Supporting Statement - Part B

Submission of Information for the Hospital Outpatient Quality Reporting Program

Collection of Information Employing Statistical Methods

1. Describe potential respondent universe.

All subsection (d) hospitals receiving reimbursement under the Outpatient Prospective Payment System (OPPS) in the United States; approximately 3,000 hospital outpatient departments (HOPDs).

2. Describe procedures for collecting information.

Data may be patient-level, or summary or aggregate data submitted directly to CMS via a secure web portal (currently, the Hospital Quality Reporting (HQR) system), or the Centers for Disease Control and Prevention's National Healthcare Safety Network by either the HOPD or their authorized vendor(s), as specified.

3. Describe methods to maximize response rates.

To maximize response rates, the Hospital Outpatient Quality Reporting Program provides for payment consequences related to program participation. Specifically, HOPDs that do not meet program requirements will receive a 2.0 percentage point reduction to their OPPS annual payment update. To reduce burden and thereby maximize response rates, the Hospital Outpatient Quality Reporting Program allows HOPDs to sample for measures that require direct data entry (i.e., Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients; Cataract Visual Function; Stroke, and Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients). In addition, CMS provides abstraction and submission tools, education and outreach, and technical assistance to any HOPDs needing assistance with program requirements. In the CY 2026 OPPS/ASC final rule, we removed the Median Time from ED Arrival to ED Departure for Discharged ED Patients measure beginning with the CY 2028 reporting period/CY 2030 payment determination. In the CY 2027 OPPS/ASC proposed rule, we are proposing removal of the Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2027 reporting period/CY 2029 payment determination.

4. Describe any tests of procedures or methods.

(a) Sampling for Chart-Abstracted Data for the Hospital Outpatient Quality Reporting Program

In an effort to reduce burden, for measures that require direct data entry under the Hospital Outpatient Quality Reporting Program, HOPDs may submit a representative sample of the denominator population instead of including all eligible cases. A sample

may consist of either 63 cases for HOPDs with a population size between 0 and 900, or 96 cases for HOPDs with a population size of greater than 900, but HOPDs are able to submit more cases if they choose. HOPDs that choose to sample must ensure that the sampled data represents their outpatient population by using either simple random sampling or systematic random sampling, and that the sampling techniques are applied consistently within a quarter. For example, quarterly samples for a sampling population must use consistent sampling techniques across the quarterly submission period. HOPDs may also submit measure data for the entire applicable patient population in lieu of sampling.

(b) Validation Policy for Chart-Abstracted and Electronic Clinical Quality Measure Data for the Hospital Outpatient Quality Reporting Program

In the CY 2027 OPPS/ASC proposed rule, we are proposing to incorporate electronic clinical quality measures (eCQMs) into the existing validation process for chart-abstracted measures beginning with CY 2027 eCQM data affecting the CY 2030 payment determination.

As currently approved, CMS selects 500 HOPDs for validation; 450 are selected randomly, and the remaining 50 are selected using targeting criteria on an annual basis for validation. Also, as currently approved, each selected HOPD is required to submit up to 12 cases per quarter (totaling 48 cases per year) for validation. In the CY 2027 OPPS/ASC proposed rule, we are proposing to: (1) reduce the validation selection pool from 500 to up to 400 HOPDs (up to 200 selected randomly and up to 200 selected using targeting criteria) beginning with validation affecting the CY 2030 payment determination, and (2) modify the number of chart-abstracted cases required for validation from 12 per quarter to a maximum of 8 per quarter per measure beginning with validation affecting the CY 2030 payment determination.

To be eligible for random selection for validation, an HOPD must have submitted at least 12 encounters to the Hospital Outpatient Quality Reporting Program Clinical Warehouse during the quarter containing the most recent available data. If the proposed modification to the required number of cases from 12 per quarter to a maximum of 8 per quarter per measure is finalized, this will be reduced to 8 encounters. The quarter containing the most recent available data is defined based on when the random sample is drawn. To be eligible for targeted selection for validation, the HOPD must be a subsection (d) hospital and meet one or more of the following criteria:

- any HOPD which failed the validation requirement that applied to the previous year's payment determination;
- any HOPD having an outlier value for a measure, e.g. a measure value that appears to deviate markedly from the measure values for other HOPDs;
- any HOPD with outlier values indicating specifically poor scores on a measure;
- any HOPD that has not been randomly selected for validation in any of the previous 3 years;

- any HOPD that passed validation in the previous year but had a two-tailed confidence interval that included 75 percent; and
- any HOPD with less than four quarters of data subject to validation due to receiving an Extraordinary Circumstance Exceptions (ECE) for one or more quarters and with a two-tailed confidence interval that is less than 75 percent.

After the random selection has been completed, the CMS Clinical Data Abstraction Center (CDAC) sends record requests by a trackable mail method to the designated Medical Record Contact at the HOPD. Each HOPD is required to submit the requested documentation to the CDAC within 30 calendar days of the date of the request (as documented on the request letter). If the HOPD fails to comply within 30 days, a "zero" score is assigned to each data element for each selected case, and the case will fail for all measures in the same topic.

(c) Validation Response Rates for the Hospital Outpatient Quality Reporting Program

To ensure consistently high response rates from selected HOPDs for validation, the CMS-designated contractor provides a 15-day reminder notice to HOPDs that have outstanding medical records. In addition, during the last week of the submission period, CMS provides a daily list of HOPDs with outstanding records to the CMS-designated contractor who then makes targeted phone calls to the HOPDs.

Once the CDAC receives the requested medical documentation, it independently re-abstracts the same quality measure data elements that the HOPD previously abstracted and submitted, and it compares the two sets of data to determine whether they match. A confidence interval using a binomial approach is used in the calculation of validation scores to account for sample variability and the possibility of small sample sizes, and that data being analyzed are binary (match, do not match). To receive a full annual payment update, HOPDs must obtain at least a 75 percent validation score for the designated time-period based upon this validation process.

5. Provide name and telephone number of individuals consulted on statistical aspects.

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