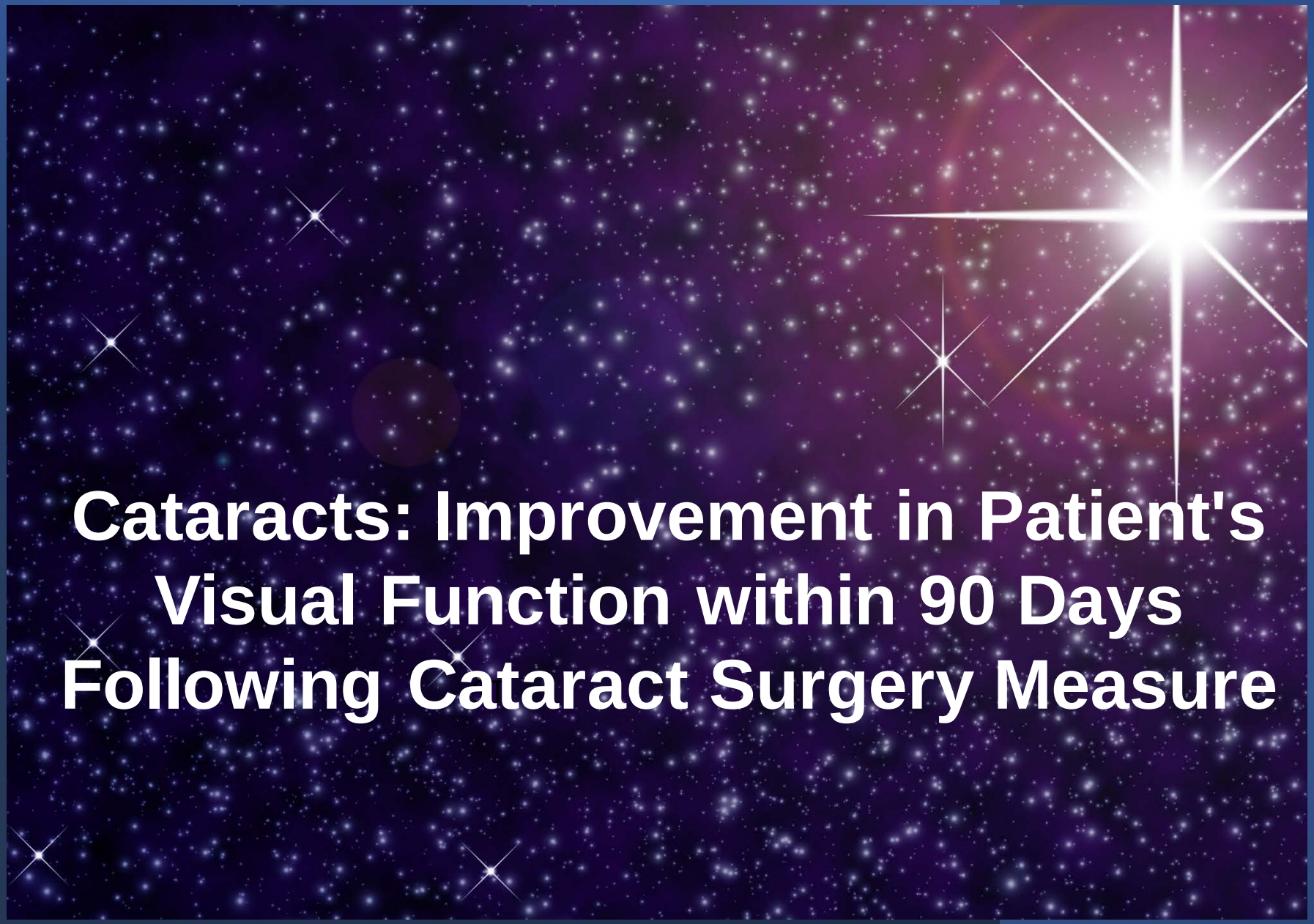
CMS-approved vendors would be required to:

- Initiate data collection no later than 21 days after the month in which a patient has a surgery or procedure at a hospital and completed within 6 weeks (42 days) after initial contact of eligible patients begins.
- Make multiple attempts to contact eligible patients unless the patient refuses or the vendor learns that the patient is ineligible to participate in the survey.

Data Collection (cont.)

- Collect survey data for eligible patients using the established quarterly deadlines to report data to CMS for each data collection period unless the hospital has been exempted from the OAS CAHPS Survey requirements under the low volume exemption.
  - Hospitals with fewer than 60 survey-eligible patients during the "eligibility period" submit the participation exemption request form on or before May 15 of the data collection calendar year.
- Collection of data and submission would be reported at the CCN level.
- Option for random sampling for more than 300 completed surveys

We invite public comment on our proposal.


Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery Measure

Proposal: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery Measure

This measure would:

- Require mandatory data submission via a CMS web-based tool.
- Begin with the CY 2023 reporting period/CY 2025 payment determination and subsequent years.

Rationale

- Addresses a high-impact condition
- Serves to improve patient-centered care
- Provides opportunities for care coordination and direct patient feedback

Measure Specifics

- Assesses the percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery
- Consists of pre-operative and post-operative visual function surveys data

We invite public comment on our proposal.

Proposed Program-Related Administrative Updates

Refining the Orbit of the Planets

Clarification

Security Official (SO) Account and Maintenance Requirements for Data Submission:

- Initial registration is required to participate in the OQR program.
- Failure to maintain an active SO account will not result in monetary penalty.

Hospital OQR Program Validation Policies Proposals

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Proposal: Use of Electronic File

Beginning with CY 2022 Reporting Period/CY 2024 Payment Determination and subsequent years:

- Discontinue the option to send paper copies of, or DCs, DVDs, or flash drives for validation
- Require to submit only electronic files for validation
  - Submit PDF copies of medical records using direct electronic file submission via a CMS-approved secure file transmission

Rationale

- Effective and efficient process
- Reduces the burden of coordinating paper-based files
- Aligns with other Hospital Quality Reporting Programs

We invite public comment on our proposal

Proposal: Changing the Time Period

Propose to change the time period to submit medical records from 45 calendar days to 30 calendar days beginning with CY 2022

Rationale

- Effective and efficient for validation
- Reduce the time needed to complete validation
- Provide hospital with feedback in a timelier manner
- Align with other Hospital Quality Reporting Programs

We invite public comment on our proposal.

Proposal: Revise Targeting Criteria

The revised targeting criteria for the 50 additional hospitals would:

- Select facilities not validated in any of the previous three years
- Have passed validation in the previous year but had a two-tailed confidence interval that included 75 percent

Rationale

- Allows more hospitals the opportunity for validation
- Targets hospitals that are in the statistical margin of error for their accuracy
- Improves data quality by increased targeting

We invite public comment on our proposal.

Expanding the Extraordinary Circumstances Exception (ECE) to eCQMs Proposals

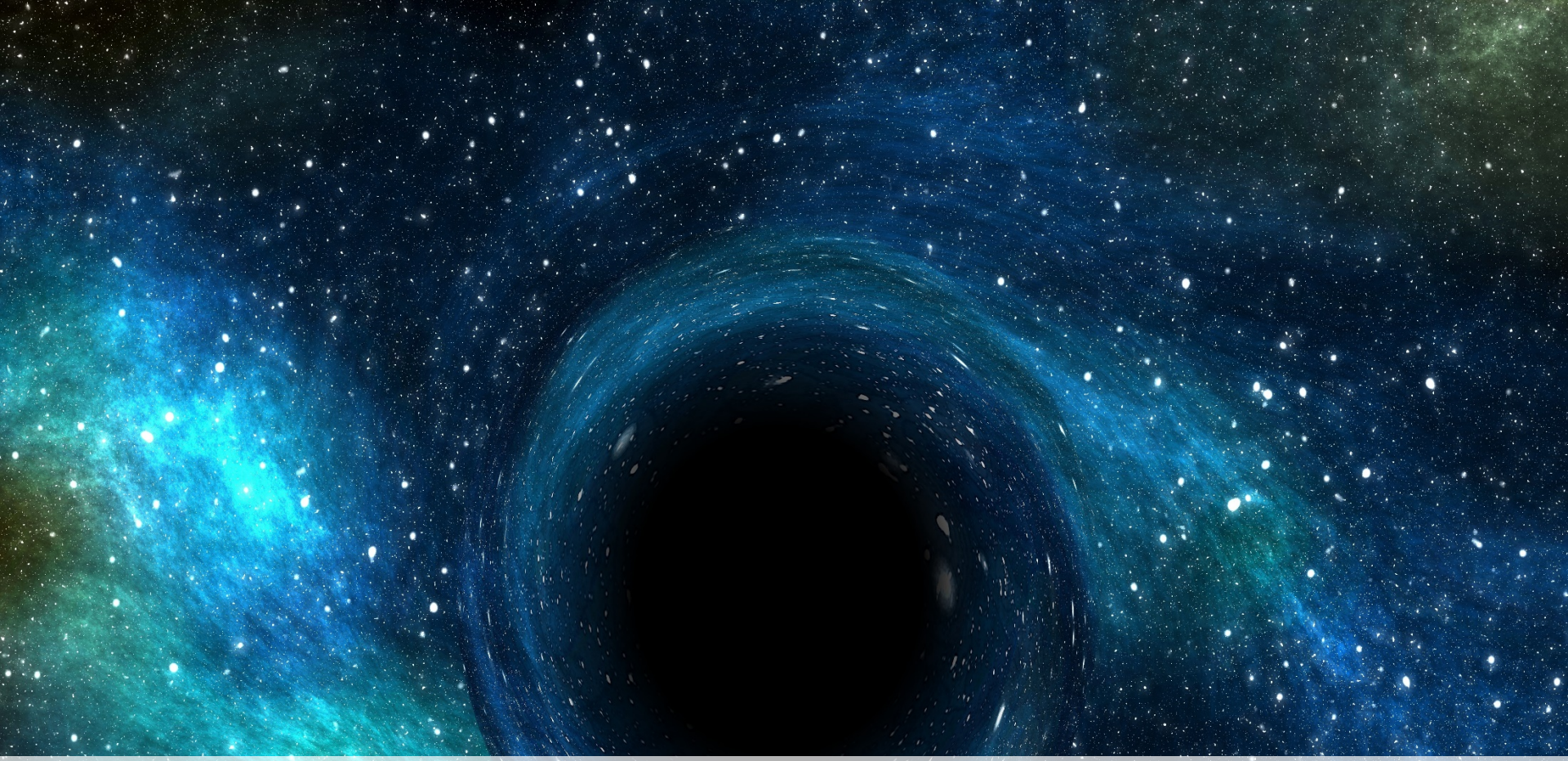
Proposal: Expand the ECE

- Beginning with the CY 2024 reporting period/ CY 2026 payment determination and subsequent years, hospitals would be able to request an exception from eCQM reporting requirements.
  - Based on hardships
  - May submit request by April 1 following the end of the reporting calendar year

Rationale

- Addresses any hardship that may impact the reporting of eCQMs
- Aligns with the Inpatient Hospital Quality Program's ECE policy for eCQMs

We invite public comment on our proposal.



Request for Information (RFI) and Comment

- Expanding the Hospital OQR Program Galaxy

Request for Comment: Future Consideration

CMS invites comment on the following:

- Potential future adoption of measures considering potential transition of procedures from inpatient to outpatient
- A respecified version of patient-reported outcome-based performance measure (PRO-PM)
- Hospital-Level, Risk Standardized Patient Reported Outcomes Measure Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)
- For details visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology

Request for Information (RFIs)

- Rural Emergency Hospitals
  - For details see page 268 of the PDF version of the proposed rule in the *Federal Register.*
- Health equity through stratified confidential reporting by variables such as people with disabilities, people of LGBTQ community, religious minorities, rural population, overall people adversely affected by persistent inequality and other applicable variables.
- Future of Digital Quality Measurement (dQM)

Background: Health Equity

CMS seeks to close equity gaps by using:

- Mapping Medicare Disparities Tool
- Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage Stratified Report
- Rural-Urban Disparities in Health Care in Medicare Report
- Standardized Patient Assessment Data Elements
- CMS Innovation Center's Accountable Health Communities Model

Seeking Information

CMS seeks information on the following:

1. The potential future application to the program measures of the two disparity methods currently used to report stratified measures.
2. The possibility of reporting stratified results confidentially in Facility-Specific Reports (FSRs) using dual eligibility as a proxy for social risk
3. The possibility of reporting stratified results using dual eligibility as the proxy for social risk publicly on Care Compare in future years
4. The potential future application of an algorithm to indirectly estimate race and ethnicity to permit stratification of measures (in addition to dual-eligibility) for facility-level disparity reporting until more accurate forms of self-identified demographic information are available
5. The possibility of facility collection, on the day of service, of a minimum set of demographic data using standardized and interoperable electronic health record standards

Future of Digital Quality Measurement (dQM)

RFI on CMS' plans to modernize its quality measurement enterprise by:

- Obtaining electronic health record (EHR) data required for quality measures via Fast Healthcare Interoperability Resources (FHIR®)-based Application Programming Interface (APIs)
- Redesigning quality measurement tools as open-source, self-contained applications
- Supporting data aggregation
- Aligning measure requirements and tools across various reporting programs and entities

Summary

- Removal of two measures
  - AMI measure set (OP-2 and OP-3)
- Adoption of three new measures:
  - STEMI eCQM
  - Breast Screening Recall Rate
  - COVID-19 Vaccination Coverage Among HCP
- Changes to existing measures
  - OP-31
  - OAS CAHPS Survey measures
- Program and administrative updates
  - Clarification regarding Security Official requirements
  - Extension of the ECE policy
  - Validation updates
- Requests for information
  - Health equity
  - Future of dQMs
  - Potential future measures including THA/TKA

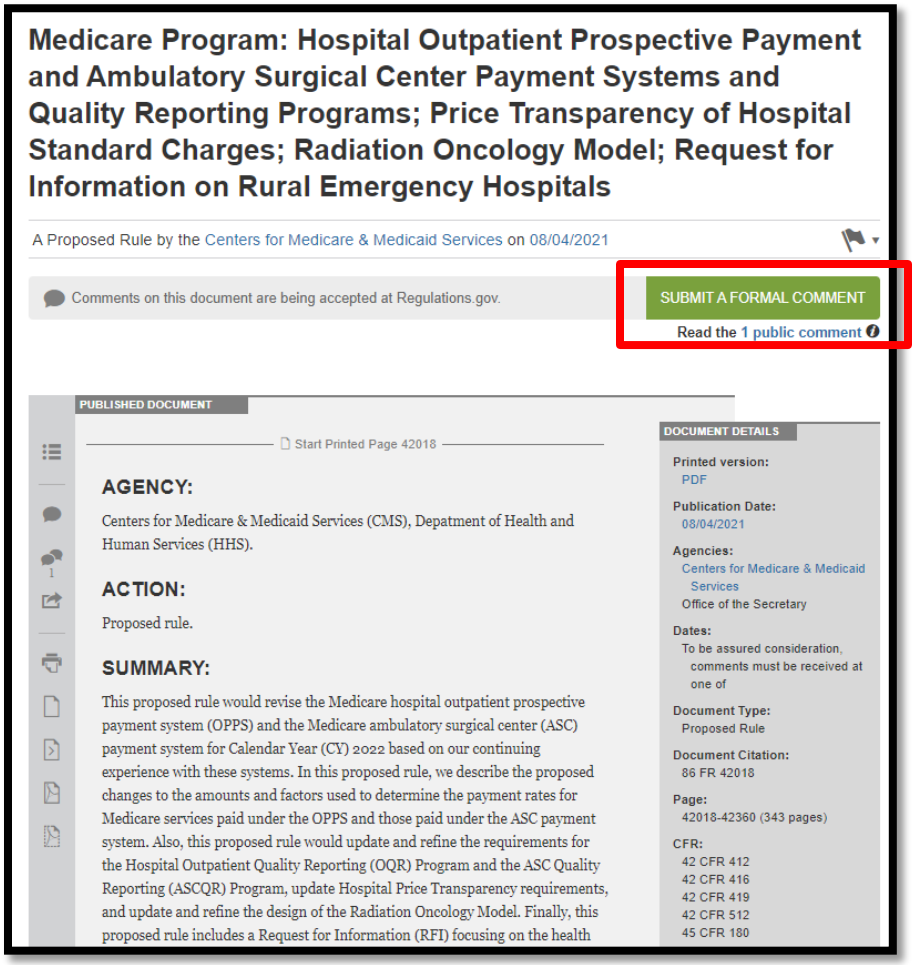
Commenting

Joining the Expanding Hospital OQR Program Galaxy

Submitting Comments

- Comments must be received by September 17, 2021.
- CMS encourages submission of electronic comments.
  - Comments may also be submitted by regular mail, express mail, or overnight mail to the designated addresses provided.
- Responses to comments will be in the final rule.

Locating the Rule



Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals

A Proposed Rule by the Centers for Medicare & Medicaid Services on 08/04/2021

Comments on this document are being accepted at Regulations.gov.

SUBMIT A FORMAL COMMENT

Read the 1 public comment

PUBLISHED DOCUMENT

Start Printed Page 42018

AGENCY:

Centers for Medicare & Medicaid Services (CMS), Depatment of Health and Human Services (HHS).

ACTION:

Proposed rule.

SUMMARY:

This proposed rule would revise the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for Calendar Year (CY) 2022 based on our continuing experience with these systems. In this proposed rule, we describe the proposed changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment system. Also, this proposed rule would update and refine the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program, update Hospital Price Transparency requirements, and update and refine the design of the Radiation Oncology Model. Finally, this proposed rule includes a Request for Information (RFI) focusing on the health

DOCUMENT DETAILS

Printed version:
PDF

Publication Date:
08/04/2021

Agencies:
Centers for Medicare & Medicaid Services
Office of the Secretary

Dates:
To be assured consideration, comments must be received at one of

Document Type:
Proposed Rule

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Page:
42018-42360 (343 pages)

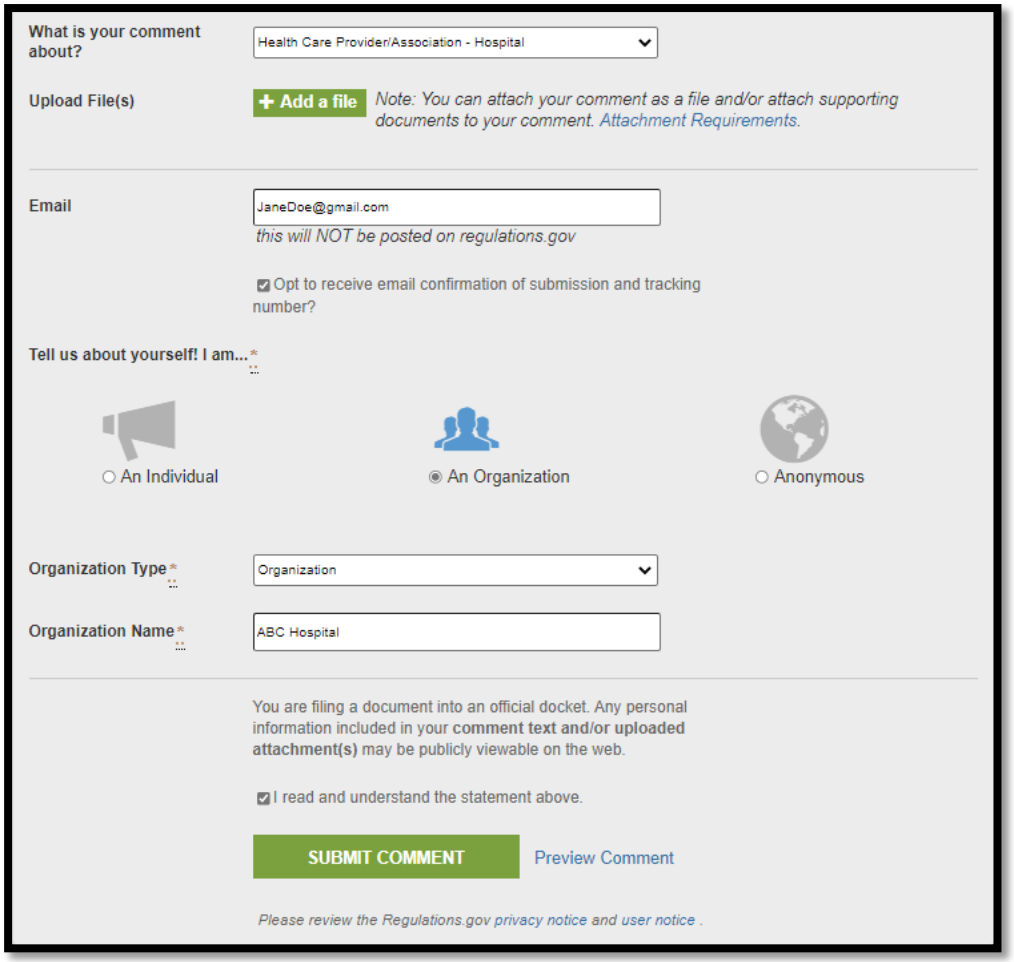
CFR:
42 CFR 412
42 CFR 416
42 CFR 419
42 CFR 512
45 CFR 180

From the *Federal Register,* select the green **Submit a Formal Comment** box

Enter Your Comment

Enter your comment in the **Comment** field. You can also attach files

Submit Your Comment



- Enter the rest of your information.
- Select the box next to “I read and understand the statement above.”
- Select the **Submit Comment** box.

References

- Proposed Rule (FR 86 42018) in the *Federal Register*
  - PDF version, pages 220-249
- For program-related questions, contact the support help desk at 866.800.5756


Thank You!

Continuing Education (CE) Approval

This program has been approved for one CE credit for the following boards:

- **National credit**
  - Board of Registered Nursing (Provider #16578)
- **Florida-only credit**
  - Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
  - Board of Registered Nursing
  - Board of Nursing Home Administrators
  - Board of Dietetics and Nutrition Practice Council
  - Board of Pharmacy

Note: To verify CE approval for any other state, license, or certification, please check with your licensing or certification board.

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