Outpatient Quality Reporting Support Team

CY 2025 OPPS/ ASC Payment System Proposed Rule Presentation Transcript

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Karen VanBourgondien: Hello, everyone, My name is Karen VanBourgondien, and 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 2025 proposed rule as it relates to both the [Hospital] OQR and REHQR Programs.

Our speakers today are Kimberly Go and Dr. Anita Bhatia. Kimberly is the Hospital OQR Program lead, and she joined CMS' [Center for] Clinical Standards and Quality in late 2022, where she served as task leader for the Electronic Prescribing for Controlled Substances Program and quality measure index. She previously worked with CMS, where she gained experience in rulemaking policy development for the Inpatient Prospective Payment System. Anita is the CMS Program Lead for the Rural Emergency Hospital Quality Reporting Program. Dr. Bhatia plays a crucial role in the development of the OPPS/ASC proposed rule and final rulings. Her contributions to the rulings are essential to the continuing success of these programs.

The objectives today are here on the slide. We will show you how to locate the rule in the *Federal Register*. Kim will discuss the three proposed health equity measures, and those do pertain to both the Hospital OQR and the REHQR Programs, as well as proposals that are specific to the Hospital OQR Program. Anita will be covering the proposals for the REHQR Program. Towards the end of the presentation, I will go through the steps to submit comments, and CMS does want your comment. They look forward to your feedback on these proposals that they will be discussing today.

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

So, here we are the direct links to the rule. That PDF version will take you to, just that, the PDF version. We've also included some addenda associated with the rule, and those can be located on cms.gov, we do have the long address here as well.

Without any further delay, let me hand things over to Kim to discuss the proposals that pertain to both the Hospital OQR and REHQR Programs.

Kimberly Go: Thank you, Karen. Significant and persistent disparities in health care outcomes exist in the United States. CMS is committed to advancing health equity and improving health outcomes through our Quality Reporting Programs. The CMS framework for health equity acknowledges that addressing health and health care disparities and achieving health equity should underpin efforts to focus attention and drive action on our nation's top health priorities. In this section, we will discuss CMS' vision for health equity, as well as the equity measures that CMS is adopting into the [Hospital] OQR and REHQR Programs this rulemaking cycle. We are committed to supporting healthcare facility leadership in building a culture of equity that focuses on eliminating health disparities to provide patients with high quality healthcare across care settings.

Inequities related to the social determinants of health may affect health related social needs, or HRSNs, which are individual-level, adverse social conditions that negatively impact an individual's health or health care and are associated with worse health outcomes and increased health care utilization. The persistent interactions among individuals, HRSNs, medical providers, practices, behaviors, and community resources significantly impact healthcare access quality and costs, as described in the CMS Equity Plan for Improving Quality in Medicare. Assessment of HRSNs is an essential mechanism for capturing the interaction between social, community, and environmental factors associated with health status and health outcomes. Adopting health equity quality measures would support the National Quality Strategy's goal of advancing health equity and whole person care.

To address these health equity issues, we are proposing the addition of three measures, the Hospital Commitment to Health Equity measure, or HCHE, Screening for Social Drivers of Health, or SDOH measure, and the Screen Positive Rate for SDOH measure. We have finalized these measures in other Medicare Quality Reporting Programs with the intent of ensuring equitable care across both the inpatient and outpatient settings to the greatest extent possible. Adopting these measures in OQR and REHQR would bring these programs into alignment with other Quality Reporting Programs and would incentivize quality reporting entities to collect and utilize data to identify critical equity gaps implement plans to address said gaps and ensure that resources are dedicated toward addressing health equity initiatives.

The first proposed measure, the Hospital Commitment to Health Equity, or the HCHE, measure, assesses a facility's commitment to health equity using five domains, which you see listed here. Domain 1: Equity is a Strategic Priority; Domain 2: Data Collection; Domain 3: Data Analysis; Domain 4: Quality Improvement; Domain 5: Leadership Engagement. If finalized, reporting the measure would begin at the calendar year 2025 reporting period for calendar year 2027 payment determination. The domains and the elements that hospitals will be attesting to are found in Table 87 in the proposed rule.

As I stated a moment ago, the HCHE measure consists of the five attestation-based domains aimed at advancing health equity. The numerator would capture the total number of domains to which the hospital or facility is able to attest affirmatively, up to a maximum of five domains. We propose a facility would only receive a point for a domain if it attested Yes to all of the elements within that domain. We would not accept an attestation whereby a facility attests Yes to some but not all of the elements. In the event a facility would not be able to attest Yes to one or more elements within a domain or the entirety of a domain, they would respond No. The denominator of the HCHE measures would constitute a total of five points. That is one point per domain.

Social drivers of health, or SDOH, is an umbrella term that refers to community-level factors that impact health and well-being. We selected five evidence-based domains to screen for HRSNs, which are noted here on the slide. These five domains were selected because they can be assessed across the broadest spectrum of individuals in a variety of settings. These domains have also established evidence of their association with health status, risk, and outcomes. Health Related Social Needs, or HRSNs, are social and economic needs that individuals experience that affect their ability to maintain their health and well-being. Consistent screening of patients for potential HRSNs helps healthcare facilities identify individuals who have historically been underserved by the healthcare system and could support ongoing quality improvement initiatives by providing data to stratify patient risk and organizational performance to address SDOH. The five-evidence based HRSN domains listed here. They will be used for both the Screening for SDOH and Screen Positive Rate for SDOH measures. These domains and their descriptions are found in Table 88 of the proposed rule. Please note that these are different from the five domains that hospitals must attest to for HCHE measure.

Our second proposed new measure, the Screening for SDOH measure, is a process measure that assesses the total number of patients aged 18 years or older on the date of service that were screened for social risk factors and specifically the five HRSNs we just discussed. We are proposing that voluntary reporting will begin in the calendar year 2025 reporting period, followed by mandatory reporting beginning with the calendar year 2026 reporting period for calendar year 2028, payment determination.

For data collection of the Screening for SDOH measure, we propose that healthcare facilities would use a self-selected screening tool to reduce burden and in recognition of the fact that some healthcare facilities may already be screening their patients for HRSNs. While we acknowledge the potential benefits of requiring all healthcare facilities to use the same screening instrument or prescribed set of standards around the number or types of screening questions used, we also recognize the benefits of providing healthcare facilities with flexibility to customize screening and

data collection to their patient populations and individual needs. We refer readers to evidence-based resources like the SIREN website for screening tool options and as the Accountable Health Community Screening Tool on cms.gov. In alignment with the Hospital IQR Program, we propose that hospitals could confirm the status of any previously reported HRSNs in another care setting and inquire about others not previously reported in lieu of re-screening a patient within the reporting period. In addition, if this information has been captured in the EHR in another outpatient setting or the inpatient setting during the same reporting period, we propose that the hospital could use that information for purposes of reporting the measure in lieu of screening the patient.

The Screening for SDOH measure is calculated as a percentage equal to the numerator over the denominator. The numerator is defined as the number of patients admitted to a hospital who are 18 years or older on the date of admission and are screened for all five HRSNs. The denominator is defined as the number of patients who are admitted to a hospital outpatient department, or REH as applicable, and who are 18 years or older. The measure excludes patients who opt out of screening or are unable to complete the screening and have no legal guardian or caregiver who can complete the screening on their behalf.

We propose that hospitals would aggregate data they collect for a numerator and the denominator, submit to CMS, and would not be required to submit patient-level data. We are proposing to require aggregate data because we believe patient-level reporting is unnecessary and would cause undue burden due to a transfer of large quantities of data. However, in the future, we may consider requiring the reporting of patient-level information. As stated, the reporting of this measure will begin with voluntary reporting followed by mandatory reporting. The one-year voluntary reporting period will provide a transition period for healthcare facilities to select and integrate screening tools into their clinical workflow processes.

Our third proposed health equity measure is the Screen Positive Rate for SDOH measure. Screen Positive Rate for SDOH is a process measure that provides information on the percentage of patients receiving care at a hospital who are 18 years or older on the date of service were screened for all five HRSNs. As with the screening for SDOH measure, we are proposing to adopt this measure, beginning with voluntary reporting for the calendar year 2025 reporting period, followed by mandatory reporting beginning with the calendar year 2026 reporting period for calendar year 2028 payment determination. While the screening for SDOH measure enables identification of individuals with HRSNs, the Screen Positive Rate for SDOH measure would allow healthcare facilities to capture the magnitude of these needs by requiring healthcare facilities to report the rates of patients who are screened positive for each of the five core HRSNs. Capturing the rate of positive HRSNs estimates the impact on healthcare utilization and quality of care and would enable the development of individual patient action plans. We believe the adoption of the Screen Positive Rate for SDOH measure would encourage healthcare facilities to track the prevalence of specific HRSNs among patients over time and use the data to stratify a risk as part of quality performance improvement efforts.

The results of the Screen Positive rate for SDOH measure are calculated and reported as five separate rates, one for each HRSN, each calculated with the same denominator. The numerator is defined as the number of patients 18 years or older receiving care at a hospital on the date of admission, who are screened for all five HRSNs and who screened positive for having a need in one or more of those HRSNs. The denominator is defined as the number of patients 18 years or older receiving care at the hospital on the date of admission and were screened for all five HRSNs during their care. This measure has the same exclusions. As the SDOH screening measure, which are seen here on the slide. Consistent with the Screening for SDOH measure, we propose to adopt the Screen Positive Rate for SDOH as an aggregate measure. As such, hospitals will be required to submit aggregated data representing the total numerator results for each of the five screening areas and the total

number of patients screened for all five of the HRSNs. Again, we are proposing to require aggregate data as we proposed for the Screening for SDOH measure, as well as beginning of a voluntary reporting period that would allow time for facilities to prepare for reporting of the measure.

For all three proposed measures, HCHE. Screening for SDOH, and Screen Positive Rate for SDOH, we are proposing that the reporting period would be January 1 through December 31 of the year. Two years prior to the applicable payment determination year, hospitals will be required to submit the data required for each of these three measures annually using a CMS-approved, web-based data collection tool available within the HQR system, starting January 1 through and including May 15 in the year prior to being applicable payment determination year. This is the same way you have been submitting your web-based measures for years. You have the reporting period and the submission period, as you always have, and those pertain to be applicable payment year. Hospitals will be able to enter, review, and correct data during the submission period. That also has not changed. Again, these health equity measures will apply to both Hospital OQR and the REHQR Programs.

Now, let's turn our attention to proposals specific to the Hospital OQR Program. It is highly recommended for you to read the rule for more complete understanding of these proposals.

First, we have selected two measures for removal from the Hospital OQR Program measure set. We are proposing to remove the MRI lumbar spine for low back pain [Lumbar Spine Imaging for Low Back Pain] and the Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low Risk Surgery measures beginning of the calendar year 2025 reporting period for calendar year 2027 payment determination. For the MRI lumbar spine and low back pain measure, studies have shown that this measure is not correlated with improved outcomes. The latest findings are consistent with responses to a 2020 request for public comment where commenters expressed concerns regarding measure exclusion conditions, imaging modalities, measure validity, and measure usability.

In response to that request for public comment, commenters also stated that an unintended consequence of using this measure may be a delayed diagnosis. For the Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low Risk Surgery measure, our routine monitoring and evaluation show that the range of cases per hospital varies greatly over time. In addition, while there was a slight average performance score improvement from payment determination year calendar year 2020 to 2024 of approximately 1 percent, the variation between the 10th and 25th percentiles of performance is not statistically distinguishable, indicating that the measure may not provide meaningful data for informing consumers about the quality of care for risk in hospitals. Based on these findings, these measures meet the criteria for measure removal Factor 2: Performance or improvement on the measure does not result in better patient outcomes.

We also have a proposal to adopt a new measure into the Hospital OQR measure set in addition to the health equity measures I discussed just a moment ago.

We are proposing to adopt the Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient-Reported Outcome-Based Performance Measure, hereafter referred to as the Information Transfer PRO-PM, beginning with voluntary reporting for calendar year 2026 followed by mandatory reporting beginning with the calendar year 2027 reporting period for calendar year 2029 payment determination. Recent studies have shown that, compared to inpatient settings, outpatient settings are associated with worse patient understanding and lower patient activation. That is an individual's understanding, competence, and willingness to participate in care decisions during the recovery, indicating an error for quality-of-care improvement. Research indicates that information that is simpler to read and more complete has been associated with fewer follow-up calls to providers, as well as less frequent hospital readmissions.

The Information Transfer PRO-PM aims to assess the level of clear, personalized recovery information provided to patients aged 18 years or older who had a surgery or procedure at a hospital. The measure reports the average score of a patient's ratings on a three-domain, nine-item survey to evaluate the clarity of the clinical information patients are given before, during, and after an outpatient surgery or procedure. The first domain, Applicability to Patient Needs, assesses whether recovery information considered a patient's health needs and personal circumstances. The second domain, Medications, examines the clarity of medication information provided, specifically guidance on taking new medications, potential side effects, and discontinuing medication. The third domain, Daily Activities, assesses the clarity of guidelines around diet, physical activity, returning to work, and driving. Results from this survey provide hospitals of patient-reported outcome data, designed to assess communication efforts and enable hospitals to reduce the risk of patient harm if the patient does not fully understand the recovery information.

We propose that the Information Transfer PRO-PM would be calculated based on PRO data collected by hospitals directly or through their authorized third-party vendors, through the survey instrument distributed to patients and their caregivers. We are proposing that the survey would be administered not less than two days post-procedure and no later than seven days post-procedure or surgery because this time frame may be more appropriate for patient reporting of specific events than longer time periods. Additionally, we are proposing a 65-day window for patient response because in pilot studies the surveys demonstrated the mean length of time between the procedure date to a survey response date was 65 days, or approximately two months. We also proposed a minimum random sample size of 300 completed surveys to ensure the reliability of the measure. Hospitals unable to collect 300 completed surveys would not be able to perform random sampling and would be required to submit data on survey responses from all completed surveys received.

The intent of the Information Transfer PRO-PM is to encourage hospitals to provide individualized recovery instructions regardless of the patient's unique characteristics. Therefore, there is no need for risk adjustment. The measure numerator is the sum of all individual scores a hospital receives from eligible respondents, which could be patients or caregivers. Individual scores are calculated using a top-box approach. Each individual score is calculated for each respondent by taking the sum of items for which the respondent gave the most positive response, Yes or Very Clear, and dividing by the number of items the respondent deemed applicable to their procedure or surgery. Applicable items are calculated by subtracting the sum of items for which the respondent selected does not apply from the total number of survey items. The measure denominator is the total number of patients 18 years or older who had a procedure or surgery in a hospital, left the hospital alive and responded to the survey. Only fully completed surveys are included in the measure calculation.

Last year, we finalized that, for the THA/TKA PRO–PM, hospitals must use the HQR system for data submission for a PRO-PM. In this proposed rule, we propose to apply the submission method to PRO-PMs in general, including the Information Transfer PRO–PM. We propose that hospitals must use the HQR system for data submission for any PRO-PM that we adopt for the Hospital OQR Program measure set. Hospitals may choose to directly submit their PRO-PM data to CMS using the HQR system or utilize a third-party entity such as a vendor or registry to submit their data using the HQR system. The HQR system allows for data submission using multiple file formats such as CSV or XML and the manual data entry option, allowing hospitals additional flexibility and data submission. The reporting period for each measure would be January 1 through December 31 or two years prior to the applicable payment determination year, and data would then be submitted annually via the HQR system, starting January 1 through May 15 the following year. That is one year prior to the applicable payment determination year. This is the same submission format used for the web-based measures for this program.

We also have three policy proposals for the Hospital OQR Program. Last year, we finalized an immediate measure suspension policy for the REHQR Program in lieu of an immediate measure removal policy. The REHQR Program's immediate measure suspension policy provides that in cases where we believe a measure raises patient safety concerns, we will suspend the measures use in the program rather than immediately remove the measure until its potential removal undergoes the standard rulemaking process. We seek to align the Hospital OQR Program with this policy. Therefore, in this rulemaking cycle, we are proposing to modify the current immediate measure removal policy in the Hospital OQR Program, so it is more appropriately referred to as the immediate measure suspension policy, beginning with calendar year 2025. Under this proposed immediate measure suspension policy, in cases where there is evidence that the collection and reporting of a measure raises potential patient safety concerns, we would suspend the measure from the program until potential removal can be proposed through the rulemaking process. We will notify hospitals and the public of a decision through standard communication channels, including program-specific Listservs and program guidance currently housed on the CMS designated website. We would then address a suspension and proposed policies regarding any such suspended measure in the next feasible rule making cycle.

Next, we propose that, beginning with the calendar year 2025 reporting period for calendar year 2027 payment determination, a hospital using EHR technology, certified to the ONC Health IT certification criteria, would be required to have its EHR technology certified to all eCQMs that are available to report under the Hospital OQR Program to meet reporting requirements. This would align the Hospital OQR Program's eCQM certification requirements with the Hospital IQR Program and Medicare Promoting Interoperability Program clinical quality measure electronic submission requirements for eligible hospitals.

Finally, in last year's rule making cycle, we finalized that data for the overall rate reporting measure and transfer patient strata would be publicly reported on both data.medicare.gov, in downloadable data files and on

Care Compare. Data for a psychiatric mental health patient stratum are not currently publicly reported on the Care Compare site. Our third policy proposal for Hospital OQR is to make data for a psychiatric mental health patient stratification available on Care Compare, including data that were previously published on data.medicare.gov but not displayed on the Care Compare site, beginning in calendar year 2025. Our routine monitoring and evaluation purpose measure has shown a median ED throughput time, or 4.7 hours for psychiatric and mental health patients, compared to 2.6 hours for non-psychiatric mental health patients, suggesting this is an area that may benefit from additional quality improvement efforts. These data will be useful for patients choosing a care location, as well as researchers and hospital staff as they attempt to address health disparities and improve a timeliness of care for mental health patients. Since the data required for public reporting are already collected and submitted by participating hospitals. Publicly reporting risk stratification would not create additional hospital burden.

That concludes my summary of the proposals for the Hospital OQR Program. Let me hand things over to Anita to discuss the proposals as they relate to the REH Quality Reporting Program.

Anita Bhatia: Thank you, Kim. I will now be covering our proposals for the Rural Emergency Hospital Quality Reporting Program,

For the Rural Emergency Hospital Quality Reporting Program, our first proposal is a modification of a measure currently adopted for the program. We are proposing to modify the reporting period for the Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery measure, beginning with the calendar year 2027 program determination. You might be thinking: Why would CMS do this? Well, now that there are more hospitals that have converted to REH status, we understand more about what these hospitals are and what services they are providing. We see that for the hospitals that have converted using a reporting period of one year, this allows only a limited number of current REHs to publicly report on this measure based on case threshold minimums. Therefore, in consideration of our statutory obligation to consider ways to account for

low case volumes and to publicly report on quality-of-care metrics for Rural Emergency Hospitals, we are proposing to increase the reporting period from one year to two years, beginning with the calendar year 2027 program determination. Under this proposal, the previously finalized one year data collection period for the calendar year 2026 program determination would remain in place, thus there would be no delay in the start of public reporting. However, beginning with the calendar year 2027 program determination, the reporting period would be supplemented with data from the prior calendar year. As we have here in our example for the calendar year 2027 program determination, the reporting period would comprise data from calendar years 2024 and 2025, that is encounters from January 1, 2024, through December 31, 2025. The longer reporting period of two years would facilitate greater case volumes for this measure, and subsequently, a larger portion of our REHs would have data that could be publicly reported going forward.

Next is a proposal regarding when a Rural Emergency Hospital would be required to submit data. CMS believes that it is necessary to specify when a hospital that converts to REH status would be required to report data to the REH Quality Reporting Program. Thus, the proposal is that an REH must begin submitting data to the REH Quality Reporting Program on the first day of the quarter, following the date that a hospital has been designated as converted to an REH. This policy aligns with that under the Hospital OQR Program.

This completes our summary of our proposals for the Hospital OQR and Rural Emergency Hospital Quality Reporting Programs. We would love to hear what you think about our proposals. Please comment and provide feedback. Every comment must be addressed, and this input is utilized in our decisions towards finalizing or not finalizing proposals. This is your opportunity to be involved and instrumental in the decisions made regarding these programs.

For details on how to comment, let me turn things back over to Karen.

Karen VanBourgondien: Okay, back to commenting and the proposed rule. To be assured consideration, comments must be submitted no later than September 9, 2024. CMS cannot accept comments by fax and does encourage submission of comment by electronic means. However, you may submit your comments by regular mail or express mail, overnight mail, and those types of things. However, please note that there are separate addresses for those types of comment responses, and those addresses can be found in the proposed rule. Please allow sufficient time for any mailed comments to be received, because, again, they need to be received by CMS no later than September 9.

When you access the *Federal Register* link here, you will be directed to the exact location of the rule in the *Federal Register*. The image you're seeing here is the top part of what you will be seeing. To begin the commenting process, you're just going to select that green Submit a Formal Comment box.

You will enter your comment in the comment field. You can also attach files, if you like. There's a green icon there for attaching files. Fill out the rest of the information you do have and provide your email.

You'll slide down that page, and you will continue to fill out the rest of the information, your organization type, name, etc. You do have to select, "I read and understand the statement above." That is your filing and document into an official docket. Any personal information included in the comment, text, and/or uploaded may be publicly viewable. So, you have to read that statement, check the "I read and understand the statement above" box, and then you're just going to simply select the Submit comment box, that green box. That's really all there is to it, to submitting your comment. Again, please do comment. CMS does look forward to hearing from you about the proposals that were discussed here today.

So, okay, I think we're running up on time for today. Anita and Kim, I want to thank you both again for joining us today and talking to all of us about CMS' proposals. It does seem like we covered a lot of information. However, if you have any follow up questions, you can feel free to put those in the Q&A tool. We have some resources here for you, again, please do comment, CMS does look forward to hearing from you. That's all the time we have today I hope this presentation was helpful to you and understanding the proposals. We look forward to your commenting and we will see you next time. Have a great day.