Quality Payment Program – 5 Quality Measures of Interest (AAHD)

From: Clarke Ross (AAHD)
Sent: Monday, July 21, 2025 4:31 PM
To: CCD and DAC members
Subject: Additional Quality Measure Topics - Medicare Physician Fee Schedule Proposed Rules

A few additional QM CMS proposals:

Delete social drivers of health
Delete hospital health equity
Priority to hospital emergency access
Focus on Safety in Star Rating

From: Clarke Ross (AAHD)
Sent: Monday, July 21, 2025 4:01 PM
To: CCD and DAC members
Subject: Medicare Physician Fee - QPP - Well-Being and Nutrition RFI

From: Clarke Ross (AAHD)
Sent: Monday, July 21, 2025 3:56 PM
To: MHLG and CWH Members
Subject: Medicare Physician Fee - QPP - Well-Being and Nutrition RFI

Follow-up topic to our MHLG integration work group discussion:

The CMS FR RFI is discussed within the context of integration of mental and physical health and preventive care. RFI from the FR (page 33754) – attached.

Quality Payment Program (QPP)

column, each ASC payment weight in the "Proposed CY 2026 Payment Weight" column was multiplied by the proposed CY 2026 conversion factor. The conversion factor includes a budget neutrality adjustment for changes in the wage index values and the annual update as reduced by the productivity adjustment. The proposed CY 2026 ASC conversion factor uses the proposed CY 2026 productivity-adjusted hospital market basket update factor of 2.4 percent (which is equal to the inpatient hospital market basket percentage increase of 3.2 percent reduced by the productivity adjustment of 0.8 percentage point). We also propose that if more recent data subsequently become available (for example, a more recent estimate of the inpatient hospital market basket percentage increase and the productivity adjustment), we would use such data, if appropriate, to determine the CY 2026 ASC conversion factor in the final rule.

In Addendum BB, there are no relative payment weights displayed in the "Proposed CY 2026 Payment Weight" column for items and services with predetermined national payment amounts, such as separately payable drugs and biologicals. The "Proposed CY 2026 Payment" column displays the proposed CY 2026 national unadjusted ASC payment rates for all items and services. The proposed CY 2026 ASC payment rates listed in Addendum BB for separately payable drugs and biologicals are based on the most recently available data used for payment in physicians' offices. For CY 2021, we finalized adding a new column to ASC Addendum BB titled "Drug Pass-Through Expiration during Calendar Year" where we flag through the use of an asterisk each drug for which pass-through payment is expiring during the calendar year (that is, on a date other than December 31st).

Addendum EE to this proposed rule provides the HCPCS codes and short descriptors for surgical procedures that are to be excluded from payment in ASCs for CY 2026.

Addendum FF to this proposed rule displays the OPPS payment rate (based on the standard ratesetting methodology), the APC device offset percentage, the device offset percentage for determining device-intensive status (based on the standard ratesetting methodology), and the device portion of the ASC payment rate for CY 2026 for covered surgical procedures.

XIV. Cross-Program Proposals for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs

A. Background

We refer readers to sections XV., XVI., and XVII. of this proposed rule for program specific background information, including the statutory authorities, and previously finalized and newly proposed measure sets, for the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs, respectively.

B. Measure Concepts Under Consideration for Future Years in the Hospital OQR, REHQR, and ASCQR Programs—Request for Information (RFI): Well-Being and Nutrition

We are seeking input on well-being and nutrition measures for consideration in future rulemaking for the Hospital OQR, REHQR, and ASCQR Programs. Well-being is a comprehensive approach to disease prevention and health promotion, as it integrates mental and physical health while emphasizing preventative care to proactively address potential health issues.[141] This comprehensive approach emphasizes person-centered care by promoting the well-being of patients and family members. We are seeking comments on tools and measures that assess overall health, happiness, and satisfaction in life, which could include aspects of emotional well-being, social connections, purpose, and fulfillment. We would like to receive input and comments on the applicability of tools and constructs that assess the integration of complementary and integrative health, skill building, and self-care.

We are also seeking comments on tools and measures that assess optimal nutrition and preventive care in the Hospital OQR, REHQR, and ASCQR Programs. 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. Such assessments may also include aspects of health that support or mediate nutritional status, such as physical activity and sleep. In this context, preventive care plays a vital role by proactively addressing factors that may lead to poor nutritional status or related health issues. These efforts not only support optimal nutrition but also work to prevent conditions that could otherwise hinder an individual's health and nutritional needs.

While we will not be responding to specific comments in response to this RFI in the CY 2026 OPPS/ASC final rule, we intend to use this input to inform our future measure development efforts.

C. Proposed Changes to the Hospital OQR, REHQR, and ASCQR Program Measure Sets

1. Proposed Removal of the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure From the Hospital OQR and ASCQR Programs Beginning With the CY 2024 Reporting Period/CY 2026 Payment Determination

We refer readers to the CY 2022 OPPS/ASC final rule where we adopted the COVID–19 Vaccination Coverage Among HCP measure into the Hospital OQR and ASCQR Programs (86 FR 63824 through 63833 and 86 FR 63875 through 63883, respectively) and the CY 2024 OPPS/ASC final rule with comment period where we modified the COVID–19 Vaccination Coverage Among HCP measure to account for updated vaccine guidance (88 FR 81963 through 81968 and 88 FR 82013 through 82017, respectively).

For the Hospital OQR and ASCQR Programs, we propose to remove the COVID–19 Vaccination Coverage Among HCP measure beginning with the CY 2024 reporting period/CY 2026 payment determination under removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program (§§ 419.46(i)(3)(i)(H) and 416.320(c)(2)(viii), respectively). Reporting on this measure currently requires reporting data on COVID–19 Vaccination Coverage Among HCP for at least 1 week every month. This requires healthcare facilities to track current vaccination status for all employees, licensed independent practitioners, adult students/trainers and volunteers, and other contract personnel and log in to the National Healthcare Safety Network (NHSN) system to report the data monthly, either manually in NHSN or by uploading a comma-separated value (CSV) file.[142] The estimated

[141] Centers for Disease Control and Prevention. (May 2024). About Emotional Well-Being. Available at *https://www.cdc.gov/emotional-well-being/about/#cdc_behavioral_basics_types-health-benefits. Accessed: April 30, 202.5.*

[142] Centers for Disease Control and Prevention. (2025). Weekly COVID–19 Vaccination Module for

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 412, 413, 415, 416, and 419

Office of the Secretary

45 CFR Part 180

[CMS–1834–P]

RIN 0938–AV51

Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the Medicare Hospital Outpatient Prospective Payment System (OPPS) and the Medicare Ambulatory Surgical Center (ASC) payment system for calendar year 2026 based on our continuing experience with these systems. We also describe the changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment systems. This proposed rule would also update and refine the requirements for the Hospital Outpatient Quality Reporting Program, Rural Emergency Hospital Quality Reporting Program, Ambulatory Surgical Center Quality Reporting Program, Overall Hospital Quality Star Rating, and hospitals to make public their standard charge information and enforcement of hospital price transparency. This rule also contains requests for information on measure concepts regarding Well-Being and Nutrition for consideration in future years for all three programs (OQR, REHQR, and ASCQR; expanding the method to control for unnecessary increases in the volume of covered OPD services to on-campus clinic visits; software as a service; and adjusting payment under the OPPS for services predominately performed in the ambulatory surgical center or physician office settings.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by September 15, 2025.

ADDRESSES: In commenting, please refer to file code CMS–1834–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

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2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1834–P, P.O. Box 8010, Baltimore, MD 21244–8010.

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For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Regulation coordination questions, contact Gina Aughenbaugh via email at *OutpatientPPS@cms.hhs.gov.*

Add-on Payment for Radiopharmaceutical Technetium-99m (Tc-99m) Derived from Domestically Produced Molybdenum-99, contact Au'Sha Washington via email at *ausha.washington@cms.hhs.gov* or Leone Kisler at *leone.kisler@cms.hhs.gov.*

Adjusting Payment under the OPPS for Services Predominantly Performed in the ASC or Physician Office Settings Request for Information, contact Elise Barringer via email at *Elise.Barringer@cms.hhs.gov.*

Advisory Panel on Hospital Outpatient Payment (HOP Panel), contact the HOP Panel mailbox at *APCPanel@cms.hhs.gov.*

Ambulatory Surgical Center Covered Procedures List (ASC CPL), contact Abigail Cesnik via email at *Abigail.Cesnik@cms.hhs.gov.*

Ambulatory Surgical Center Quality Reporting (ASCQR) Program measures, contact Marsha Hertzberg via email at *Marsha.Hertzberg@cms.hhs.gov.*

Ambulatory Surgical Center Quality Reporting (ASCQR) Program policies, contact Anita Bhatia via email at *Anita.Bhatia@cms.hhs.gov.*

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Cancer Hospital Payments, contact Scott Talaga via email at *Scott.Talaga@cms.hhs.gov.*

CMS Web Posting of the OPPS and ASC Payment Files, contact Gil Ngan via email at *Gil.Ngan@cms.hhs.gov.*

Composite APCs (Multiple Imaging and Mental Health) and Comprehensive APCs (C–APCs), contact Elise Barringer via email at *Elise.Barringer@cms.hhs.gov.*

Device-Intensive Status and No Cost/Full Credit and Partial Credit Devices, contact Scott Talaga via email at *Scott.Talaga@cms.hhs.gov.*

Graduate Medical Education (GME) Accreditation, contact *DAC@cms.hhs.gov.*

Hospital Outpatient Quality Reporting (OQR) Program policies, contact Kimberly Go via email at *Kimberly.Go@cms.hhs.gov.*

Hospital Outpatient Quality Reporting (OQR) Program measures, contact Kristina Rabarison via email at *Kristina.Rabarison@cms.hhs.gov.*

Hospital Outpatient Visits (Emergency Department Visits and Critical Care Visits), contact Elise Barringer via email at *Elise.Barringer@cms.hhs.gov.*

Hospital Price Transparency, contact Sarah Wheat via email at *PriceTransparencyHospitalCharges@cms.hhs.gov.*

Inpatient Only (IPO) Procedures List, contact Abigail Cesnik via email at *Abigail.Cesnik@cms.hhs.gov.*

Market-Based Data Collection and Market-Based MS–DRG Relative Weight Methodology Issues, contact *DAC@cms.hhs.gov.*

Medical Review of Certain Inpatient Hospital Admissions under Medicare Part A for CY 2026 and Subsequent Years (2-Midnight Rule), contact Nate Vercauteren via email at *Nathan.Vercauteren@cms.hhs.gov.*

Medicare OPPS Drug Acquisition Cost Survey, contact Cory Duke via email at *Cory.Duke@cms.hhs.gov* or Gil Ngan at *Gil.Ngan@cms.hhs.gov* or Nate Vercauteren at *Nathan.Vercauteren@cms.hhs.gov.*

Method to Control Unnecessary Increases in the Volume of Outpatient Services, contact Elise Barringer via email at *Elise.Barringer@cms.hhs.gov.*

New Technology Intraocular Lenses (NTIOLs), contact Scott Talaga via email at *Scott.Talaga@cms.hhs.gov.*

Non-Opioid Policy or Implementation of Section 4135 of the Consolidated Appropriations Act (CAA), 2023,

burden of collecting this information annually across all 3,200 hospitals in the Hospital OQR Program is between $1,446,400 and $1,687,680. Across the 4,590 ASCs in the ASCQR Program, the estimated annual burden is between $2,074,680 and $2,420,766. We refer readers to section XXIII. of this proposed rule for more details on this estimated burden calculation.

When we first adopted the COVID–19 Vaccination Coverage Among HCP measure for the Hospital OQR and ASCQR Programs, the U.S. was in the midst of a Public Health Emergency (PHE) that incurred millions of cases and over 718,000 COVID–19 deaths (86 FR 63825 and 86 FR 63875 through 63876, respectively).[143] While preventing the spread of COVID–19 remains a public health goal, the PHE ended on May 11, 2023.[144] In addition, the number of deaths due to COVID–19 in the U.S. has decreased since the adoption of this measure. In August 2021, when this measure was being proposed, the U.S. was averaging over 6,000 deaths related to COVID–19 per week.[145] In April 2023, the last full month of the PHE, weekly number of deaths attributed to COVID–19 averaged around 1,300.[146] With the end of the PHE and the decrease in COVID–19 deaths, we believe the continued costs and burden to healthcare facilities of tracking and monthly reporting on this measure outweigh the benefit of continued information collection on COVID–19 vaccination coverage among HCP. As it may be costly for hospitals and ASCs to continue to report on the COVID–19 Vaccination Coverage Among HCP measure, removal of this measure would allow for the Hospital OQR and ASCQR Programs to focus on other clinical goals.

If this proposal is finalized as proposed, hospitals and ASCs that do not report their CY 2024 reporting period data for the COVID–19 Vaccination Coverage Among HCP measure to CMS would not be considered noncompliant with the measure for their CY 2026 payment determination (that is, hospitals and ASCs that do not report CY 2024 reporting period data would not be penalized for CY 2026 payments due to this measure). Any COVID–19 Vaccination Coverage Among HCP measure data received by CMS would not be used for public reporting or payment purposes.

If this proposal is not finalized as proposed, hospitals and ASCs that do not report their CY 2024 reporting data for the COVID–19 Vaccination Coverage Among HCP measure to CMS would be considered noncompliant with the measure for their CY 2026 payment determination and would receive a letter of noncompliance. Payment adjustments would apply to CY 2026 payment determination for fee-for-service claims as previously finalized.

We invite public comment on this proposal.

2. Proposed Removal of the Hospital Commitment to Health Equity (HCHE) Measure From the Hospital OQR and REHQR Programs and the Facility Commitment to Health Equity (FCHE) Measure From the ASCQR Program Beginning With the CY 2025 Reporting Period/CY 2027 Payment or Program Determination

We refer readers to the CY 2025 OPPS/ASC final rule with comment period where we adopted the Hospital Commitment to Health Equity (hereafter referred to as HCHE) measure into the Hospital OQR and REHQR Programs and the Facility Commitment to Health Equity (hereafter referred to as FCHE) measure into the ASCQR Program (89 FR 94368 through 94381). For the Hospital OQR, REHQR, and ASCQR Programs, we propose to remove the HCHE and FCHE measures beginning with the CY 2025 reporting period/CY 2027 payment or program determination under removal Factor 8, due to the costs associated with achieving a high score on the measure outweighing the benefit of its continued use in the program (§§ 419.46(i)(3)(i)(H), 419.95(e)(3)(i)(H), and 416.320(c)(2)(viii), respectively).

When adopted, we intended the collection of data described in the five domains of these measures to provide hospital, REH, and ASC leadership with meaningful and actionable health data to drive quality improvements to eliminate health disparities. Based on feedback received from hospitals, REHs, and ASCs, as well as a re-focus on clinical outcomes and direct patient care, for which the HCHE and FCHE measures, as structural measures, do not directly measure, the burden of collecting these measures may outweigh the benefits. Removal of these measures would alleviate an estimated annual burden of approximately 533 hours, at a cost of $22,518, across all participating hospitals (89 FR 94523); 6 hours, at a cost of $332, across all participating REHs (89 FR 94530); and 746 hours, at a cost of $41,313 across all participating ASCs (89 FR 94534).

An important goal of the Hospital OQR, REHQR, and ASCQR Programs is moving forward in the least burdensome manner possible while maintaining a parsimonious set of meaningful quality measures and continuing to incentivize improvement in the quality of care provided to patients. Removing these measures from the Hospital OQR, REHQR and ASCQR Programs serves this goal. Our priority is a re-focus on measurable clinical outcomes as well as identifying quality measures on topics of prevention, nutrition, and well-being. As such we refer readers to our request for comment on "Measure Concepts under Consideration for Future Years in the Hospital OQR, REHQR, and ASCQR Programs—Request for Information (RFI): Well-Being and Nutrition" in section XIV.B. of this proposed rule.

We acknowledge that some hospitals, REHs, and ASCs may have expended resources to implement some or all of the activities described in the HCHE and FCHE measures attestation statements in order to be able to attest "yes" for measure reporting purposes.

If this proposal is finalized as proposed, hospitals, REHs, and ASCs that do not report their CY 2025 reporting period data for the HCHE or FHCE measure to CMS would not be considered noncompliant with the measure for purposes of their CY 2027 payment or program determination (that is, hospitals, REHs, or ASCs that do not report CY 2025 reporting period data would not be penalized for CY 2027 payments due to this measure, if applicable). Any HCHE or FCHE measure data received by CMS would not be used for public reporting or payment purposes.

If this proposal is not finalized as proposed, hospitals, REHs, or ASCs that do not report their CY 2025 reporting data for the HCHE or FCHE measures to CMS would be considered noncompliant with the measure for their CY 2027 payment or program determination and would receive a letter of noncompliance. Payment adjustments would apply to CY 2027 payment determination fee-for-service (FFS) claims as previously finalized in

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Healthcare Personnel. Available at *https://www.cdc.gov/nhsn/pdfs/hps/covidvax/2025-hcp-combined-protocol-508.pdf. Accessed: April 30, 2025.*

[143] Centers for Disease Control and Prevention. (2025). COVID Data Tracker. Available at *https://covid.cdc.gov/covid-data-tracker/#trends_totaldeaths_select_00. Accessed: April 30, 2025.*

[144] U.S. Department of Health and Human Services. (2023). COVID–19 Public Health Emergency. Available at *https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html. Accessed: April 30, 2025.*

[145] Centers for Disease Control and Prevention. (2025). COVID Data Tracker. Available at *https://covid.cdc.gov/covid-data-tracker/#trends_weeklydeaths_select_00. Accessed: April 30, 2025.*

[146] Centers for Disease Control and Prevention. (2025). COVID Data Tracker. Available at *https://covid.cdc.gov/covid-data-tracker/#trends_weeklydeaths_select_00. Accessed: April 30, 2025.*

the Hospital OQR and ASCQR Programs.

We invite public comment on these proposals.

3. Proposed Removal of Two Social Drivers of Health Measures From the Hospital OQR, REHQR, and ASCQR Programs Beginning With the CY 2025 Reporting Period

We propose to remove two social drivers of health (SDOH) process measures from the Hospital OQR, REHQR, and ASCQR Programs beginning with the CY 2025 reporting period: Screening for Social Drivers of Health (adopted at 89 FR 94381 through 94398); and Screen Positive Rate for Social Drivers of Health (adopted at 89 FR 94398 through 94403).

We propose to remove the SDOH measures beginning with the CY 2025 reporting period under removal Factor 8, the costs associated with the measure outweigh the benefit of its continued use in these programs (§§ 419.46(i)(3)(i)(H), 419.95(e)(3)(i)(H), and 416.320(c)(2)(viii), respectively). We have heard from some hospitals, REHs, and ASCs concerned with the costs and resources associated with screening patients via manual processes, manually storing such data, training staff, and altering workflows for these measures. In the CY 2025 OPPS/ASC final rule with comment period, we estimated a total annual burden of 6,878,055 hours at a cost of $168,460,032 in the Hospital OQR Program (89 FR 94523 and 94524), 12,984 hours at a cost of $318,163 in the REHQR Program (89 FR 94530 and 94531), and 711,479 hours at a cost of $17,447,164 in the ASCQR Program (89 FR 94534 and 94535), to screen all admitted patients in accordance with measure specifications for Screening for Social Drivers of Health and report the measure data. For Screen Positive Rate for Social Drivers of Health, we estimated a total annual burden of 533 hours at a cost of $29,518 in the Hospital OQR Program (89 FR 94524), 6 hours at a cost of $332 in the REHQR Program (89 FR 94531 and 94532), and 746 hours at a cost of $41,313 in the ASCQR Program (89 FR 94535), to report the measure data. We note that the HQR system calculates the rate for these two measures, and that hospitals, REHs, and ASCs' responsibility is to report the aggregate number of patients screened, the aggregate number of patients that screened positive, and their total patient population. Further, we note that these measures document an administrative process and report aggregate level results, and do not shed light on the extent to which providers are ultimately connecting patients with resources or services and whether patients are benefiting from these screenings.

We have concluded that the costs of the continued use of these measures in the Hospital OQR, REHQR, and ASCQR Programs outweigh the benefits to facilities and patients. Removal of these measures would alleviate the burden on hospitals, REHs, and ASCs to manually screen each patient and submit data each reporting cycle, allowing hospitals, REHs, and ASCs to focus resources on measurable clinical outcomes and direct patient care. This will also remove the patient burden associated with repeated SDOH screenings across multiple healthcare facilities. We refer readers to our request for comment, "Measure Concepts under Consideration for Future Years in the Hospital OQR, REHQR, and ASCQR Programs—Request for Information (RFI): Well-Being and Nutrition" in section XIV.B. of this proposed rule for more information regarding our areas of focus for new measures. We acknowledge that some hospitals, ASCs and REHs may have expended resources to implement SDOH screenings, however, hospitals that had already implemented such screenings prior to adoption of the measures would not have expended similar resources. The objectives of the Hospital OQR Program continue to incentivize the improvement of care quality and health outcomes for all patients through transparency and use of appropriate quality measures.

We invite public comment on these proposals.

D. Proposed Updates to the Extraordinary Circumstances Exception (ECE) Policy for the Hospital OQR, REHQR, and ASCQR Programs

1. Background

Under our current Extraordinary Circumstances Exception (ECE) regulations, we have granted exceptions to data submission deadlines and requirements for the Hospital OQR, REHQR, and ASCQR Programs in the event of extraordinary circumstances beyond the control of a hospital, REH, or ASC (42 CFR 419.46(e); 419.95(g); 416.310(d), respectively). Extraordinary circumstances may include, but are not limited to, natural disasters or systemic problems with data collection systems.[147] We refer readers to the CY 2022 OPPS/ASC final rule with comment period (86 FR 63873), the CY 2024 OPPS/ASC final rule with comment period (88 FR 82076), and the CY 2018 OPPS/ASC final rule with comment period (82 FR 59474 through 59475) for further background about the ECE policies for Hospital OQR, REHQR, and ASCQR Programs, respectively. We also refer readers to the QualityNet website for program-specific requirements for submitting an ECE request.[148]

Our ECE policy provides flexibility for Hospital OQR, REHQR, and ASCQR Program participants toward meeting program requirements in the event of an extraordinary circumstance. For instance, we recognize that, in circumstances where a full exception is not applicable, it is beneficial for a hospital, REH, or ASC to report data later than the reporting deadline. Delayed reporting authorized under our ECE policy allows temporary relief for a hospital, REH, or ASC experiencing an extraordinary circumstance while preserving the benefits of data reporting, such as transparency and informed decision-making for beneficiaries and providers alike. Accordingly, we propose to update our regulations to specify that an ECE could take the form of an extension of time for a hospital, REH, or ASC to comply with a data reporting requirement if CMS determines that this type of relief would be appropriate under the circumstances.

2. Proposal To Update the Extraordinary Circumstances Exception (ECE) Policy for the Hospital OQR, REHQR, and ASCQR Programs

We propose to update the current Hospital OQR, REHQR, and ASCQR Program ECE policies codified at 42 CFR 419.46(e); 419.95(g); and 416.310(d), respectively, to include extensions of time as a form of relief and to further clarify the policy. Specifically, we propose to update the regulations at 42 CFR 419.46(e)(1); 419.95(g)(1); and 416.310(d)(1) to state that CMS may grant an ECE with respect to reporting requirements in the event of an extraordinary circumstance—defined as an event beyond the control of a hospital, REH, or ASC (for example, a

[147] Centers for Medicare & Medicaid Services. (May 2024). Quality Program Extraordinary Circumstances Exceptions (ECE) Request Form. QualityNet. Available at *https://qualitynet.cms.gov/files/677e843f50ed8df7419f60e1?filename=HQR_ECE_Req_Form_CY_2025.pdf. Accessed: April 30, 2025.*

[148] Centers for Medicare & Medicaid Services. Hospital OQR Program Extraordinary Circumstances Exceptions (ECE) Policy: *https://qualitynet.cms.gov/outpatient/oqr/participation%23tab2#tab2;* REHQR Program Extraordinary Circumstances Exceptions (ECE) Policy: *https://qualitynet.cms.gov/reh/rehqr/participation#tab2;* and ASCQR Program Extraordinary Circumstances Exceptions (ECE) Policy: *https://qualitynet.cms.gov/asc/ascqr/participation%23tab3#tab2. Accessed: April 30, 2025.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 412, 413, 415, 416, and 419

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ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the Medicare Hospital Outpatient Prospective Payment System (OPPS) and the Medicare Ambulatory Surgical Center (ASC) payment system for calendar year 2026 based on our continuing experience with these systems. We also describe the changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment systems. This proposed rule would also update and refine the requirements for the Hospital Outpatient Quality Reporting Program, Rural Emergency Hospital Quality Reporting Program, Ambulatory Surgical Center Quality Reporting Program, Overall Hospital Quality Star Rating, and hospitals to make public their standard charge information and enforcement of hospital price transparency. This rule also contains requests for information on measure concepts regarding Well-Being and Nutrition for consideration in future years for all three programs (OQR, REHQR, and ASCQR; expanding the method to control for unnecessary increases in the volume of covered OPD services to on-campus clinic visits; software as a service; and adjusting payment under the OPPS for services predominately performed in the ambulatory surgical center or physician office settings.

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Non-Opioid Policy or Implementation of Section 4135 of the Consolidated Appropriations Act (CAA), 2023,

natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing)—that affected the ability of the hospital, REH, or ASC to comply with one or more applicable reporting requirements with respect to a calendar year.

We propose that the steps for requesting or granting an ECE would remain the same as the current ECE process, detailed by CMS at the QualityNet website or a successor website.[149] However, at proposed § 419.46(e)(2)(i); 419.95(g)(2)(i); and 416.310(d)(2)(i), we propose that a hospital, REH, or ASC, respectively, may request an ECE within 30-calendar days of the date that the extraordinary circumstance occurred. Our current policy allows a request within 90 days; this proposed change would align the Hospital OQR, REHQR, and ASCQR policy with CMS systems implementation requirements across all quality reporting programs. Under this proposed codified policy, we clarify that CMS retains the authority to grant an ECE as a form of relief at any time after the extraordinary circumstance has occurred. For the Hospital OQR, REHQR, and ASCQR Programs, at proposed §§ 419.46(e)(2)(ii); 419.95(g)(2)(ii); and 416.310(d)(2)(ii), respectively, we propose that CMS notify the requestor with a decision in writing. If CMS grants an ECE to the hospital, REH or ASC, the written decision will specify whether the hospital, REH, or ASC is exempted from one or more reporting requirements or whether CMS has granted the hospital, REH, or ASC an extension of time to comply with one or more reporting requirements.

Additionally, at §§ 419.46(e)(3); 419.95(g)(3); and 416.310(d)(3), we propose that CMS may grant an ECE to one or more hospitals, REHs, or ASCs 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 hospital, REH, or ASC to comply with a quality data reporting requirement, or that an extraordinary circumstance has affected an entire region or locale. As is the case under our current policy, any ECE granted will specify whether the affected hospitals, REHs, or ASCs are exempted from one or more reporting requirements or whether CMS has granted the hospital, REH, or ASC an extension of time to comply with one or more reporting requirements.

This proposed ECE policy would provide further reporting flexibility for a hospital, REH, or ASC and clarify the ECE process.

We invite public comment on these proposals.

XV. Hospital Outpatient Quality Reporting (OQR) Program

A. Background and History of the Hospital OQR Program

The Hospital Outpatient Quality Reporting (OQR) Program is a pay-for-reporting program intended to ensure transparency and quality of care furnished at hospital outpatient departments (HOPDs). Section 1833(t)(17)(A) of the Social Security Act (the Act) states that subsection (d) hospitals (as defined under section 1886(d)(1)(B) of the Act) that do not submit data required for measures selected with respect to such a year, in the form and manner required by the Secretary, will incur a 2.0-percentage point reduction to their annual Outpatient Department (OPD) fee schedule increase factor.

We refer readers to the CY 2011 OPPS/ASC final rule with comment period (75 FR 72064 through 72065) for a detailed discussion of the statutory history of the Hospital OQR Program. The Hospital OQR Program requirements are codified at 42 CFR 419.46. We also refer readers to the CMS website at *https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hospital-outpatient-quality-reporting-program* for general background on the Hospital OQR Program, as well as the CMS QualityNet Hospital OQR website at *https://qualitynet.cms.gov/outpatient* for current program requirements and measure specifications.

B. Proposed Changes to the Hospital OQR Program Measure Set

We propose to adopt the Emergency Care Access & Timeliness electronic clinical quality measure (eCQM) beginning with voluntary reporting for the CY 2027 reporting period followed by mandatory reporting beginning with the CY 2028 reporting period/CY 2030 payment determination. In addition, we propose to remove the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients (Median Time for Discharged ED Patients) measure and the Left Without Being Seen measure, beginning with the CY 2028 reporting period/CY 2030 payment determination, if the Emergency Care Access & Timeliness eCQM is finalized as proposed. We propose to modify the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level—Outpatient) measure (Excessive Radiation eCQM) from mandatory reporting to voluntary reporting beginning with the CY 2027 reporting period.

We also refer readers to section XIV.C. of this proposed rule, Cross-Program Proposals, where we discuss our proposals to remove the following Hospital OQR Program measures: (1) COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure beginning with the CY 2024 reporting period/CY 2026 payment determination; (2) Hospital Commitment to Health Equity (HCHE) measure beginning with the CY 2025 reporting period/CY 2027 payment determination; (3) Screening for Social Drivers of Health (SDOH) measure beginning with the CY 2025 reporting period; and (4) Screen Positive Rate for SDOH measure beginning with the CY 2025 reporting period.

1. Proposed Adoption of the Emergency Care Access & Timeliness eCQM Beginning With Voluntary Reporting for the CY 2027 Reporting Period Followed by Mandatory Reporting Beginning With the CY 2028 Reporting Period/CY 2030 Payment Determination

a. Background

Occupancy and boarding rates in U.S. emergency departments (EDs) continue to worsen and exceed pre-pandemic levels.[150] 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.[151] A recent report from the Agency for Healthcare Research and Quality (AHRQ) characterized patient ED boarding as a growing public health

[149] Centers for Medicare & Medicaid Services. Hospital OQR Program Extraordinary Circumstances Exceptions (ECE) Policy: *https://qualitynet.cms.gov/outpatient/oqr/participation%23tab2#tab2;* REHQR Program Extraordinary Circumstances Exceptions (ECE) Policy: *https://qualitynet.cms.gov/reh/rehqr/participation#tab2;* and ASCQR Program Extraordinary Circumstances Exceptions (ECE) Policy: *https://qualitynet.cms.gov/asc/ascqr/participation%23tab3#tab2. Accessed: April 30, 2025.*

[150] Moore, C. & Heckmann R. (2025). Hospital Boarding In The ED: Federal, State, And Other Approaches. *Health Affairs Forefront.* Available at *https://www.healthaffairs.org/content/forefront/hospital-boarding-ed-federal-state-and-other-approaches. Accessed: April 30, 2025.*

[151] Moore, C. & Heckmann R. (2025). Hospital Boarding In The ED: Federal, State, And Other Approaches. *Health Affairs Forefront.* Available at *https://www.healthaffairs.org/content/forefront/hospital-boarding-ed-federal-state-and-other-approaches. Accessed: April 30, 2025.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 412, 413, 415, 416, and 419

Office of the Secretary

45 CFR Part 180

[CMS–1834–P]

RIN 0938–AV51

Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the Medicare Hospital Outpatient Prospective Payment System (OPPS) and the Medicare Ambulatory Surgical Center (ASC) payment system for calendar year 2026 based on our continuing experience with these systems. We also describe the changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment systems. This proposed rule would also update and refine the requirements for the Hospital Outpatient Quality Reporting Program, Rural Emergency Hospital Quality Reporting Program, Ambulatory Surgical Center Quality Reporting Program, Overall Hospital Quality Star Rating, and hospitals to make public their standard charge information and enforcement of hospital price transparency. This rule also contains requests for information on measure concepts regarding Well-Being and Nutrition for consideration in future years for all three programs (OQR, REHQR, and ASCQR; expanding the method to control for unnecessary increases in the volume of covered OPD services to on-campus clinic visits; software as a service; and adjusting payment under the OPPS for services predominately performed in the ambulatory surgical center or physician office settings.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by September 15, 2025.

ADDRESSES: In commenting, please refer to file code CMS–1834–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the "Submit a comment" instructions.

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Non-Opioid Policy or Implementation of Section 4135 of the Consolidated Appropriations Act (CAA), 2023,

XVIII. Overall Hospital Quality Star Rating Modification To Emphasize the Safety of Care Measure Group

A. Summary

In the CY 2025 OPPS/ASC final rule with comment period (89 FR 94514 through 94521), we summarized broad public input received on a Request for Information (RFI) discussing potential methodologic modifications to the Safety of Care measure group within the Overall Hospital Quality Star Rating that is published on the provider comparison tool on *Medicare.gov* (*https://www.medicare.gov/care-compare/*). The potential modifications discussed in that RFI aimed to emphasize the contribution of the Safety of Care measure group to the Overall Hospital Quality Star Rating. In that RFI, we also noted our intention to potentially issue additional RFIs or undertake rulemaking on this topic in the future.

Patient safety constitutes a fundamental component of the CMS National Quality Strategy, representing a sustained commitment to fostering optimal health outcomes and ensuring the safest possible care for all patients.[259] As we noted in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94514 through 94521), we believe that increasing the influence of the Safety of Care measure group is a necessary and appropriate methodological change. Patient safety is cornerstone to healthcare delivery and the foundational principle of professional oaths is to "do no harm." Prioritizing safety for both patients and healthcare workers align with this fundamental commitment. Considering the public input received and further internal analyses conducted, we propose to make the following modifications to the Overall Hospital Quality Star Rating methodology: (1) implement a 4-star cap for hospitals in the lowest-performing quartile of the Safety of Care measure group) for the 2026 Overall Hospital Quality Star Rating, and (2) implement a blanket 1-star reduction for hospitals in the lowest-performing quartile of the Safety of Care measure group for the 2027 Overall Hospital Quality Star Rating and thereafter.

B. Background

The Overall Hospital Quality Star Rating provides a summary of certain existing hospital quality information on *Medicare.gov*[260] based on publicly available quality measure results reported through CMS' hospital quality measurement programs, by assigning hospitals between 1 and 5 stars, a way that is simple and easy for patients to understand (85 FR 86193). The Overall Hospital Quality Star Rating methodology was developed and is maintained according to the guiding principles of scientific validity, maximizing inclusion of hospitals and measure information, accounting for heterogeneity of available measures and hospital reporting, accommodating changes in the underlying measures, aligning with CMS hospital quality measure programs to the extent feasible, transparency of the methodology, and responsiveness to input from stakeholders. The Overall Hospital Quality Star Rating was first introduced and reported on our Hospital Compare website in July 2016 (now reported on Care Compare on *Medicare.gov*) and has been refreshed multiple times.

In the CY 2021 OPPS/ASC final rule with comment period (85 FR 86193), we codified the Overall Hospital Quality Star Rating methodology, including several methodology refinements, intended to improve the simplicity and predictability of measure emphasis within the methodology over time, and comparability of ratings among hospitals. We also finalized the inclusion of Veterans Health Administration (VHA) hospitals and Critical Access Hospitals (CAHs) in the Overall Hospital Quality Star Rating. In the CY 2023 OPPS/ASC final rule with comment period (87 FR 72233), we provided additional information on the previously finalized policy to incorporate VHA hospitals and finalized a proposal to amend 42 CFR 412.190 to revise how we would refresh the Overall Hospital Quality Star Rating annually. In the CY 2025 OPPS/ASC final rule with comment period (89 FR 94514 through 94521) we summarized public input received on the following potential methodological updates to greater emphasize patient safety in the Overall Hospital Quality Star Rating: (1) Reweighting the Safety of Care Measure Group, (2) Policy-based 1-Star Reduction for Poor Performance on Safety of Care, and (3) Reweighting the Safety of Care measure group combined with a Policy-based Star Rating Cap. We refer readers to section XXIV. (Overall Hospital Quality Star Rating Modification to Emphasize the Safety of Care Measure Group: Request for Information (RFI)) of the CY 2025 OPPS/ASC final rule with comment period (89 FR 94514 through 94521) for additional information.

C. Current Overall Hospital Quality Star Rating Methodology (§ 412.190)

Measures reported on the provider comparison tool on *Medicare.gov*[261] that meet the criteria for inclusion in the Overall Hospital Quality Star Rating are organized into five conceptually coherent measure groups: Safety of Care, Mortality, Readmission, Patient Experience (all of which include outcome measures), and Timely and Effective Care (which includes a selection of process measures).

The current Overall Hospital Quality Star Rating methodology includes eight general steps. First, measures are selected from those publicly reported on Care Compare on *Medicare.gov* through certain CMS hospital inpatient and outpatient quality programs. Second, the direction of all included measures that indicate better performance with a lower score are reversed to uniformly reflect that a higher score indicates better performance for all the measures, and all measure scores are standardized to a single, common scale to account for differences in measure score units. Third, measures are arranged into measure groups. Each measure group contains several publicly reported measures to produce a robust measure group score, which is reflective of differences in hospital quality. Fourth, the measure group scores are calculated as a simple average of the measure scores. Measure group scores are then standardized to a common scale, making varying scores comparable. Fifth, the hospital summary score is calculated as a weighted average of the standardized measure group scores. Specifically, each measure group score is multiplied by the assigned weight for that measure group. The weighted measure group scores are then summed up to generate the hospital summary score. If a hospital has no measure scores in a measure group (for example, by not achieving sufficient sample size in any of the measures), the weight is redistributed proportionally across the remaining measure groups. Sixth, minimum reporting thresholds are applied. To receive an Overall Hospital Quality Star Rating, hospitals must report at least three measures in each of at least three measure groups, one of which must be either the Mortality or Safety of Care measure groups. Seventh, peer grouping is applied. Hospitals are grouped into one of three peer groups based on the number of measure groups for which

[259] *https://www.cms.gov/files/document/cms-national-quality-strategy-handout.pdf.*

[260] *https://www.medicare.gov/care-compare/resources/hospital/overall-star-rating.*

[261] *https://www.medicare.gov/care-compare/.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 412, 413, 415, 416, and 419

Office of the Secretary

45 CFR Part 180

[CMS–1834–P]

RIN 0938–AV51

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AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

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