Outpatient Quality Program Systems and Stakeholder Support Team

CY 2022 OPPS Final Rule: How to Succeed in OQR Quality Reporting

Presentation Transcript

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January 19, 2022
2 p.m. Eastern Time

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Karen VanBourgondien: Hello everyone. 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 degree in public health. She started her federal career in 2009 with the Social Security Administration and joined CMS in 2012. We are extremely fortunate to have Shaili involved with this program. Shaili will be discussing the final rule as it relates to the Hospital OQR Program, and I will hand things over to Shaili in just a few minutes.

The learning objectives are on this slide. We also have the chat box available for any questions you may have. Later in the presentation, we do hope to share some of those questions with you, if we are able if time allows.

So, before we discuss the final rule, let me just cover a few pieces of information and some announcements. Now, we run into this frequently. HARP is not synonymous with HQR, the Hospital Quality Reporting System. HARP is a secure identity management portal provided by CMS. Creating an account via HARP provides users with a user identification and password that can be used to sign into multiple CMS applications.

So, Hospital Quality Reporting, or HQR, is the system where you report your data, get reports, and things of that nature. So, with your HARP credentials you can access HQR, Managed File Transfer, as well as other CMS applications.

Recently, CMS announced an update to the status classifications for Security Officials in the HQR System. Anyone that does not log into HQR, to their HQR account, within 90 days will be listed as inactive. You need to be active in order to receive reports and enter data. So, if you report data for a single hospital, you will simply log into the My Profile on the landing page. You really don't need to do anything else, just log in.

If you are a Security Official for multiple facilities, you will need to log in to each of those organizations to remain ACTIVE. Again, you are just going to sign into the My Profile for each hospital that you report. So, keep your login capability current. You don't want to be locked out, or worse, have your account dismantled. So, if that occurs, then you're going to have to go through the whole process again. You really don't want to do that, especially if it's close to a submission deadline.

Also, make sure you have the appropriate roles you need in order to receive reports. All this can be done within the HQR System. There are also tutorials that are helpful as well, and the direct link here on the slide will take you directly to the tutorials.

We send a lot of communications out through the QualityNet email service. You can sign up for that email service on the home page of QualityNet. You can also use the link we show right here on this slide. It does takes about five minutes maybe to sign up. It is just a no-cost way, easy way, to stay in the loop on current program-related information, education, deadlines, and things of that nature. So, make sure you have signed up for the QualityNet email service. Also, make sure you have the specifications manual available. The manual will always ensure you are collecting and reporting accurate data as specified in the manual.

We are conducting a webinar on reviewing the program requirements, new tools, and resources, and that will be coming up in the near future. We will also be posting an On Demand webinar for the new COVID-19 measure. So, we'll send out notices announcing those presentations. So, make sure that you are signed up for that QualityNet email service.

The calendar year 2022 rule was very lengthy. We went into quite a bit of detail during the proposed rule webinar. Today, though, we will not be focusing on details, but we will let you know what you need to know to report successfully for this program. We do encourage you however to read the rule for points of clarification and details.

The final rule is published annually and can be found in the *Federal Register*. For the finalized proposals specific to the Hospital OQR Program, you will refer to pages 365 through 418 of the PDF version. There are also addenda related to the proposed and final rules with comment period, and they are located online at CMS.gov. We do have the direct link to that here on the slide as well. So, without further delay, let's begin our discussion on the final rule. Let me turn things over to Shaili Patel. Shaili?

Shaili Patel: Thank you, Karen. As Karen mentioned, we covered an enormous amount of information in the rule. For the sake of simplicity, we are going to discuss the finalized proposals in brief detail, but I do encourage you to refer to the rule for more in-depth comprehension.

In the Calendar Year 2022 OPPS/ASC Proposed Rule, we proposed to remove two measures: OP-2: Fibrinolytic Therapy Received Within 30 Minutes of Emergency Department Arrival and OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention. The OP-2 and OP-3 measures are chart-abstracted measures, which result in greater provider burden due to manual abstraction.

We proposed this removal beginning with the calendar year 2023 reporting period for the calendar year 2025 payment determination due to the availability of a more broadly applicable measure. After consideration of public comments, we have finalized this proposal as proposed.

As these removals take place starting with the calendar year 2023 reporting period for the calendar year 2025 payment determination, you may have a question as to when will you stop reporting data for OP-2 and OP-3. As you can see on this slide, you will continue to report data for OP-2 and OP-3 until August 1, 2023, for the Quarter 1 2023 reporting period, which is applicable towards calendar year 2025 payment determination. In other words, you are not required to submit data for OP-2 and OP-3 for calendar year 2024 reporting period for calendar year 2026 payment determination.

In the Calendar Year 2022 OPPS/ASC Proposed Rule, we proposed to adopt three new measures: STEMI eCQM, as a voluntary measure for the calendar year 2023 reporting period, and then mandatory beginning with the calendar year 2024 reporting period; COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) measure, beginning with the calendar year 2022 reporting period; and Breast Cancer Screening Recall Rates measure, beginning with the calendar year 2023 payment determination.

Starting with the STEMI eCQM, with the removal of OP-2 and OP-3, we proposed and finalized the adoption of OP-40: STEMI eCQM into the Hospital OQR Program measure set, which would serve as a replacement for the two measures we removed. We believe that the adoption of the STEMI eCQM will capture the OP-2 and OP-3 measure populations and expand beyond these populations to comprehensively measure the timeliness and appropriateness of STEMI care.

After consideration of the public comments we received, we finalized this measure to be voluntary for the calendar year 2023 reporting period and mandatory reporting starting with calendar year 2024 reporting period for the calendar year 2026 payment determination and subsequent years. We believe the timeline will provide hospitals with sufficient time to practice and operationalize reporting transitioning from OP-2 and OP-3 to the STEMI eCQM.

The OP-40 measure is a process measure. This measure calculates the percentage of ED patients with a STEMI diagnosis who received appropriate treatment such as PCI, fibrinolytic therapy, or transfer. As an eCQM, the OP-40 measure allows for the retrieval of data directly from the electronic health record using patient-level data. We believe that it is a more broadly applicable measure and transitions the Hospital OQR Program toward the use of EHR data for quality measurement.

The use of the STEMI eCQM measure, in lieu of the OP-2 and OP-3 measures, will eliminate the need for manual abstraction and reduce burden for the hospitals. It will also broaden the group of measured STEMI patients included in the measure to include patients who present to and receive primary PCI at a PCI-capable facility, which is the vast majority of STEMI patients. This is discussed in detail in the final rule. We encourage you to access the rule and the full specifications for this measure by using the link provided on the slide.

Let's talk a little bit more about the specifics of eCQMs and the file format. For eCQMs, data are collected in EHRs and health information technology systems using standardized formats to promote consistent representation and interpretation, as well as to allow for systems to compute data without needing human interpretation. These standards are referred to as content exchange standards. This allows the data to be exchanged across EHRs and health IT systems while retaining their meaning.

Commonly used content exchange standards include the Quality Reporting Document Architecture, or QRDA. The QRDA standard provides a document format and standard structure to electronically report quality measurement data. We believe electronically reporting data elements formatted according to the QRDA standard would promote consistent representation and more efficient calculation of eCQM measure results.

In alignment with the Hospital Inpatient Quality Reporting Program file format, we finalized our proposal that, beginning with the calendar year 2023 reporting period, hospitals must submit eCQM data via the QRDA Category I file format; may use third parties to submit QRDA Category I files on their behalf; and may either use abstraction or pull the data from non-certified sources in order to then input these data into CEHRT for capture and reporting QRDA Category I.

Also regarding eCQMs, we proposed and finalized zero denominator declarations and case threshold exemptions. These will also align with the start of the STEMI eCQM beginning with the calendar year 2023 reporting period for calendar year 2025 payment determination. The case threshold exemption means that for each quality measure for which hospitals do not have a minimum number of patients that meet the population denominator criteria for the relevant reporting period, hospitals would have the ability to declare a ‘‘case threshold exemption’’ if they have five or fewer applicable discharges. Case threshold exemptions are entered on the Denominator Declaration screen within the HQR System. So, if a hospital experiences five or fewer outpatient discharges per quarter, or 20 or fewer outpatient discharges per year, for both Medicare and non-Medicare combined, hospital could be exempt from reporting on that eCQM.

Therefore, if the hospital does not have patients that meet the denominator criteria of STEMI eCQM, the hospital can submit a zero in the denominator. Submission of a zero in the denominator for an eCQM counts as a successful submission for the Hospital OQR Program.

In the Calendar Year 2022 OPPS/ASC Proposed Rule, we proposed to require eCQM data submission by the end of two months following the close of the calendar year for the calendar year 2023 reporting period and for subsequent years. We believe that by aligning with the Hospital IQR and Promoting Interoperability Programs deadlines, we would not add unnecessary burden. However, we also considered a submission deadline of May 15 to align with the submission deadline for the Hospital OQR [Program] web-based measures. The submission deadline may be moved to the next business day if May 15 falls on a weekend or on a Federal holiday. After consideration of public comments, we have finalized May 15 as the data submission deadline for eCQMs starting with calendar year 2023 reporting period and subsequent years.

This slide maps out the deadlines beginning with the voluntary quarter for the calendar year 2023 reporting period. Data submission is mandatory beginning with calendar year 2024 reporting period with required one self-selected quarter. You may, however, submit more quarters on voluntary basis. After calendar year 2024, you will gradually work up to full one year or four quarters of reporting starting with the calendar year 2027 reporting period. We also proposed that hospitals would have a review and corrections period for eCQM data submitted to the Hospital OQR Program. We received no comments on this proposal. Therefore, we have finalized this proposal as proposed.

The review and corrections period for eCQM data will run concurrently with the data submission period, which is from the time the submission period opens to the submission deadline. In the HQR System, providers can submit QRDA Category I test and production data files and can correct QRDA Category I test and production data files before production data is submitted for final reporting. We encourage early testing and the use of pre-submission testing tools to reduce errors and inaccurate data submissions in eCQM reporting, as the HQR System does not allow data to be submitted or corrected after the annual deadline.

Please access the website listed on the slide to become familiar with this new measure. As you can see, the landing page of this resource has a lot of information at your disposal. We will provide education on eCQMs and the reporting of the STEMI eCQM in the near future. We will send out notification of these educational webinars as time draws closer. Until then, please access the resource here on the slide as well as the resources defined in the rule.

Moving on to the second adoption of a measure. After consideration of the public comments, we finalized our proposal to adopt the COVID–19 Vaccination Coverage Among HCP measure, designated as OP-38. Reporting for the new COVID-19 measure begins with the calendar year 2022 reporting period for the calendar year 2024 payment determination. Based on the comments we received; we believe that reporting a single HCP count for each healthcare facility enrolled in NHSN would reduce burden. Therefore, in collaboration with the CDC, facilities will report data to NHSN by enrolled facility. The CDC will then translate and submit the data to CMS on behalf of the hospital by CCN.

Acute care facilities would count HCP working in all inpatient or outpatient units that are physically attached to the acute care facility 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 (such as sharing medical privileges or patients), regardless of distance from the acute care facility and also share the same CCN. The COVID-19 HCP vaccination measure will assess the percentage of hospital's healthcare workforce that has been fully vaccinated.

The denominator of 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 the vaccination.

The numerator 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.

The reporting would be through the CDC's National Healthcare Safety Network web-based surveillance system. We initially believed it would be ideal to have HCP vaccination data for every week of each month, but we are mindful of the time and resources that hospitals would need to report the data. Hospitals will collect the data for at least one, self-selected week during each month of the reporting quarter by the deadline, and data will be reported quarterly by the specified deadline. Specifications of this measure are available on the NHSN/CDC link here on this slide.

Based on the public comment, we are finalizing a modification to our proposal. We will not finalize our plan to add one additional quarter of data during each advancing refresh, until the point that four full quarters of data is reached and then report the measure using four rolling quarters of data. Instead, we will only report the most recent quarter of data. This would result in more meaningful information that is up to date and not diluted with older data.

We will then publicly report the percentage of HCP who received a complete course of the COVID-19 vaccination per CCN. This single HCP count per CCN will inform the public of the percentage of vaccinated HCP at a particular healthcare facility, which will provide meaningful data and help improve the quality of care. We have finalized our proposal to publicly report the measure, which will begin with the January 2023 Care Compare refresh, or as soon as technically feasible, using data collected from Quarter 1 2022 which is January 1, 2022, through March 31, 2022.

To further clarify when you will begin reporting this measure, we finalized that reporting would begin with the calendar year 2022 reporting period. The dates for that reporting period are from January 1 through March 31, 2022. As we discussed you will collect data for at least one, self-selected week during each month in that quarter. So, for Quarter 1 2022, that would be one week of submission each for January, February, and March of 2022. The submission deadline to submit that first quarter of data is August 15, 2022.

So, that's the first quarter, but what about the rest of the quarters? Back to what I was saying before about this measure being implemented across programs. First, as I discussed, this measure is being reported per CCN. So, hospitals will report once for both the inpatient and outpatient programs. However, the two programs have different quarters associated with their payment years.

Inpatient will start reporting Quarter 3 data with a deadline of May 16, 2022. The outpatient program will start reporting their Quarter 1 2022 data, which are January 1 through March 31 encounters. This has a deadline of August 15, 2022.

For simplicity's sake, since the hospital is reporting as a whole for both inpatient and outpatient, the Quarter 4 data that will be reported to meet the inpatient program requirements will not cause any issue for the outpatient program, since the first deadline for the OQR program is technically August 15. For program requirement purposes, the extra quarter is viewed as additional data as it does not apply to the payment year.

Moving on to the third measure. To address the health and clinical risks associated with too many or too few breast cancer screening recalls, we proposed to adopt the Breast Cancer Screening Recall Rates measure. We note that we originally proposed the measure as Breast Screening Recall Rates Measure. However, based on comments we received, we have renamed this measure as Breast Cancer Screening Recall Rates.

After consideration of public comment, we have finalized OP-39, beginning with calendar year 2023 payment determination using a data collection period of July 1, 2020, through June 30, 2021, and then data collection periods from July 1 through June 30 of the following year, starting three years before the applicable payment calendar year for subsequent years. Please note that claims for the initial patient population would be identified from July 1 through May 17 of each year, with numerator cases occurring from July 1 through June 30 annually.

Facilities with performance rates that are less than 12 percent and greater than 5 percent are likely recalling an appropriate number of Medicare FFS beneficiaries following screening mammography or screening DBT; that means, on average, facilities will recall about 7 percent of patients who undergo a screening mammography or screening DBT. If a facility's score is lower than 5 percent, they may be missing cases of cancer; conversely, if their score is above 12 percent, the facility may be recalling too many patients for follow-up imaging. This will allow the public to make informed decisions about their care.

We intend for this measure to move facilities toward the 5 to 12 percent range of recall rates. Facilities that are above or below the range should consider implementation of internal quality-improvement procedures to ensure they are not missing cases or recalling individuals unnecessarily.

This claims-based process measure documents breast cancer screening recall rates at the facility level. The Breast Cancer Screening Recall Rates measure would calculate the percentage of Medicare FFS fee-for-service beneficiaries for whom a traditional mammography or DBT screening study was performed that was then followed by a diagnostic mammography, DBT, ultrasound of the breast, or MRI of the breast in an outpatient setting or office setting on the same day or within 45-calendar days of the index image. Specific measure details are located on the QualityNet website, and you can access that information by visiting the website listed on the slide.

Let's look at how the data collection for the OP-39 measure will look.

Beginning with the calendar year 2023 payment determination, we will use a data collection period of July 1, 2020 to June 30, 2021. For subsequent years, we will use data collection periods from July 1 through June 30 for three years prior to the applicable payment calendar year as you can see here on the slide. Because the measure is calculated using claims data that are already submitted to Medicare program for payment purposes, facilities do not have to manually abstract measure data for submission. This means the measure will not result in any increase in information collection burden.

In the calendar year 2022 final rule, we also finalized measures that were either voluntary or suspended in the [Hospital] OQR Program. Starting with OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery, this measure has been adopted in the [Hospital] OQR Program for voluntary reporting since the calendar year 2015 reporting period. We emphasize the value of this measure and continue to believe that OP-31 addresses a high-impact condition and that it provides opportunities for care coordination and direct patient feedback.

In the calendar year 2022 proposed rule, we proposed mandatory reporting beginning with the calendar year 2025 reporting period. Our overall goal for the OP-31 measure is to encourage the coordination of care across health care settings, providers, and suppliers as frequently as possible. We aim to see hospitals, ophthalmologists, and other clinicians (such as optometrists) actively and routinely engaged in exchanging information to better communicate and coordinate the care of patients. We understand that it may be difficult and complex to share data generated in different settings.

Based on the comments received, we believe a two-year extension from our originally proposed timeline of the calendar year 2023 reporting period will provide hospitals with sufficient amount of time to implement coordination strategies between the surgeon and the ophthalmologist, provide staff training, and operationalize the measure for successful reporting in the [Hospital] OQR Program. Therefore, we finalized mandatory collection beginning with the calendar year 2025 reporting period for the calendar year 2027 payment determination and subsequent years. As a reminder, this is a web-based measure submitted via the HQR System.

For those of you who have always submitted data on this measure, you may continue to do so. For those of you that have not voluntarily submitted data, we encourage gaining experience of submitting this measure voluntarily as the mandatory reporting begins with the calendar year 2025 reporting period. You will use the reporting period, or patient encounters from January 1 through December 31 of 2025. The data will need to be entered into the HQR System during the submission period, which is anytime from January 1 through May 15, 2026.

Next, regarding the survey measures, in the calendar year 2022 proposed rule, we proposed to resume OP-37 OAS CAHPS. Specifically, we proposed voluntary reporting beginning with the calendar year 2023 reporting period, followed by mandatory reporting beginning with the calendar year 2024 reporting period for calendar year 2026 payment determination.

Implementing the OAS CAHPS Survey-based measures in the [Hospital] OQR Program will enable patients to compare patient experience of care data across multiple hospitals as part of their healthcare decision-making. In addition, we believe implementing these measures will incentivize hospitals to factor patient experience of care into their quality improvement efforts more proactively.

The National OAS CAHPS Survey voluntary reporting program is independent of the [Hospital] OQR Program. The reporting process for hospitals to submit OAS CAHPS Survey data would remain unchanged. The OAS CAHPS Survey is administered to all eligible patients—or a random sample thereof—who had at least one outpatient surgery or procedure during the applicable month. The guidelines manual for these measures can be found at the link on this slide. The data collection and submission for the OAS CAHPS Survey measure will be reported at the CCN level.

The OAS CAHPS Survey data will be made publicly available along with the other OQR measure data on Care Compare to enable consumers to make informed decisions as well as encourage healthcare facilities to make continued improvements to provide quality of care. We believe that these survey-based measures will be useful to assess aspects of care where the patient is the best or only source of information and to enable objective and meaningful comparisons between hospital outpatient departments.

We finalized additional collection modes using a web-based mode, web with mail follow-up of non-respondents, and web with telephone follow-up of non-respondents for administrating the survey. While we did not propose solely digital modes of conducting the OAS CAHPS Survey, we are analyzing whether a web-only or digital-only format would be appropriate for OAS CAHPS Survey-based measures, which could potentially further reduce administrative burden. You can access additional information about modes of administration on the OAS CAHPS website listed on this slide.

With regards to reporting requirements, via their CMS-approved survey vendor, hospital data collection must be initiated no later than 21 calendar days after the month in which a patient has a surgery or procedure at a hospital. Hospital collect survey data for eligible patients using the established quarterly deadlines to report data for each data collection period.

Surveys can be completed up to 42 days following the invitation to complete the survey, unless the hospital has been exempted from the OAS CAHPS Survey requirements under the OAS CAHPS low-volume exemption policy. This exempts hospitals that treat fewer than 60 survey-eligible patients during the “eligibility period.”

So, the vendor needs to initiate surveys no later than 21 days after the surgery or procedure and the surveys should be completed within six weeks or 42 days following the initial invitation to complete the survey.

More on the reporting requirements: We finalized a target number of 300 completed surveys annually. The survey data reported using a Medicare participating hospital's CCN must include all eligible patients from all outpatient locations (whether the hospital outpatient department is on campus or off campus) of an eligible Medicare participating hospital; or, if more than 300 completed surveys are anticipated, a hospital can choose to randomly sample their eligible patient population.

The low volume exemption, which exempts hospital outpatient departments with fewer than 60 survey-eligible patients during the ‘‘eligibility period,” the calendar year before the data collection period. Such facilities will need to submit the participation exemption request form, which is made available on the OAS CAHPS Survey website listed on this slide on or before May 15 of the data collection year, which is the calendar year before the data collection period. As finalized previously, all exemption requests will be reviewed and evaluated by CMS. For hospitals that do not have an exemption, the submission deadlines would be posted on the OAS CAHPS Survey website again listed on this slide.

We encourage you to access the rule as well as the OAS CAHPS website for more comprehensive discussion. As I mentioned previously, we finalized voluntary reporting beginning with the calendar year 2023 reporting period and mandatory reporting beginning with calendar year 2024 reporting period for calendar year 2026 payment determination. So, for the mandatory reporting, and for the first submission, hospitals will use Quarter 1 2024 data, and you will submit sometime in July. As this time comes closer, we will provide further information.

On this slide you will see the deadlines for the calendar year 2024 reporting period. Hospitals should check-in regularly with survey vendors to ensure that that vendors are properly submitting timely survey data. Data cannot be altered after the data submission deadline, but data can be reviewed prior to submission deadline.

Now, let's move on to the finalized administrative proposals.

First, the update regarding the validation policy. We have removed the option to send medical records via paper and removable media. Hospitals will now be required to use electronic submission. We also finalized the proposal to reduce number of days to submit medical records from 45 days to 30 calendar days.

Lastly, we have finalized our proposal to enhance the targeting criteria to select 50 additional hospitals. Based on this revised targeting criteria, we will 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. These changes will begin with the calendar year 2022 reporting period for calendar year 2024 payment determination and subsequent years.

In the [Hospital] OQR Program, we currently have Extraordinary Circumstances Exceptions, or ECE, policy in place; however, in this final rule, we have extended this policy to now include eCQMs. We will expand our established ECE policy to allow hospitals to request an exception from the Hospital OQR Program's eCQM reporting requirements based on hardships preventing hospitals from electronically reporting. Any hospital that wishes to request an exemption must submit its request to CMS by April 1 following the end of the reporting calendar year in which the extraordinary circumstances occurred. This change begins with the calendar year 2024 reporting period for calendar year 2026 payment determination and for subsequent years.

In the calendar year 2022 proposed rule, we requested feedback and comment on various aspects of information related to the future of quality reporting. I will not be going into greater detail on this as the information is extensive; however, please refer to the final rule for more information on the request as well as a summary of feedback we received on various topics.

We requested stakeholder comment on potential future adoption on, first, the Patient-Reported Outcomes/Total Hip and Knee Replacement. Due to potential elimination of the inpatient only list, more procedures, such as joint replacement, are expected to be performed in the outpatient setting. Second, [we requested stakeholder comment on] potential future adoption of measures for the program, again given the gradual move of procedures to the outpatient setting from the inpatient setting of care.

We also requested comment on Rural Emergency Hospitals, which would be a new provider type; health equity; and the future of digital quality measures for quality reporting programs. We are interested in comments on our plans to modernize its quality measurement enterprise. We will consider all the comments we received in the future rulemaking. I believe that covers the final rule content. Now, let me hand things back off to Karen.

Karen VanBourgondien: Thank you, Shaili. Shaili provided a lot of information. There is so much going on, but don't worry about that, you've got this. Let's go ahead and review what is necessary for you to do to meet program requirements.

First, let me take you through the measures of the program, starting with the clinical data. That's the chart-abstracted measures reported quarterly. OP-2 and OP-3 will be removed with the calendar year 2023 reporting period. Shaili discussed this earlier with you. You're going to continue to enter that data until August 1 of 2023. So, the very last time you're going to submit data for OP-2 and OP-3 will be that Quarter 1 data which is due August 1, 2023. Just refer back to that calendar that Shaili went over earlier with you.

The other two measures (OP-18 and OP-23) will continue as before. There were no changes to those measures. On the top of this slide are the web-based measures. OP-22 is actually an ED throughput measure. We have it listed here with the web-based measures because it is entered annually in the HQR System. There were no changes to OP-22 and OP-29, so they will continue as before.

Mandatory reporting for OP-31 begins with the calendar year 2025 reporting period, so you will definitely start the reporting for that at that time as Shaili talked about. That will be no later than May 16 of 2026. So, you still have some time for that.

OP-38, the new COVID-19 vaccination measure, you will begin reporting. You probably already have for inpatient. You will start, for the purposes of this program, using January 1, 2022, encounters. That's the beginning. Yet, as Shaili discussed, as these measures are reported per CCN, inpatient and outpatient are reported one time together. They are not reported separately.

On this slide are the claims-based measures. These data are collected via paid Medicare claims for cases that meet measure criteria. No manual abstraction is necessary on behalf of the hospital. The new OP-39 measure, that is the Breast Cancer Screening Recall Rates, that is going to begin with calendar year 2023 payment determination and that will use patient encounters from July 1, 2020 through June 30, 2021. It will use those encounters.

For the survey measures, mandatory reporting begins with the calendar year 2024 reporting period for the 2026 payment determination year. The new STEMI eCQM starts off with voluntary reporting of one quarter for the calendar year 2023 reporting period, and mandatory reporting begins the following year, the calendar year 2024 reporting period. That would be for the 2026 payment determination year.

So, what do you have coming in the immediate future? So, here on this slide, we have what you will need to report from now until August 2022.

The next two clinical quarterly submissions are just like they were the last quarter. You're going to report for OP-2, OP-3, OP-18, and OP-23. Remember, you're going to continue to report data for OP-2 and OP-3 until August of 2023. That will be for the Quarter 1 2022 data. Web-based measures are submitted as before. The mandatory reporting for OP-31 begins with the 2025 reporting period. However, you can certainly begin reporting data voluntarily up until that time.

The new COVID-19 measure began with the 2022 reporting period, which means it began with January 1, 2022, encounters. As we discussed a few times now, inpatient and outpatient programs are reporting together one number because the measure the data is collected per hospital CCN.

For the COVID-19 measure, you are reporting that information into the NHSN system. If you are not aware, this is completely separate from the HQR System where you submit your web-based measures and your other measures. There is a lengthy enrollment and registration process. If you do not have anybody reporting these data, please begin your registration process now, if you haven't already. You will not be able to report your data if you do not have the appropriate access and roles. Typically, in the hospital setting, infectious diseases report these data. Certainly, reach out if need be, and make sure that somebody is reporting the information.

Please access the NHSN website for details on this process. The link is here on the slide. Additionally, we do have NHSN's email address here as well. As I mentioned earlier, we will post an On Demand webinar with regard to the new COVID-19 vaccination measure next month. We will send out information, a Listserve information, and we will have all of that on our website, QualityReportingCenter.com. So, stay tuned for that.

There are also additional resources related to this new measure on the slide. You can access the links here. Lastly, we do have a new tool for you. This is a database. It's on our website. It is a Facility Compare Dashboard. You can just click on the link here on the slide. This is a tool you can use to access your facility's data and compare your hospital to others by location, state, nationally, whatever you choose.

We will also be including a tutorial on this new resource in our upcoming webinar. So, hopefully you will be able to attend that. Shaili, we have a few minutes. Do you mind if we just take a few questions from the chat box and discuss them together?

Shaili Patel: Of course, Karen.

Karen VanBourgondien: Okay, this one we have. We've received this a lot either by phone or through the Q&A Tool. The question is this: Is the COVID-19 measure the same for the inpatient program and for the [Hospital] Outpatient Quality Reporting Program?

Shaili Patel: Thank you for the question. Yes, it is the same measure. You will report that data once per hospital CCN. There is no need to enter data for the inpatient and outpatient programs separately. Again, your hospital will report data by CCN. If your hospital does not report the data, that also means then your hospital will not meet program requirements for both the Hospital Inpatient as well as the Outpatient Quality Reporting Program.

Karen VanBourgondien: Thank you, Shaili. Next question, this is about the STEMI. Why are hospitals self-selecting which quarters of data to submit for the STEMI eCQM before mandatory reporting? Shaili, can you answer that one?

Shaili Patel: Sure. The reason we finalized the self-selecting of quarters is because we believe that allowing the flexibility to self-select quarters of eCQM data to report will allow hospitals to gradually transition toward more robust eCQM reporting. Additionally, the ability to self-select quarters of data will provide the necessary time to gain experience and operationalize integration of eCQMs in the Hospital OQR Program.

Karen VanBourgondien: Thank you, Shaili. I know we are running a little short on time, but we've also got quite a few questions about this one. So, this is about OP-31. This person says, "I am concerned about the OP–31 measure being mandatory as we are concerned about the operational complexity of collection and sharing data for the measure across physicians and our hospital outpatient settings. Administering surveys and tracking responses for the OP–31 measure would be burdensome and our EHR systems are not compatible across physicians and our hospital." Shaili, can you address that?

Shaili Patel: Sure. We highly encourage hospitals, ophthalmologists, and other clinicians to engage in exchanging information actively and routinely to better communicate and coordinate the care of patients to promote quality of care. However, we do acknowledge the complexity of administering and sharing data for this measure across different settings. In response to these concerns, we finalized the requirement to report OP–31 beginning with calendar year 2025 reporting period and calendar year 2027 payment determination, instead of our originally proposed data collection beginning with the calendar year 2023 reporting period. We believe that the two-year extension will provide facilities with sufficient time for clinics and staff to address potential issues with extracting and sharing patient data.

The two-year extension will also allow facilities to prepare and update systems and technologies and prevent additional reporting burden. Lastly, we would like to emphasize the value of this measure. We continue to believe that OP-31 addresses a high-impact condition and provides opportunities for care coordination and direct patient feedback.

Karen VanBourgondien: Thank you, Shaili. I'm sorry we are running out of time. I wish we could take more questions. Again, that's all the time we have today. Thank you everyone for joining us. Shaili, we thank you as well. Thanks again for taking your time and reviewing the final rule with us. We appreciate your time. Thanks again, everyone, and have a great day.