Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

CY 2026 Hospital 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. Thank you for joining us today as CMS discusses the proposals put forth in the calendar year 2026 proposed rule.

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

The objectives for today are here on the slide. We are going to be showing you where to locate the rule in the *Federal Register*. Kim will discuss the Request for Information and proposals which extend across the outpatient quality reporting. Programs, and she will also cover the proposals specific to the Hospital OQR Program. Anita will discuss proposals specific to the Rural Emergency Hospital Quality Reporting Program. At the end of the presentation, we will cover submitting comments on the proposals discussed here today.

I'd like to just make certain that the content covered on today's call should not be considered official guidance. This webinar is intended to provide information only. Please refer to the proposed rule, located in the *Federal Register* to clarify and provide a more complete understanding of the proposals for the programs we are going to be discussing today.

Here there are direct links to the rule. We do highly recommend you read the rule yourselves for a more complete understanding of the proposals. Without any further delay, let me hand things over to our first speaker, Kim, to discuss the cross-program proposals. Kim?

Kimberly Go: Thank you, Karen. To begin, let's start with the Request for Information extended across the outpatient quality reporting programs.

We are seeking input from all of you on measures related to well-being and nutrition for consideration in future rulemaking for the Hospital OQR, REHQR, and ASCQR Programs.

Specifically, CMS is seeking input on well-being and nutrition measures for consideration in future rulemaking. Well-being is a comprehensive approach to disease prevention and health promotion as it integrates mental and physical health while emphasizing preventive care to proactively address potential health issues. This comprehensive approach emphasizes person-centered care by promoting well-being of patients and family members. We are seeking comment on tools and measures that address overall health, happiness, and satisfaction in life. This could include aspects of emotional well-being, social connections, purpose, and fulfillment. We would like to receive input and comment on tools and constructs that asses complimentary and integrative health, skill building, and self-care.

We are also seeking comments on tools and measures that assess optimal nutrition and preventive care. Assessments for nutritional status may include strategies, guidelines, and practices that promote healthy eating habits and ensure individuals receive the necessary nutrients for maintaining health, growth, and overall well-being. While we will not be responding to specific comments in response to this RFI in the calendar year 2026 OPPS/ASC final rule, we intend to use this input to inform our future measure development efforts.

There were several proposals to remove measures across the outpatient quality reporting programs for the Hospital OQR, REHQR, and ASCQR Programs.

CMS is proposing the removal of the COVID-19 Vaccination Coverage Among Healthcare Personnel measure as well as the three equity measures: the Screening for Social Drivers of Health, or SDOH, measure; the Screen Positive Rate for SDOH measure; the Facility Commitment to Health Equity, or FCHE, for ASCs; and the Hospital Commitment to Health Equity, or HCHE, measure for hospital outpatient departments and REHs.

These measures are proposed for removal under Factor 8: The costs associated with these measures outweigh the benefits of their continued use in CMS quality reporting programs. Removal of these measures would allow for the [Hospital] OQR, REHQR, and ASCQR Programs to focus on clinical goals. We will now walk through each of these measures that are being proposed for removal.

For the Hospital OQR, REHQR, and ASCQR Programs, CMS is proposing to remove the COVID-19 Vaccination Coverage Among Healthcare Personnel measure beginning with the calendar year 2024 reporting period for calendar year 2026 payment determination. If finalized as proposed, facilities that did not report COVID-19 HCP measure data would not be penalized for payment determination, and any measure data submitted would not be used for public reporting or payment purposes.

CMS is also proposing to remove the HCHE/FCHE and both SDOH measures beginning with the calendar year 2025 reporting period for calendar year 2027 program determination. As with the COVID-19 HCP measure, if finalized as proposed, facilities that do not report HCHE/FCHE measure data would not be penalized for payment determination, and any measure data submitted would not be used for public reporting or payment purposes. As a reminder, the SDOH measures are voluntary for the calendar year 2025 reporting period, so any measure data submitted would not be used for public reporting or payment purposes.

Moving on to administrative proposals regarding the Extraordinary Circumstance Exception process the [Hospital] OQR, REHQR, and ASCQR Programs. The current Extraordinary Circumstance Exception policy provides flexibility for program participants in meeting program requirements in the event of an extraordinary circumstance, such as a cyberattack or a natural disaster. However, we recognize that, in circumstances where a full exception is not applicable, it is beneficial for a facility to report data later than the reporting deadline.

Delayed reporting authorized under our ECE policy allows temporary relief for participating facilities experiencing an extraordinary circumstance while preserving the benefits of data reporting, such as transparency and informed decision-making for beneficiaries and providers.

Accordingly, we are prosing an update our current policy. Under current ECE regulations, CMS has granted exceptions to data submission deadlines and requirements in the event of extraordinary circumstances beyond the control of a facility. We are proposing to update our regulations to specify that an ECE could take the form of an extension of time for a facility to comply with a data reporting requirement if CMS determines that this type of relief would be appropriate under the circumstances. You can find the ECE regulations in the rule at the specified location here on the slide.

We are also proposing that a facility may request an ECE within 30 calendar days of the date that the extraordinary circumstance occurred. This current policy allows a request within 90 days. So, if this proposal is finalized, instead of having 90 days to submit an ECE, you will have 30 days. Additionally, we propose that CMS notify the requestor with a decision in writing. If CMS grants an ECE to the facility, the written decision will specify whether the facility is exempted from one or more reporting requirements or whether CMS has granted the facility an extension of time to comply with one or more reporting requirements. Lastly, we propose that CMS may grant an ECE to one or more facilities that have not requested an ECE if CMS determines that a systemic problem with a CMS data collection system directly impacted the ability of the facility to comply with a data reporting requirement or that an extraordinary circumstance has affected an entire region or locale. That completes our discussion on proposals that apply across all the outpatient quality reporting programs.

Karen VanBourgondien Thank you, Kim. Let's stop here for just a minute and do a polling question. The first polling question does have to do with what you just covered.

So, Rachel if you don't mind launching that first polling question. The question is: If the COVID-19 HCP measure is removed, you would still have to submit data for all four quarters for the 2025 reporting period. Is that true or false? I will give everyone just a minute to make their selection. Just think back to what Kim said and the proposal.

OK. We have a lot of responses coming in. We will wait just a few more minutes. Rachel, if you will close the voting. I think that we are at the end. Just about everyone has made their decision.

OK. The answer is false. That is correct. You would not have to submit the rest of your 2025 reporting period data. This measure is proposed for removal beginning with the calendar year 2024 reporting period. So, if that is finalized, you would not have to submit the rest of the 2025 reporting period data. So, let's wait and see what happens in the final rule. The final rule is usually published in the beginning to mid-November timeframe. So, stay tuned. We will certainly bring you information on that. I think that is it for this polling question. Thank you, everybody. Let me turn things back over to Kim. Kim?

Kimberly Go: Thank you, Karen. We will now discuss proposals that are specific to the Hospital OQR Program. For OQR, we are proposing one measure adoption, two measure removals, as well as a modification to a measure already in the OQR measure set.

We'll begin with the proposed adoption of a new electronic clinical quality measure called Emergency Care Access & Timeliness. Recent studies indicate that delays in the timeliness of emergency department care are associated with patient harm, and occupancy and boarding rates in U.S. emergency departments continue to worsen and exceed pre-pandemic levels. ED boarding, defined as holding a patient in the ED after the patient is admitted or placed into observation status at a hospital, often occurs due to shortages of inpatient beds and staff and contributes to ED crowding, leading to safety risks for patients and stressful working conditions for healthcare personnel.

To address these issues, we propose to adopt the Emergency Care Access & Timeliness eCQM beginning with voluntary reporting for the calendar year 2027 reporting period followed by mandatory reporting beginning with the calendar year 2028 reporting period for calendar year 2030 payment determination. We believe this would provide hospital outpatient departments sufficient time to test and integrate the eCQM into existing clinical workflows. Additionally, limiting voluntary reporting to one year prioritizes addressing long ED wait times and ED boarding. We also propose to require the new eCQM data submission by May 15 in the year prior to the affected payment determination year, in alignment with our policies on eCQM submission deadlines. This deadline aligns with the other web-based measures reported in HQR for the Hospital OQR Program.

The Emergency Care Access & Timeliness eCQM is specified in a standard electronic format, utilizing data extracted electronically from EHRs, with all data coming from defined fields in electronic sources. The measure is specified for the hospital setting and calculates the proportion of four outcome metrics that quantify access to and timeliness of care in an ED setting against specified thresholds which include one hour for patient wait time; whether the patient left the ED without being evaluated; four hours for patient boarding time in the ED as defined by a decision to admit order to ED departure for admitted patients; and eight hours for patient length of stay, or the time from ED arrival to ED physical departure, as defined by the ED departure timestamp.

The measure denominator includes all ED encounters associated with patients of all ages, for all-payers, during a 12-month period of performance. Patients can have multiple encounters during a period of performance, and each encounter is eligible to contribute to the calculation of the measure. The measure numerator includes any ED encounter in the denominator where the patient experiences any one of the following:
1) The patient waited longer than one hour after arrival to the ED to be placed in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination.
2) The patient left the ED without being evaluated.

3) The patient boarded in the ED for longer than four hours. 4) The patient had an ED length of stay of longer than 8 hours.

An encounter is considered part of the numerator if it includes any one of the four numerator events, with events not being mutually exclusive and each contributing only once to the numerator. ED encounters with ED observation stays are excluded from components (3) and (4) but are included in the denominator. Patients who have a "decision to admit" after an ED observation stay remain excluded from the calculations for criteria (3).

The measure score is first calculated at the individual ED level as the proportion of ED encounters where any one of the four outcomes occurred. The results of the Emergency Care Access & Timeliness eCQM are stratified into four groups, two by age. That is 18 years and older and under 18 years. Two are by mental health diagnoses, with and without. The stratification of results by age and mental health diagnosis, as well as standardization of measure performance scores by volume, is sufficient to account for differences between hospitals without further need for risk adjustment. We believe eCQMs allow for retrieval of data directly from an EHR, reducing administrative burden on hospitals and minimizing errors due to manual abstraction of data. For additional guidance on this eCQM, please refer to the eCQI Resource Center website.

Next, we will discuss our two proposed measure removals. We are proposing to remove the Median Time for Discharged ED Patients measure and the Left Without Being Seen measure, beginning with the calendar year 2028 reporting period for calendar year 2030 payment determination, if the Emergency Care Access & Timeliness eCQM is finalized as proposed. The proposed removal of two chart-abstracted measures in conjunction with the proposed adoption of the Emergency Care Access & Timeliness eCQM would reduce hospital outpatient provider department burden by replacing two chart-abstracted measures with one digital quality measure.

While the Median Time for Discharged ED Patients and the Left Without Being Seen measures require manual intervention to retrieve data from clinical documentation, the Emergency Care Access & Timeliness eCQM allows for automated extraction of patient-level data directly from the electronic health record.

The Median Time for Discharged ED Patients and Left Without Being Seen measures are being removed under Factor 4, the availability of a more broadly applicable measure across settings, populations, or conditions for the topic. The numerator components of the Emergency Care Access & Timeliness eCQM overlap with the patient population and measure specifications of the Median Time for Discharged ED Patients measure as well as the Left Without Being Seen measure, in addition to capturing the same data elements as the Median Time for Discharged ED Patients and Left Without Being Seen measures, the Emergency Care Access & Timeliness eCQM measures boarding time in the ED and time from arrival to placement in a treatment room, which are not currently captured by any other measure currently in the Hospital OQR Program measure set.

Our last proposal specific for the Hospital OQR Program is a modification. That is, we are proposing to modify the reporting requirements for the Excessive Radiation eCQM in the Hospital OQR Program by maintaining voluntary reporting instead of mandatory reporting of the measure, beginning with the calendar year 2027 reporting period. Our proposal to maintain indefinite voluntary reporting of this measure arises from continued feedback expressing concerns about the complex interfaces necessary to develop, maintain, and report the Excessive Radiation eCQM, including the financial burden and operational feasibility needed to translate CT radiology data into standardized eCQM-consumable data used by the measure. This modification would also provide CMS with additional time to monitor implementation progress, including data collection burden and response rates. We will continue to consider feedback regarding this measure and may propose additional changes in future rulemaking.

Karen VanBourgondien Thank you, Kim. If you don't mind, let's stop again. Rachel, if you wouldn't mind launching the next polling question. The question is: If the proposal for the new eCQM, for the Emergency Care Access & Timeliness eCQM, if that proposal is finalized, when would voluntary reporting begin? So, go ahead and make your selection there. a, b, or c. When do you think you are going to begin reporting voluntarily? Let's give everybody a few minutes. a, b, or c. Some of you are choosing c. You can choose to begin when to report. I like it. OK, a couple more seconds. OK. Rachel. I think you can share the results.

A is correct. You will begin voluntary reporting in the calendar year 2027 reporting period followed by mandatory reporting the following year, 2028 reporting period, and that is for the 2030 payment determination. So, great job everyone. Rachel, go ahead and close the poll. Thanks, everybody for contributing to the poll. Once again, let me hand things back over to Kim.

Kimberly Go: That concludes my summary of the finalized proposals for the Hospital OQR Program. Let me hand things over to Anita now to discuss the finalized proposals as they relate to the REH Quality Reporting Program. Thank you.

Anita Bhatia: Thank you, Kim. In addition to the cross-program proposals that Kim just discussed, there are only two Rural Emergency Hospital Quality Reporting Program-specific proposals.

As with the Hospital Outpatient Quality Reporting Program, we propose to adopt the Emergency Care Access & Timeliness eCQM for the Rural Emergency Hospital Quality Reporting Program. However, for the Rural Emergency Hospital Quality Reporting Program, the reporting of this eCQM is an option instead of reporting the Median Time for Discharged ED Patients measure.

Reporting would begin with the calendar year 2027 reporting period for the calendar year 2029 program determination. We propose to require Emergency Care Access and Timeliness eCQM data submission by May 15 in the year prior to the affected program determination year. In alignment with our policies on eCQM submission deadlines, we also propose to report data from the Rural Emergency Hospital Quality Reporting Program as soon as it is feasible on a CMS website such as the Compare tool on Medicare.gov or any successor website after a 30-day preview period.

Our proposal to adopt this eCQM as an either/or measure into the Rural Emergency Hospital Quality Reporting Program measure set is in response to public comment recommending that CMS add eCQMs as optional measures initially. If finalized, the Emergency Care Access & Timeliness eCQM would be the first eCQM in the Rural Emergency Hospital Quality Reporting Program measure set. This proposal introduces eCQM reporting to the Rural Emergency Hospital Quality Reporting Program without imposing a mandatory reporting requirement. With this approach Rural Emergency Hospitals can evaluate existing electronic health record infrastructure and gain experience using eCQMs with a flexible timeline. If the proposal to adopt the Emergency Care Access & Timeliness eCQM for the Rural Emergency Hospital Quality Reporting Program is finalized, CMS will monitor the effect of this measure in Rural Emergency Hospital and revise thresholds as appropriate.

Form, manner, and timing: Some of you may be familiar with eCQM data submission and reporting requirements that exist for other hospital programs. We propose to update program policies by establishing these for the Rural Emergency Hospital Quality Reporting Program. In alignment with the Hospital Outpatient Quality Reporting Program, we propose that the technical specifications for eCQMs for the Rural Emergency Hospital Quality Reporting Program would be contained in the CMS Annual Update for the Hospital Quality Reporting Programs. For eCQMs, we would generally update the measure specifications on an annual basis through the Annual Update.

This includes code updates, logic corrections, alignment with current clinical guidelines, and additional guidance for Rural Emergency Hospitals and electronic health record vendors to collect and submit data on eCQMs from electronic health records. The Annual Update and implementation guidance documents are available on the eCQI Resource Center website.

Previously, we finalized and codified three requirements relating to eCQM certification for the submission of eCQM data in the Hospital Outpatient Quality Reporting Program. We propose to adopt and codify the same eCQM certification requirements in the Rural Emergency Hospital Quality Reporting Program, beginning with the calendar year 2027 reporting period, which affects calendar year 2029 program determinations and to add a new paragraph: Requirements for Submission of electronic Clinical Quality Measures, eCQMs, under the Rural Emergency Hospital Quality Reporting Program.

With this alignment, we propose REHs to utilize technology certified to Office of the National Coordinator for Health Information Technology's, or ONC's, health information technology certification criteria. The health information technology used for eCQM reporting by Rural Emergency Hospitals must be certified to all eCQMs, That is tested and validated on each individual eCQM available to report under the Rural Emergency Hospital Quality Reporting Program. Additionally, we propose to codify the requirement that Rural Emergency Hospitals use the most recent version of the eCQM electronic measure specifications for the applicable reporting period available on the eCQI Resource Center website. We also propose that certified electronic health record technology would not need to be recertified each time the eCQM specifications are updated to a more recent version. The most current specifications are available on the eCQI Resource Center website. Details on the eCQM policy can be found in the calendar year 2025 OPPS/ASC final rule. The specified location for this is on this slide.

We propose to utilize the same file format requirements currently applied in the Hospital Inpatient Quality Reporting, [Hospital] Outpatient Quality

Reporting, and Medicare Promoting Interoperability Programs for Rural Emergency Hospitals. Under this alignment, Rural Emergency Hospitals would submit eCQM data under the three requirements listed on this slide.

Under this proposal related to file format, we would expect QRDA [Category] I files to reflect data for one patient per file per quarter with five key elements necessary to identify the file. As listed here, these would be CCN; CMS Program Name; EHR Patient ID; reporting period specified in the Reporting Parameters Section; and electronic health record submitter ID.

Zero denominator declarations and case threshold exemptions: We propose that, if Rural Emergency Hospital's electronic health record is certified to an eCQM, but the Rural Emergency Hospital does not have patients that meet the denominator criteria of that eCQM, the Rural Emergency Hospital could submit a zero in the denominator for that eCQM; submission of a zero in the denominator for an eCQM would qualify as a successful submission for that eCQM. Additionally, if an Rural Emergency Hospital's electronic health record system is certified to report an eCQM and the Rural Emergency Hospital has five or fewer outpatient encounters per quarter or 20 or fewer outpatient encounters per year, that Rural Emergency Hospital would be exempt from reporting on that eCQM. Case threshold exemptions would be able to be entered on the denominator declaration screen within the Hospital Quality Reporting system available during the submission period. The exemption would not have to be utilized; Rural Emergency Hospitals could report those individual cases if they would like to do so.

Karen VanBourgondien: Thank you, Anita. So, let's stop here again briefly and do our last polling question for the day. Rachel, would you mind launching that? The question is: If the proposal for the new eCQM, the Emergency Care Access & Timeliness eCQM, if that is finalized, REHs can choose to submit this new eCQM or they can continue to submit data for OP-18: Median Time for Discharged ED Patients. Is that true or false? What do you guys think? That is for Rural Emergency Hospitals.

OK We will give a few more minutes. There are still some people taking the poll. Rachel, I think that will do it. We can close the poll.

A, True, is correct. It is going to be optional for REHs. They can report for the new eCQM if it is finalized or they can continue to report the clinical data measure, OP-18. Either one is fine. If finalized, that new eCQM would begin with the calendar year 2027 reporting period, and that would be for the 2029 program determination. Again, thank you, everybody for your appreciation. Let me turn things back over to Anita.

Anita Bhatia: This concludes my summary of the proposals for the Rural Emergency Hospital Quality Reporting Program. We do want to hear your comments regarding these proposals. So, please comment. For details on submitting your comments, let me turn things over to Karen.

Karen VanBourgondien: Thank you, Anita. To be assured consideration, comments must be submitted no later than September 15, 2025. CMS cannot accept comments by fax and does encourage submission of comment by electronic means. You may submit comment via regular mail, or by express or overnight mail. However, these do have separate addresses for those two types of mails. You may resource those addresses in the proposed rule. If you do use one of the nonelectronic submission formats, please allow sufficient time for mailed comments to be received before the close of the comment period. Any comments that are received, CMS will be sharing in the final rule.

To get to the Comment page, when you access the *Federal Register* link, which is here on this slide, you will be directed to the exact location of where this rule is in the *Federal Register*. To begin the commenting period, you are just going to select the green Submit a Formal Comment box. You see that here on the right side of your screen.

You will enter your comment in the Comment field. Fill in the required boxes. You can even attach files if you care to do so.

Scroll down that same page and enter the rest of your information in the designated fields. Once you have completed the information, be sure to check "I read and understand the statement above." The Submit Comment box will not turn green unless that little box is selected, and it is necessary for your comment to be entered. Once you complete that, you just simply click on the Summit Comment button. That's it. That is all you have to do to submit your comment. So, please do comment. CMS does look forward to hearing from you and hearing what you have to say about the proposals that Kim and Anita discussed here today.

Before we close out today, let's review the measures for both the Hospital OQR and REHQR Programs and include any proposals that were discussed as well.

Beginning with the measures specific to the Hospital OQR Program, here are the clinical chart-abstracted measures, and you can see the Median Time for Discharged ED Patients measure. This is for the current reporting period. So, the OP-18 measure is proposed for removal for the calendar year 2030 payment determination if the Emergency Care Access & Timeliness eCQM is finalized as proposed. There were no proposals related to OP-23. So, that remains unchanged.

Here are the web-based measures submitted through the HQR system. The dates here are for the current reporting period. OP-22 is proposed for removal for the calendar year 2028 reporting period, and that would be for the calendar year 2030 payment determination. Again, that is if the Emergency Care Access & Timeliness eCQM is finalized as proposed.

Here are the health-equity, web-based measures which are also reported in HQR. OP-43 and OP-44 were already in voluntary status for the 2025 reporting period, and they are all proposed for removal for the current reporting period. So, if that proposal is finalized, you would not have to report data for any of these measures, these equity measures, by the May 15, 2026, deadline. Stay tuned on the final rule. We will see what happens with that proposal.

Next, the COVID-19 measure is reported in the NHSN system. Again, you are looking at the current reporting period. This measure is proposed for removal beginning with the 2024 reporting period for the 2026 payment determination. Data for that reporting period has already been submitted. Here, again, you are looking at the current reporting period. So, if the removal is finalized, you would not have to submit all these quarters here. Typically, the final rule is posted in early to mid-November. So, again, we want to stay informed. It just may be that you would not have to submit your data by November 17 if the proposal to remove this measure is finalized.

Here we see the claims-based measures for the Hospital OQR Program for the current reporting period. There were no proposals related to these measures. So, nothing is going to change for these measures.

Next, we see the two PRO-PM measures for the Hospital OQR Program. The THA/TKA PRO-PM was finalized previously and began voluntary reporting for this current reporting period. That's calendar year 2025 reporting period. Voluntary reporting will continue for the next four years. Mandatory reporting for this measure will not begin until the 2031 payment determination. The Information Transfer PRO-PM will begin with voluntary reporting with the calendar year 2026 reporting period followed by a mandatory reporting period the following year, for this current reporting period. Their submission of data is not required for the Information Transfer PRO-PM.

Here, next, we have the OAS CAHPS measure, OP-37. CMS did not propose any changes to the OAS CAHPS measure. Mandatory reporting has already begun, and you will continue to report via your CMS-approved vendor for this measure. Here, on this slide, you are looking at the current reporting period. We have the applicable dates as they relate to the current reporting period.

Lastly, for the Hospital OQR Program, are the eCQMs. There were no proposed changes to the OP-40 STEMI measure. So, you will continue to report that as you have. This current calendar year 2025 reporting period, the Excessive Radiation eCQM began with voluntary reporting.

However, as Kim discussed earlier, CMS did propose that the Excessive Radiation eCQM continue with voluntary reporting. So, if that proposal is finalized, you will not switch into mandatory reporting for the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults. That's otherwise known as the Excessive Radiation eCQM. In the bottom table, you can see the newly proposed Emergency Care Access & Timeliness eCQM. CMS did propose to begin with voluntary reporting in the calendar year 2027 reporting period followed by mandatory reporting the following year.

Slide 52. So, that completes our measures for the Hospital OQR Program. So, let's turn our attention the REHQR Program.

The eCQM, the Emergency Care Access & Timeliness eCQM, that is the proposal that Anita and Kim both discussed. Reporting will begin with the calendar year 2027 reporting period for the calendar year 2029 program determination. As we discussed, reporting for this new eCQM, if it is finalized, will be optional.

With that, here we see the chart-abstracted measures. You can see the Median Time for Discharged ED Patients measure and the dates as they relate to the current reporting period. When optional reporting begins for the new eCQM, you can report that measure, or you can just continue reporting for OP-18. Either one is fine. Again, we are going to look forward to the final rule to see if that proposal was finalized to add the eCQM.

Here are the current claims-based measures for the REHQR Program, and we are looking at the current reporting period. CMS did not propose any changes related to the claims-based measures. Nothing is going to change there.

Lastly are the health equity, web-based measures. Just as with the Hospital OQR Program, these measures are proposed for removal for the current reporting period. That's for the calendar year 2025 reporting period for the calendar year 2027 program determination.

So, if that proposal is finalized, and those measures are removed, you will not need to submit these data by the May 15, 2026, deadline.

We have some resources here should you need them. Of course, our number is right there at the top. We are always glad to help if you need anything. Other important contact information is also on this slide.

Kindly take our post-event survey. We do appreciate your feedback. Just click on this link here and take the survey. We hope the information shared here today was helpful. We appreciate your attendance. Have a great day.