Outpatient Quality Program Systems and Stakeholder Support Team

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

Moderator

Karen VanBourgondien, BSN, RN
Outpatient Quality Program Systems and Stakeholder Support Team

Speaker

Shaili Patel, MPH
Program Lead, Hospital Outpatient Quality Reporting (OQR) Program
Centers for Medicare & Medicaid Services (CMS)

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Karen VanBourgondien: Hello everyone. Welcome and thank you for joining us. My name is Karen VanBourgondien. Our speaker today is Shaili Patel. Shaili is the CMS Program Lead for the Hospital OQR Program. She has a master's in public health. She started her federal career back in 2009 with the Social Security Administration and joined CMS in 2012. We are extremely fortunate to have Shaili involved with these programs.

Shaili will be discussing the proposed rule as it relates to the Hospital OQR Program today. So, without any further delay, let me turn things over to Shaili. Shaili?

Shaili Patel: Thank you, Karen. Good afternoon, everyone. Thank you again for joining us. We have much to discuss today, so let's begin with measure-related proposals.

In this proposed rule, we are proposing to remove two chart-abstracted measures. The two measures we are proposing to remove are OP-2 and OP-3. The OP-2 measure assesses the number of ED Acute Myocardial Infarction patients with ST-segment elevation on the ECG closest to arrival time receiving fibrinolytic therapy during the ED visit, and with the time from ED arrival to fibrinolysis of 30 minutes or less. The OP-3 measure assesses the median time from ED arrival to time of transfer to another facility for acute coronary intervention.

The proposed removal would begin with calendar year 2023 reporting period, or calendar year 2025 payment determination. We are proposing removal of OP-2 and OP-3 under removal Factor 4, the availability of a more broadly applicable measure, which we'll discuss just in a moment. These two measures are also chart-abstracted, which results in greater provider burden due to manual abstraction.

Let's move on to proposals for measure adoption. We are proposing the adoption of three new measures.

We are proposing to adopt the ST-Segment Elevation Myocardial Infarction electronic clinical quality measure, or STEMI eCQM. As discussed, a moment ago, this new measure would serve as a replacement for the OP-2 and OP-3 measures as it would capture the populations of both of those measures.

We propose to start with voluntary reporting beginning with the calendar year 2023 reporting period and with mandatory reporting beginning with the calendar year 2024 reporting period. The addition of this measure aligns with the Meaningful Measures quality priority of promoting effective prevention and treatment of chronic disease.

The measure, in lieu of the OP-2 and OP-3 measures, would broaden the measured STEMI patients including patients who present to and receive primary PCI at a PCI-capable facility, which is the vast majority of STEMI patients, instead of only including patients presenting to non PCI-capable facilities and receiving either fibrinolytics or being transferred to a PCI-capable facility.

We are proposing to adopt the STEMI eCQM for the use in the Hospital OQR Program because of its importance in measuring timely delivery of guideline-based reperfusion therapies appropriate for the care of ED patients with a diagnosis of STEMI.

The STEMI eCQM better supports compliance with the full group of STEMI patients for the management of STEMI by measuring timeliness and appropriateness of care for STEMI patients in the ED by using patient-level clinical data available in the certified electronic health record technology. As such, we believe that this measure has the potential to reduce adverse health outcomes. Additionally, the proposed measure is an eCQM which would eliminate the need for manual chart abstraction.

The STEMI eCQM is a process measure that assesses the percentage of ED patients aged 18 years or older with a diagnosis of STEMI who received appropriate treatment.

The denominator includes all ED patients 18 years or older diagnosed with STEMI who do not have contraindications to fibrinolytic, antithrombotic, and anticoagulation therapies. The numerator includes ED-based STEMI patients whose time from ED arrival to fibrinolytic therapy is 30 minutes or fewer; or non-transfer ED-based STEMI patients who received PCI at a PCI-capable hospital within 90 minutes of arrival; or ED-based STEMI patients who were transferred to a PCI-capable hospital within 45 minutes of ED arrival at a non-PCI-capable hospital.

In terms of reporting periods, we are proposing incremental reporting which will allow time for hospitals to prepare, offer training, and gain experience with reporting data for the STEMI eCQM. This chart summarizes the reporting periods associated with this measure. For the calendar year 2023 reporting period, hospitals may submit STEMI eCQM data for any quarters voluntarily. For the calendar year 2024 reporting period or calendar year 2026 payment determination, hospitals would report one self-selected calendar quarter of data. For the calendar year 2025 reporting period or calendar year 2027 payment determination, hospitals would report two self-selected calendar quarters of data. For the calendar year 2026 reporting period or calendar year 2028 payment determination, hospitals would report three self-selected calendar quarters of data. Lastly, beginning with the calendar year 2027 reporting period or calendar year 2029 payment determination and for subsequent years, hospitals would report all four calendar quarters (one calendar year) of data for the STEMI eCQM.

Let's now discuss submission requirements for the STEMI eCQM. For the Hospital OQR Program, we are proposing to require hospitals to utilize certified technology updated consistent with the 2015 Edition Cures Act. This proposal would also align with the eCQM requirements in the Hospital IQR Program. As previously discussed in detail, this proposal would start with a voluntary period and then subsequent required submissions beginning with the 2015 Edition Cures Act 2023 reporting period.

We understand that in some cases, a hospital may not meet the case threshold of discharges for this eCQM. Therefore, starting with calendar year 2023, we propose to align with the case threshold exemption with the Medicare Promoting Interoperability and the Hospital IQR Programs.

The case threshold exemption means that for each quality measure for which hospitals do not have a minimum number of patients that meet the patient population denominator criteria for the reporting period, hospitals would have the ability to declare a "case threshold exemption" if they have five or fewer applicable discharges. In other words, for the Hospital OQR Program, if the hospital experiences five or fewer outpatient discharges per quarter or 20 or fewer outpatient discharges per year, both Medicare and non-Medicare combined, then the hospitals could be exempt from reporting on the STEMI eCQM. However, hospitals could report those individual cases if they chose to do so. Additionally, we are proposing that the hospitals would have a review and corrections period for eCQM data submitted to the Hospital OQR Program, which would run concurrently with the data submission period. The review and corrections period is from the time the submission period opens to the time submission deadline.

In the HQR System, providers can submit data in test and production data files and can correct data before production data are submitted for final reporting. We do encourage early testing and the use of pre-submission testing tools to reduce error and inaccurate data submissions in eCQM reporting. As with the other web-based measures, the HQR System does not allow data to be submitted or corrected after the annual deadline. We look forward to your comments for this proposal related to eCQMs.

We all know the impact of COVID-19 and the effects it has had on the health care setting. Although personal protective equipment and other infection control precautions can reduce the likelihood of transmission in health care settings, COVID-19 can spread between staff and patients or from patient to patient given the close contact that may occur during the provision of care.

Given the impact of COVID-19 on health care, we believe it is important to require that hospital outpatient departments report health care personnel vaccination information. Therefore, we are proposing to adopt COVID-19 Vaccination Coverage Among Health Care Personnel. The measure would assess the proportion of a hospital's health care workforce that has been vaccinated against COVID-19.

Given the time sensitive nature of this measure and the current Public Health Emergency, we are proposing that hospitals would be required to begin reporting data on the proposed measure beginning January 1, 2022, for the calendar year 2024 payment determination for the Hospital OQR Program.

Under CMS's Meaningful Measures Framework, the COVID-19 measure addresses the quality priority of Promote Effective Prevention and Treatment of Chronic Disease through the Meaningful Measures Area of Preventative Care.

The CDC has emphasized that health care settings can be high risk places for COVID-19 exposure and transmission. Again, we believe vaccination is a crucial part of the nation's strategy to effectively counter the spread of COVID-19. We believe it is important to require hospitals to report HCP vaccination information for health care facilities to assess whether these facilities are taking steps to limit the spread of COVID-19 among their health care workers and to help sustain the ability to continue serving their communities throughout the Public Health Emergency and beyond.

We also believe that publishing the HCP vaccination rates would be helpful to many patients, including those who are at high-risk for developing serious complications from COVID-19, as they choose hospital outpatient departments for treatment.

The COVID-19 HCP Vaccination Coverage measure is a process measure developed by the CDC to track COVID-19 vaccination coverage.

The denominator for the HCP measure is the number of HCP eligible to work in the hospital for at least one day during the reporting period, excluding persons with contraindications to COVID-19 vaccination that are described by CDC. The numerator for the HCP measure is the cumulative 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 an FDA-authorized vaccine for COVID-19.

Vaccination coverage for purposes of this measure 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.

Acute care facilities would count HCP working in all inpatient or outpatient units that are physically attached to the inpatient acute care facility site and share the same CCN, regardless of the size or type of unit. Facilities would also count HCP working in inpatient and outpatient departments that are affiliated with the specific acute care facility, regardless of distance from the acute care facility and also share the same CCN. More detailed specifications are available on the CDC's website link shown on this slide.

As I mentioned, we are proposing to report beginning January 1, 2022, for the calendar year 2024 payment determination and proposing quarterly reporting periods. We did consider annual reporting periods; we are proposing quarterly reporting periods given the immediacy of the Public Health Emergency and the importance of alignment across quality payment programs for this measure.

Hospitals would report the measure through the CDC's 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 to the NHSN before the quarterly deadline in order to meet Hospital OQR Program requirements. The CDC would calculate a single quarterly vaccination coverage rate for each hospital, which would be calculated by taking the average of the data from the three submission periods submitted by the hospital for that quarter.

If finalized, CMS would publicly report each quarterly COVID-19 HCP vaccination coverage rate as calculated by the CDC. Once four quarters are available, data would be refreshed on a quarterly basis with the most recent four quarters. This quarterly average COVID-19 vaccination coverage would be publicly reported. We look forward to your comment on this proposal.

The next proposal is regarding breast imaging and effective recall rates in the outpatient setting. Facilities performing diagnostic mammography or digital breast tomosynthesis, otherwise known as DBT, as a result of false-positive screening study or other errant data have the potential to expose women to unnecessary follow-up. This could result in increased prevalence of radiation-induced cancer in younger women, including those carrying related gene mutations. In contrast, recalling too few women for follow-up imaging may lead to delayed diagnoses, higher stages at diagnosis, and/or undetected cases of breast cancer. To address the health and clinical risks associated with too many or too few breast screening recalls, we are proposing to adopt the Breast Screening Recall Rates measure. This measure would be added to a measure set focused on imaging efficiency. While this measure, as currently specified, would not provide data on outcomes, the number of patients who were recalled and subsequently diagnosed with cancer, it would give facilities information to use in examining their own imaging practices.

We propose this measure to begin with the calendar year 2023 payment determination using the data collection period of July 1, 2020, to June 30, 2021, then data collection from July 1 through June 30 of the following year, starting three years before the applicable payment calendar year for subsequent years.

The rationale for this measure is that it would fill the gap in women's health and oncology care that was left in the Hospital OQR Program portfolio following the removal of the Mammography Follow-Up Rates measure, OP-9.

More specifically, this measure would directly address the reason OP-9 was removed from the Hospital OQR Program by bringing the measure into alignment with current clinical practice and emerging scientific evidence through the addition of screening and diagnostic DBT. Results from the measure could also be used to identify opportunities for improving the efficiency and quality of care provided at a given facility.

This measure would address the Meaningful Measure priority areas 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 targeted recall range; reducing the harm associated with too many recalls, which can lead to unnecessary radiation exposure, anxiety, distress, and increased costs or resource utilization; and lastly, addressing the issue of inappropriately low recall rates, which may lead to delayed diagnoses, diagnoses at a later stage, or undetected cases of breast cancer.

As for the measure specifications, this is a claims-based process measure which documents breast screening recall rates at a facility level. As a reminder, as a claims-based measure, your hospital will not have to manually abstract and report this measure.

The measure would calculate the percentage of Medicare Fee For Service beneficiaries for whom a traditional mammography, or DBT, screening study was performed that was then followed up by a diagnostic mammography, or DBT, ultrasound, or an MRI of the breast in an outpatient setting on the same day or within 45 calendar days of the index image.

The measure denominator includes Medicare Fee For Service beneficiaries who received a screening mammography or DBT study.

The numerator consists of 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 look forward to your comment on our proposal to adopt Breast Screening Recall Rate measure into the OQR program.

In the Calendar Year 2022 OPPS/ASC Proposed Rule, we are also proposing some modifications to previously adopted measures for the OQR program.

Let's begin with the survey measures.

We previously adopted the OP–37 OAS CAHPS measure to assess patient experience with care following a procedure in a hospital outpatient department. These survey-based measures rate patient experience as a means for empowering patients and improving the quality of care.

In the Calendar Year 2018 OPPS/ASC Final Rule, we delayed the implementation of these measures due to lack of sufficient operational and implementation of data. At that time, we expressed interest in investigating the feasibility of offering OAS CAHPS Surveys using a web-based format. As a result, we have made revisions and designed a mode experiment to assess the impact of adding web-based survey administration.

We are proposing to restart the OP–37 OAS CAHPS measure by proposing to link reporting of measure data with payment determination as part of the OQR program. We want to note that the National OAS CAHPS voluntary reporting program that started in the 2015 reporting period is independent of the Hospital OQR Program. We also want to note that the facilities would not be providing surveys separately to meet the OQR program requirements.

For the Hospital OQR Program, we are proposing voluntary data collection and reporting beginning with the calendar year 2023 reporting period and followed by mandatory data collection and reporting beginning with the calendar year 2024 reporting period or calendar year 2026 payment determination.

Having had the opportunity during the delayed implementation to investigate the concerns about the patient response rate and data reliability, we believe that the patients are able to respond to OAS CAHPS questions, and that those responses are reliable based on our previous experiences collecting voluntary data for public reporting since 2016. We reaffirm that the OAS CAHPS survey-based measure assesses important aspects of care where the patient is the best or only source of information.

We also continue to believe that the benefits of this measure, such as giving patients the opportunity to compare and assess quality of care in the outpatient setting in a standardized and comparable manner, outweighs the burden. Additionally, the implementation of these measures would enable objective and meaningful comparisons between hospital outpatient departments and patient experience.

For implementation of this measure, we are proposing to incorporate two additional modes for administration which would include web with mail follow-up and web with telephone follow-up of non-respondents. Again, this is in addition to previously available mail-only, telephone-only, and mixed mode of mail with telephone follow-up to reach non-respondents.

There are specific vendor requirements associated with this measure. Hospitals would have to contract with a CMS-approved OAS CAHPS Survey vendor to conduct or administer the survey. We believe that a neutral third-party should administer the survey for these facilities and it is our belief that an experienced survey vendor will be best able to ensure reliable results. Hospitals would need to register an OAS CAHPS Survey in order to authorize the CMS-approved vendor to administer the survey and submit data on their behalf by the specified data submission deadlines.

Note, these vendors are already being utilized by hospitals for the HCAHPS measure that's in the inpatient quality reporting program.

For all proposed modes of administration, we are proposing that data collection would be initiated no later than 21 calendar days after the month in which a patient has a procedure and be completed within six weeks or 42 days, after the initial contact of eligible patients begins.

Hospitals, via their CMS-approved survey vendors, would make multiple attempts to contact eligible patients unless the patient refuses or the facility or vendor learns that the patient is ineligible to participate in the survey.

In addition, we are proposing that facilities, via their CMS approved vendor, collect survey data for eligible patients using the established quarterly deadlines to report data to CMS for each data collection period, unless the facility has been exempted from the OAS CAHPS Survey requirements under our minimum case volume for program participation, or the low-volume exemption policy.

The low-volume exemption exempts facilities that treat fewer than 60 survey-eligible patients during the eligibility period, the calendar year before the data collection period. A facility would submit the participation exemption request form, which will be made available on the OAS CAHPS Survey website on or before May 15 of the data collection year.

All data collection and submission for the OAS CAHPS Survey measures would be reported at the CCN level, and if data collection and reporting becomes mandatory in calendar year 2024 reporting period as proposed, then all eligible hospitals in a CCN would be required to participate in the OAS CAHPS Survey. However, this would exclude those that meet and receive an exemption for having fewer than 60 survey eligible patients during the year preceding the data collection period.

The survey data reported for a CCN must include eligible patients from all eligible hospitals covered by the CCN, or if more than 300 completed surveys are anticipated, a facility can choose to randomly sample their eligible patient population. We look forward to your comment on this proposal.

Moving on to the cataracts measure, OP-31, to measure improvement in a patient's visual function within 90 days following cataract surgery. This measure has been voluntary in the OQR program since its adoption in 2017. Submission of this measure would be through the HQR System and will begin with the calendar year 2023 reporting period or calendar year 2025 payment determination.

Our rationale behind this proposal remains unchanged. We continue to believe that this measure "addresses a high-impact condition" that is not otherwise adequately addressed in our current measure set. Additionally, OP–31 serves to improve patient-centered care by representing an important patient reported outcome and provides opportunities for care coordination as well as direct patient feedback. We also believe that hospitals have had several years to familiarize and operationalize this measure to confidently report starting with calendar year 2023.

This measure 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. The measure data consists of pre-operative and post-operative visual function surveys.

Initially, we were concerned that if physicians used different surveys to assess visual function, then the measure could produce inconsistent results. However, current research indicates that using different surveys will not result in inconsistencies, as the allowable surveys are scientifically validated. We invite your comment regarding this proposal.

Let's move on to discuss proposals on some program-related administrative updates.

First, a point of clarification. We previously indicated that hospitals would be required to maintain a current QualityNet Security Official for as long as the hospital participates in the program.

We are clarifying that failing to maintain an active QualityNet Security Official once a hospital has successfully registered a security official and has established participation in the Hospital OQR Program will not result in an annual payment penalty for the OQR program.

We are also proposing changes to the current validation policy for this program to further align with other quality reporting programs. Under our current validation policy, hospitals may choose to submit paper copies of medical records for chart-abstracted measure validation, or they may submit copies of medical records for validation by securely transmitting electronic versions of medical records. Submission of electronic versions can either entail downloading or copying the digital image of the medical record onto CD, DVD, or flash drive, or submission of PDF files using a secure file transmission process after logging into HQR System.

Starting with quarter one, calendar year 2022 reporting period, we are proposing to discontinue the option for hospitals to send paper copies, CDs, DVDs, or flash drives containing medical records for validation affecting the calendar year 2024 payment determination. We are also proposing to require hospitals to instead submit electronic files only when submitting copies of medical records for validation of chart-abstracted measures.

Under this proposal, hospitals would be required to submit PDF copies of medical records using direct electronic file submission via a CMS-approved secure file transmission process as directed by CDAC. We would continue to reimburse hospitals at $3.00 per chart, consistent with the current reimbursement amount for the electronic submission of charts.

Our reasoning behind this proposal is that hospitals have rapidly adopted EHR systems as their primary source of information about patient care. We monitor the medical records submissions to the CMS Clinical Data Abstraction Center, or CDAC, and have found that almost two-thirds of hospitals already use the option to submit PDF copies of medical records as electronic files.

In our assessment based on this monitoring, we believe requiring electronic file submissions can be more effective and efficient process for hospitals selected for validation and further align with the Hospital IQR Program's validation policy.

Requiring electronic file submission reduces the burden of not only coordinating numerous paper-based medical records, but also having to then ship the papers or physical digital media storage to the CDAC. This change would align with the validation policy used for the Hospital IQR Program. We look forward to your comment on this proposal.

In previous years, charts were requested by the CMS CDAC contractor and hospitals were given 45 calendar days from the date of the request to submit the requested records. If any record(s) were not received by the 45 day requirement, the CMS CDAC contractor assigned a 0 validation score to each measure in a missing record. Using data from the CDAC, we have found that a large majority of hospitals that have participated in the OQR program data validation efforts have submitted their records prior to 30 calendar days in the current process. Therefore, starting with the calendar year 2022, we are proposing to change the time period given to hospitals to submit medical records to CDAC contractor from 45 calendar days to 30 calendar days.

This new deadline modification proposal would reduce the time needed to complete validation, provide hospitals with timely feedback on their abstraction accuracy, and to further align with other quality reporting programs' validation policy.

The last proposal for validation policy regards targeting criteria. We previously codified that the validation selection will be based on random sample of 450 hospitals as well as additional 50 targeted hospitals based on the failed validation requirements in previous payment determination year, or the hospital has an outlier value for a measure based on the data it submits.

In this proposed rule, we are proposing to revise the current established targeting criteria used to select 50 additional hospitals. Specifically, the proposed revised targeting criteria would select hospitals that have not been randomly selected for validation in any of the previous three years and any hospital that passed validation in the previous year but had a two-tailed confidence interval that included 75 percent. This proposal would allow more hospitals the opportunity for validation. By adding the targeting criteria for hospitals with a two-tailed confidence interval that includes 75 percent, we can target those hospitals that are in the statistical margin of error for their accuracy, which includes hospitals that both pass and fail on this level.

We believe that this proposal would also improve data quality by increased targeting of hospitals with possible or confirmed past data quality issues. Additionally, this proposal would also respond to stakeholder concerns of lack of methodology to address hospitals for which both passing and failing levels of accuracy were included for the statistical margin of error. We look forward to your feedback on the proposals related to validation.

I spoke earlier about the proposal to adopt the STEMI eCQM. We are proposing to expand our current ECE policy to include currently proposed eCQMs, as well as future adoption of eCQMs in the OQR program.

Starting with the calendar year 2024 reporting period, we are proposing to expand our current ECE policy to allow hospitals to request an exception from the Hospital OQR Program's eCQM reporting requirements based on hardships preventing hospitals from reporting. We are proposing that a hospital participating in the Hospital OQR Program that wishes to request an exemption must submit its request to CMS by April first following the end of the reporting calendar year in which the extraordinary circumstances occurred.

This proposal would address any hardships that the facility may have that impact the reporting of the eCQMs. It also aligns with the other quality reporting programs' ECE policy for eCQMs. We also request your comment on this proposal.

Let's talk about the future. In the calendar year 2021 final rule, we finalized the gradual elimination of the inpatient-only list with the removal of approximately 300 primarily musculoskeletal-related services. To address these changes, we seek comment to adopt potential future quality measures to ensure quality of care as we move in to the future with more services being available in the outpatient setting.

To reiterate, as technology and surgical techniques advance, services will continue to transition off the IPO list and become payable in the outpatient setting. We recognize that there may be a need for more measures that inform decision-making regarding care and for quality improvement efforts, particularly focused on the behaviors of services that become newly eligible for payment in the outpatient setting. In light of this, we seek comment on potential future adoption of measures that would allow better tracking of quality of care for services that transition from the inpatient-only list and become eligible for payment in the outpatient setting. Therefore, we invite public comment on the potential future adoption of measures for our consideration that addresses care quality in the hospital outpatient setting.

We are also requesting comment on the potential future adoption of a respecified version of a patient-reported, outcome-based performance measure for two such procedures, elective primary total hip arthroplasty and total knee arthroplasty, which were removed from the IPO list effective with calendar year 2020 and calendar year 2018. We also solicited comment for inclusion in the Fiscal Year 2022 IPPS/LTCH PPS Proposed Rule.

We are seeking your feedback and comment on the potential adoption of the Hospital-Level, Risk Standardized Patient Reported Outcomes Measure Following Elective Primary Total Hip and/or Total Knee Arthroplasty, also known as THA/TKA.

In this proposed rule, we are requesting information for Rural Emergency Hospitals, Health Equity, and Future of Digital Quality Measurement.

For the Rural Emergency Hospitals (REH), we are soliciting stakeholder input as we consider the health and safety standards that, in accordance with the statute, should apply to REH in order for them to be certified to participate in the Medicare program. We are also seeking broad input on the concerns of rural providers that should be taken into consideration by CMS in establishing additional Condition of Participations for Rural Emergency Hospitals. Specifics on this request can be found on page 268 of the PDF version on the *Federal Register*.

The next request for information regards our efforts to close the health equity gap. To date, we have included providing transparency of health disparities, supporting providers with evidence-informed solutions to achieve health equity, and reporting to providers on gaps in quality by using tools such as CMS Mapping Medicare Disparities Tool, as well as other reports noted on this slide.

In this RFI, we are specifically seeking input on 1) the potential application to the Hospital OQR Program measures of two disparity methods that are currently being used to confidentially report stratified measures in the Hospital Readmissions Reduction Program 2) the possibility of reporting stratified results confidentially in Facility-Specific Reports 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 application of an algorithm to indirectly estimate race and ethnicity to permit stratification of measures for facility-level disparity reporting until more accurate forms of self-identified demographic information are available 5) lastly, the possibility of facility collection, on the day of service, of minimum set of demographic data using standardized and interoperable electronic health record standards.

This is a very brief information on the RFI and we encourage you to refer to the Calendar Year 2022 OPPS/ASC Proposed Rule for more comprehensive understanding of the request. We truly look forward to your feedback on our request.

The last RFI regards our plans to modernize quality measurements.

In summary, to accomplish our goal of modernizing quality measurements, we would like your feedback on obtaining electronic health record data required for quality measures via Fast Healthcare Interoperability Resources® (FHIR)-based Application Programming Interface redesigning quality measurement tools as open-source self-contained applications, supporting data aggregation, and aligning measure requirements and tools across various reporting programs and entities.

For all RFIs, we will not be responding to specific comments submitted in response to our request in the Calendar Year 2022 OPPS/ASC Final Rule. However, we will actively consider all input as we develop future regulatory proposals and guidance. Any updates to specific program requirements related to quality measurement and reporting requirements for the OQR program will be addressed through future rulemaking, as necessary.

Again, please refer to the rule for details and we look forward to your feedback on our proposals and requests for comments and information.

We covered a lot of information today. Our proposals included the removal of two measures, the adoption of three new measures, changes to previously adopted measures, program updates, as well as requests for comment and information. Lastly, we seek to align all of our programs to the extent possible as I mentioned throughout the presentation. Please comment as your feedback is greatly valued.

That concludes my discussion on the proposals that are included in the Calendar Year 2022 OPPS/ASC Proposed Rule. I would like to hand it back to Karen to discuss how to comment on our proposals. Karen.

Karen VanBourgondien: Thank you, Shaili. You covered a lot of information and thank you for that. As Shaili mentioned, CMS does want your feedback. So, please comment.

To be assured consideration, comments must be submitted no later than September 17. CMS cannot accept comments by fax transmission and does encourage submission of comment by electronic means. You can submit comments by regular mail, express mail, or overnight mail. There are, however, separate addresses for those types of mail. So, you would resource the specified addresses found in the proposed rule. Please allow sufficient time for any mailed comments to be received before the close of the comment period.

To begin the commenting process, from the direct federal link, which is on this slide, you would select the green Submit a Formal Comment box.

The box will open, and you can enter your comment in the Comment box. You can also choose to attach files if that is necessary.

If you scroll down that same page, you will continue to enter the rest of your information. You must select the box where it says, "I read and understand the statement above." You have to select that box in order to then click on the green Submit Comment box. That's it. That's all there is to it in order to submit a comment. So, please do comment.

The direct link to the proposed rule in the *Federal Register* is here on the slide. This is the link to the PDF version. Remember you can make a difference, so please submit your comments regarding the proposals that Shaili discussed with us today. Every comment is read and CMS will respond to commenter feedback in the final rule.

As always, if you have any program-related questions or you need assistance, please give our help desk a call. Our number is here on the slide. We are always happy to hear from you.

That is all the time we have today. We appreciate you joining us. Shaili, thank you for joining us. It's always nice to have CMS here to share with us these very important proposals.

Also, please let us know on the survey at the end of the presentation what topics you would like to see education on for the Hospital OQR Program. We always do appreciate your feedback and your input.

Thanks everyone. Have a great rest of your day.