Outpatient Quality Reporting Support

CY 2027 OPPS/ASC Payment Systems Proposed Rule Presentation Transcript

Speakers

Kimberly Go, MPA
Program Lead, Hospital Outpatient Quality Reporting (OQR) Program, CMS
Anita J. Bhatia, PhD, MPH
Program Lead, Rural Emergency Health (REH) Quality Reporting Program, CMS
Karen VanBourgondien, RN, BSN
Outpatient Quality Reporting Support Team

August 5, 2026
2 p.m. Eastern

Karen VanBourgondien: Hello, everyone. My name is Karen VanBourgondien. I am with the Outpatient Quality Reporting Support Team. Thanks for joining us today as CMS discusses the proposals put forth in the calendar year 2027 proposed rule.

Our CMS speakers today are Kimberly Go and Dr. Anita Bhatia. Kimberly Go is the Program Lead for the Hospital Outpatient Quality Reporting Program. She joined CMS' Center for Clinical Standards and Quality 2022 and brings a decade of experience in rulemaking and policy development. Anita Bhatia is the CMS Program Lead for both the Rural Emergency Hospital and Ambulatory Surgical Center Quality Reporting Programs, and she has more than 25 years of experience with policy development and evaluation at CMS.

If you have any questions regarding the information presented today, please submit them into the QualityNet Q&A Tool. We do have a direct link here on the slide, and we will also place that link in the chat box.

I'd like to make certain that the content covered on today's call should not be considered official guidance. This webinar is only intended to provide information regarding program requirements. Please refer to the proposed rule in the *Federal Register* to clarify and provide a more complete understanding of the proposals that CMS will be discussing today.

So, we do have the direct link to the rule in the *Federal Register*. We highly recommend you that read the rule for yourself. It will give you a more complete understanding of the proposals.

We have the agenda here, and we will be discussing any proposals that relate to the three programs. CMS will be summarizing those proposals. If you have not yet downloaded the PowerPoint from the QualityReportingCenter.com website, you can access the PowerPoint by clicking on the paperclip icon. Once you click on that icon, it should allow you to download a copy of the PowerPoint.

We do have a list of acronyms that we will be using during the presentation here for your convenience and reference.

Without any further delay, let me hand things over to our first speaker, Kimberly Go, to discuss the cross-program measure removal and the proposals for the Hospital OQR Program. Kim?

Kimberly Go: Thank you, Karen. Let's start with the cross-program proposal for the Hospital Outpatient and ASC Quality Reporting Programs.

CMS is proposing to remove the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure from the Hospital Outpatient Quality Reporting and ASC Quality Reporting Programs beginning with the Calendar Year 2027 reporting period affecting the calendar year 2029 payment determination. Both the Hospital Outpatient Quality Reporting Program and ASC Quality Reporting Program include the Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient measure which is tied more closely to outcomes of continued interest and importance.

Next, we have some proposals for the validation process for the Hospital OQR Program.

To ensure the accuracy and reliability of eCQM data, we propose to incorporate the validation of eCQM data into the Hospital Outpatient Quality Reporting Program's existing validation process as well as to streamline certain validation processes. Specifically, we propose to change the validation selection pool from 500 to 400 hospitals; update the number of cases for chart-abstracted and eCQM validation; include eCQM validation in the timing and submission of medical record requests; align the submission quarters for chart-abstracted and eCQM validation; establish an eCQM validation scoring method based on data accuracy; update the educational review process for validation results; and remove the requirement to resubmit materials previously submitted for validation reconsideration requests.

We anticipate the cumulative impact of these proposals would reduce burden for hospitals while increasing the accuracy of data reported under the program to better facilitate beneficiary decision-making and hospital quality improvement efforts.

To incorporate validation of eCQMs into the existing Hospital Outpatient Quality Reporting Program data validation process, we propose that validation begin with each eCQM when there is a full year of data available. For example, hospitals are required to submit all four quarters of data for the OP-40: STEMI eCQM beginning with data from the calendar year 2027 reporting period. Therefore, validation for the STEMI eCQM would begin with data from calendar year 2027 reporting period. Validation for the Emergency Care Access & Timeliness eCQM would begin with data from the calendar year 2028 reporting period, which is the first year that submitting four quarters of data for this measure is mandatory. Any future eCQMs adopted into the measure set would become eligible for validation after mandatory reporting of a full year of data is in effect.

Next, we propose up to 200 hospitals would be selected at random and up to 200 hospitals would be selected using targeting criteria for a total of up to 400 hospitals selected for validation beginning with hospital selections for validation affecting the calendar year 2030 payment determination. This change would reduce the total number of hospitals selected for validation each year from 500 to 400 hospitals, while maintaining a sufficiently reliable sample size. We would require any hospital selected for validation, either randomly or after meeting targeting criteria, to submit both chart-abstracted measure and eCQM data for validation.

We propose to revise the number and distribution of cases selected for validation to ensure a balanced assessment across measure types. Specifically, we propose to validate up to 32 randomly selected patient cases for chart-abstracted clinical process of care measures and up to 32 randomly selected patient cases for eCQMs, starting with validation of calendar year 2027 data affecting the calendar year 2030 payment determination.

Under this proposed validation policy, all hospitals selected for validation purposes would receive a total of five medical record requests for complete supporting medical record documentation from CMS or its designated contractor: That is four quarterly requests containing randomly selected chart-abstracted cases and one annual request containing randomly selected eCQM cases.

To maintain the continuity of annual validation activities, CMS is proposing a one-year transition period in which the validation results for calendar year 2027 chart-abstracted data would affect both the calendar year 2029 and calendar year 2030 payment determination. Please note that we would not automatically reselect a hospital that failed to meet the validation requirements for the calendar year 2029 payment determination under the targeting criterion for validation affecting the calendar year 2030 payment determination. For the calendar year 2030 payment determination, calendar year 2027 chart-abstracted data would be used again in combination with calendar year 2027 eCQM data for validation. That is, validation results for CY 2027 chart-abstracted measure data would impact both the calendar year 2029 and calendar year 2030 payment determinations. Additionally, hospitals selected for validation based on calendar year 2027 chart-abstracted data affecting the calendar year 2029 payment determination would not be selected again (either randomly or targeted) for validation for the same data affecting calendar year 2030 payment determination.

The table here illustrates our proposed changes, including a transition year, to align the validation for chart-abstracted and eCQM data. For the calendar year 2029 payment determination, calendar year 2027 chart-abstracted data would continue to be used for the calendar year 2029 payment determination under the existing 2-year cycle. In other words, there will be no change from our current policy for the calendar year 2029 payment determination.

For the calendar year 2030 payment determination, which is the transition year, calendar year 2027 chart-abstracted data would be used again in combination with calendar year 2027 eCQM data for validation. These data would impact both the calendar year 2029 and calendar year 2030 payment determinations. After the transition year, for the calendar year 2031 payment determination, calendar year 2028 chart-abstracted and eCQM data will be used for validation in the 3-year cycle.

We propose that eCQM validation scores would be determined using the same methodology currently used to score chart-abstracted measure validation. We are proposing this scoring for eCQMs to begin with calendar year 2027 eCQM data affecting the calendar year 2030 payment determination. The proposed validation scoring aligning with the current scoring for chart-abstracted measure validation includes that eCQM validation scoring would be based on the accuracy of eCQM data or the extent to which data abstracted for validation matches the data submitted to CMS. Consistent with the data validation scoring threshold currently applied to chart-abstracted measures, a minimum score of 75 percent accuracy would be required for the hospital to pass the eCQM validation requirement. Applying an upper bound of a 90 percent two-sided confidence interval with a 75 percent lower bound threshold level is appropriate because it accounts for sampling variability, reflects a reasonable standard of data accuracy, and aligns with existing validation thresholds for chart-abstracted measures while allowing for legitimate differences in hospital data implementation.

Under the current educational review process for chart-abstracted measures if a hospital requests an educational review for any of the first three quarters of validation and this review yields incorrect CMS validation results for chart-abstracted measures, the corrected quarterly score will be used to compute the final confidence interval. We propose to revise our policy to allow the results of educational reviews for all four quarters of chart-abstracted measure validation to be reflected in the final validation score prior to the calculation of the confidence interval.

Under the proposal to extend the validation timeline from a 2-year cycle to a 3-year cycle, sufficient time would become available to complete educational reviews for all four quarters. As a result, any corrected scores from educational reviews across all quarters would be used in calculating the final confidence interval. For eCQMs, we propose extending the educational review process established for chart-abstracted measure validation to eCQM validation beginning with validation affecting the calendar year 2030 payment determination (that is, starting with validated data from calendar year 2027). We believe that expanding the educational review process to include eCQMs would allow hospitals to better understand the processes and data for eCQM validation.

We also propose to revise existing regulations to no longer require hospitals to resubmit materials previously submitted to CMS for validation reconsideration requests unless specifically requested by CMS and to require only that the hospital provide any evidence supporting its validation reconsideration request. This change beginning with data from the calendar year 2026 reporting period affecting the calendar year 2028 payment determination. Removing resubmission of medical documentation as a requirement for validation reconsideration would reduce administrative burden for most hospitals that do not have revised records to submit, as well as for CMS to collect and track medical records that are already available. Hospitals that need to submit a revised medical record may still do so, but those hospitals that would otherwise be submitting copies of previously submitted records would no longer be required to submit them.

To summarize, we invite public comment on the proposed changes regarding data validation in the Hospital Outpatient Quality Reporting Program, including incorporating eCQM validation into the existing validation process for chart-abstracted measures, reducing the validation selection pool from 500 to 400 hospitals, updating the number of cases for chart-abstracted and eCQM validation, transitioning from a 2-year to a 3-year cycle between the reporting period and the payment determination year, establishing the eCQM validation scoring method, expanding the

educational review process to include eCQM validation, and no longer requiring hospitals to resubmit materials previously submitted for validation reconsideration requests.

In this rulemaking cycle, we also have a Request for Information for the Advance Care Planning eCQM.

We are seeking feedback on potential inclusion of an Advance Care Planning electronic clinical quality measure and other quality measure concepts related to advance care planning for the hospital outpatient setting. Advance care planning is a continuous process that supports patients in understanding and communicating their goals, values, and preferences regarding future medical care and decision-making. As more procedures shift from the inpatient to the outpatient setting, complex procedures may increasingly be furnished in hospital outpatient departments. Outpatient encounters can provide repeated opportunities for clinicians to build relationships with patients over time, which may support the initiation or updating of advance care planning documentation, including when patients are relatively stable or before their illness progresses. Regular reassessment and transparent communication are essential to maintaining person-centered care. Advance care planning facilitates shared decision-making by documenting patient preferences and ensuring that care remains aligned with patients' goals across care settings and transitions.

The Advance Care Planning eCQM was proposed for adoption in other quality reporting programs such as the Hospital Inpatient Quality Reporting, PPS-Exempt Cancer Hospital Quality Reporting, and Medicare Promoting Interoperability Program. Potentially adopting the eCQM across our quality reporting programs promotes the use of standardized advance care planning documentation in the electronic health record. Alignment in documentation helps ensure that care remains aligned with patients' stated preferences, leverages electronic health records to facilitate health information exchange, and supports the advancement of person-centered care across the care continuum.

The eCQM is calculated as a proportion by dividing the number of patients who meet the numerator criterion by the total number of eligible patients who meet the denominator criterion. The numerator comprises any one of the following: an advance care planning document, for example, an advance directive/living will; or documentation that an advance care planning discussion resulting in a documented decision occurred during the measurement period. The denominator includes all patients aged 18 years and older at the start of the measurement period who are discharged from a hospitalization during the 12-month measurement period.

We are seeking input on the importance, relevance, appropriateness, and applicability of including the Advance Care Planning eCQM in the Hospital Outpatient Quality Reporting Program, as well as on other measure concepts related to advance care planning for the outpatient hospital setting. We invite public comment on the topics seen her on the slide.

That concludes information related to the Hospital Outpatient Quality Reporting Program. Let me hand things over to Anita to discuss the finalized proposals as they relate to the REH Quality Reporting Program.

Anita Bhatia: Thank you, Kim. CMS is not proposing any changes to the Rural Emergency Hospital Quality Reporting Program in this proposed rule. The Rural Emergency Hospital Quality Reporting Program has been implemented per statute and is designed to ensure transparency and quality for care provided by rural emergency hospitals.

This brings us to the Ambulatory Surgical Center Quality Reporting Program information. Kim spoke earlier about the proposed removal of the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure which would apply to the Hospital Outpatient Quality Reporting Program and the ASC Quality Reporting Program. In addition to this proposed measure removal, we are requesting information regarding the possible stratification of the ASC-4: All-Cause Transfer/Admission Measure.

CMS previously adopted the All-Cause Transfer/Admission measure in the Ambulatory Surgical Center Quality Reporting Program in the calendar year 2012 OPPS/ASC final rule with comment period. The All-Cause Transfer/Admission measure is an outcome measure that assesses the rate of patients receiving care in an ambulatory surgical center who require transfer to a hospital or admission to a hospital upon discharge from the ASC. The current measure does not distinguish the phase of care in which a transfer occurs.

CMS is considering whether adding a phase of care stratification relative to the surgical encounter could improve the ability to interpret and use the All-Cause Transfer/Admission measure. An example of a stratification would be pre-procedure, intra-procedure, and post-procedure. The current measure reports an overall rate of transfers and admissions and does not specify when during the ASC encounter the need for transfer is identified. Stratification by phase of care could improve attribution and use across the diverse range of ASC services, including non-operative procedures such as those associated with pain management for hospital transfers/admissions associated with ASC care.

Thus, we seek public comment on clinically meaningful and operationally feasible approaches for incorporating a phase of care stratification for the All-Cause Transfer/Admission measure. Specifically, we seek input on potential stratification frameworks, including appropriate time anchors, their operational definitions, and corresponding time windows that could be used to define each stratification category. That concludes our summary of the Rural Emergency Hospital and ASC Quality Reporting Programs proposed rule information for this rulemaking. We encourage comment. Public comment is your opportunity to contribute to rulemaking decisions and resulting policy formation. To discuss how to comment, let me turn things back over to Karen.

Karen VanBourgondien: Thank you, Anita. To be assured consideration, comments must be submitted to CMS no later than August 31, 2026.

CMS cannot accept comments by fax and does encourage submission of comment by electronic means. You can submit comment by regular mail, or express, or overnight mail. These are separate addresses for these two types of mails, and you can access those exact addresses in the proposed rule. If you choose to use the snail mail option, please allow sufficient time for your comment to be mailed, to get there by the August 31 deadline.

When you access the *Federal Register* link, you will be directed to the exact location of the rule in the *Federal Register*. To begin the commenting process, you are just going to select the green Submit a Public Comment box.

That will take you to the Comment page. You can enter your comment in the comment field. You can also attach files if you choose.

Just scroll down that same page and enter the rest of the information in the designated fields. Fill in all the necessary information and make sure you click on: I read and understand the statement above. The Submit Comment box will not turn green unless that box is selected and the necessary information has been entered. Once you have completed all that, you will simply click the Summit Comment button. That's it. That is all there is to submitting your comment. Again, please do comment. CMS does look forward to hearing from you about the proposals that were discussed here today.

We are going to take a little time to review the measure sets for each program.

We are going to begin with the Hospital OQR Program measure set.

Beginning with the clinical chart-abstracted measures, OP-18 and OP-23, the slide displays the current calendar year 2026 reporting period. OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients will be removed from this program in the calendar year 2028 reporting period.

That will be for the 2030 payment determination when it is replaced with the ECAT eCQM. I will talk about that in a little ,ore detail in a few minutes. There were no changes or proposals related to OP-23. That measure will remain unchanged.

Next are the web-based measures for the Hospital OQR Program. As you know, these measures are submitted through the Hospital Quality Reporting system, or HQR. Again, we are looking at the calendar year 2026 reporting period; and as CMS discussed earlier, they are proposing the removal of the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure. That is OP-29 for the Hospital OQR Program. The proposed removal that they are proposing to begin with is the calendar year 2027 reporting period. If that proposal is finalized, this current reporting period will be the last time you report data for that measure. As a reminder, OP-22, like OP-18, will be removed and replaced with the ECAT eCQM beginning with the calendar year 2028 reporting period.

Claims-based Measures: Here you are looking again at the current calendar year 2026 reporting period. CMS made no proposed changes to these measures. So, collection of data for these measures will remain the same.

PRO-PM Measures: The THA/TKA PRO-PM began voluntary reporting for the calendar year 2025 reporting period. Mandatory reporting will begin in the calendar year 2028 reporting period for the 2031 payment determination. At this point, that's really not that far away. So, please start preparing. There will be a webinar on this measure in August so keep a look out for the notification of that event. Information Transfer PRO-PM, OP-46: That measure began this year with voluntary reporting followed by mandatory reporting next year. There were no proposed changes to either of these measures.

OAS CAHPS Measure: CMS did not propose any changes to the OAS CAHPS measure. You will continue to report via your CMS-approved vendor for this measure. Here on the slide you can see the current reporting period.

Your next submission deadline for your vendor will be October 14, 2026, and that will be for Quarter 2 data. That Quarter 2 data is for April 1 through June 30.

eCQMs: Here on the slide you are looking at the current reporting period. That is why you are only seeing the OP-40 measure, the STEMI measure. The reporting period began with January 1, and it extends through until December 31, 2026. You will report at least three quarters of data and enter that data by the submission deadline of May 17, 2027. The deadline is on the 17th of May because the 15th falls on a weekend. So, the deadline is extended to the following Monday.

eCQMs for the following year, for the calendar year 2027 reporting period, you see the addition of the ExRad and ECAT measures. For the calendar year 2027 reporting period, reporting for the STEMI measure will require hospitals to report all four quarters of data. The Excessive Radiation, or ExRAD, measure is voluntary. You can choose to report data for that measure or not. Of course, CMS does encourage reporting. However, if your hospital does not report data for the ExRAD measure, it will not impact your payment. As I mentioned earlier, the Emergency Care Access & Timeliness eCQM, or ECAT for short, will begin with voluntary reporting in the calendar year 2027 reporting period followed by mandatory reporting the following year. For the Hospital OQR Program, the ECAT measure will replace OP-22 and OP-18 when mandatory reporting begins, and that will be with the calendar year 2028 reporting period. At that point, you will not report data for OP-18 or OP-22. That concludes the summary of the measure set for Hospital OQR Program, and don't forget to make plans for the TKA/THA webinar. Mandatory reporting is right around the corner, so make sure you are prepared.

Now, we are going to move on for the measure set for the REH Quality Reporting Program.

Here is the clinical chart-abstracted measure, OP-18, for the current reporting period.

The OP-18 measure is the only chart-abstracted measure in the REH Quality Reporting Program. Right now, you are reporting for this measure. We will talk about the eCQM and how it affects the REH Quality Reporting Program in just a minute.

So, claims-based measures, you can see the measures here on the slide. Again, for the current reporting period, there were no proposed changes to any of these measures. So, collection of data will go unchanged for the REH Quality Reporting Program.

Lastly, we are going to talk about the new eCQM and the eCQM for the REH Quality Reporting Program. Next year, that is the calendar year 2027 reporting period, REHs can decide if they want to continue reporting the chart-abstracted OP-18 measure or report for the new ECAT eCQM. Unlike the Hospital OQR Program, reporting the ECAT eCQM for the REH Quality Reporting Program is optional. You can choose either one. You can report the chart-abstracted measure, OP-18, or you can report the ECAT measure, the new eCQM. It's up to you. If your REH decides to report for the new ECAT measure, then you won't report for OP-18. It is completely optional. That sums up the measure set for the REH Quality Reporting Program.

Lastly, we are going to review the measure set for ASC Quality Reporting Program.

Beginning with web-based measures for the current reporting period, you can see all the web-based measures. You will continue to report these measures annually in the HQR system for this current reporting period. However, as we discussed earlier, CMS did propose the removal of the ASC-9 measure with the calendar year 2027 reporting period. So, again, if that proposal is finalized, the calendar year 2026 reporting period will be the last reporting period that you will collect and submit data for that measure if it is finalized for removal. There were no other proposed changes to any of the web-based measures. The calendar year 2026 reporting period runs from January1 through December 31 of 2026.

You will submit these data next year by the May 17, 2027, deadline.

Next are the claims-based measures for this program, and there were no proposed changes to these measures. So, collection of data will go on unchanged. As a reminder, data for claims-based measures are extracted from paid Medicare claims and do not require any manual abstraction on the part of the ASC.

The ASC Quality Reporting Program has one PRO-PM measure, and that is the THA/TKA PRO-PM. It is currently in voluntary reporting. Mandatory reporting will begin with the 2028 reporting period. So, because of the way these pre and post dates work, it's not that far off. So, please, again, we are having that THA/TKA webinar. Please attend on August 19. We will go ahead and put a link in the chat box to the Quality Reporting Center website, and you can continue checking there. It is scheduled for August 19, but you can keep checking there to see when it's posted. If you are signed up for a listserve, you will get a notice through the QualityNet email service.

Last is the OAS CAHPS measure. CMS did not propose any changes to this measure for the ASC Quality Reporting Program. Your deadlines are the same as the Hospital OQR Program. The OAS CAHPS data are collected and submitted by a CMS-approved vendor, and the data are submitted quarterly. You can see the quarters here. Now, these deadlines are program deadlines. That means that your vendor has to submit the data that you provide, by these dates that you are seeing here, under the Submission Deadline on this slide. Your vendor most definitely has different dates that you must provide to them your data. So, you have to get your data to your vendor timely so that your vendor can submit your data to CMS timely. So, make sure you adhere to the dates that your vendor provides to you. Your next data submission is going to be October 14, 2026. That's for Quarter 2 data.

That sums up the ASC measure set. Let's just provide a few tidbits of information before we close out today.

Here are two very important websites that you should be aware of. From the QualityNet website, you can find program information, the specifications manual, program details, and measure information. You can sign up for email notifications that I mentioned and much more. On the QualityReportingCenter.com website, you can find program information, including the Guide to Successful Reporting for all programs. Take time to access these websites; they really do have a wealth of information. You can also register for our webinars on the QualityReportingCenter.com website. So, just access that website and look out for that TKA/THA webinar coming up soon.

Additional resources here that are also important, of course, our number is right there at the top. Reach out anytime. If you do have any questions, you can always ask that question through the QualityNet Question and Answer Tool. Then, we also have that CCSQ, Center for Clinical Standards and Quality, Service Center information. You would want to contact CCSQ for things like you are locked out HQR, password problems, technical issues with reporting your data in HQR, and those types of things.

Kindly take our post-event survey. We really do appreciate your feedback. Thank you, again, to Kim and Anita for taking time to summarize the proposals in this year's proposed rule. We really appreciate your time. Have a great day, everybody.