PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

Support Contractor

PCHQR Program: FY 2019 IPPS/LTCH PPS Final Rule

Presentation Transcript

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Lisa Vinson: Good afternoon, we would like to welcome everyone to today's PPS-Exempt Cancer Hospital Quality Reporting Program Outreach and Education Event entitled: PCHQR Program Fiscal Year 2019 IPPS/LTCH PPS Final Rule. My name is Lisa Vinson and I serve as the Program Lead for the PCHQR Program within the Hospital Inpatient Value, Incentives and Quality Reporting, or VIQR, Outreach and Education Support Contractor. I will be the moderator for today's event. The materials for today's presentation were developed by our team in conjunction with our CMS Program Lead, Caitlin Cromer, who will be the main speaker for today's presentation. Caitlin is a Social Science Research Analyst working in the Quality Measurement and Value-Based Incentives Group, or QMVIG, within the Clinical Standards and Quality at CMS. As the title indicates, we will be discussing the Fiscal Year 2019 IPPS/LTCH PPS Final Rule. Today's event is specific for participants in the PCHQR Program. Although the final rule contains content that addresses the Hospital Inpatient Quality Reporting, or IQR, and Long-term Care Hospital, or LTCH, Quality Reporting Programs, we will only be focusing on the PCHQR Program section. If your facility is participating in the Hospital IQR or LTCH programs, please contact your program lead to find out when there will be a presentation on your section of the fiscal year 2019 final rule. If you have questions about the content of today's presentation, please submit them using the chat function. As time allows, our presenters will address these during today's event. If time does not allow all questions to be answered during today's event, remember that the slides, recording and transcript, and questions and answers will be posted following today's presentation on *QualityNet* and *Quality Reporting Center*. Next slide please.

As usual, here's the acronyms and abbreviations list. Acronyms and abbreviations that you will hear and see today include CY for calendar year, FY for fiscal year, HHS for U.S. Department of Health and Human Services, IPPS for inpatient perspective payment system, LTCH for long-term care hospital, NQF for National Quality Forum and PPS for prospective payment system. Slide 7 please.

The purpose of today's event is to provide an overview of the Fiscal Year 2019 IPPS/LTCH PPS Final Rule focusing on the impact of the changes on the PCHQR Program. On Slide 8, we will take a look at the objectives.

There are three main objectives for today's event. At the culmination of this presentation, program participants should be able to locate the Fiscal Year 2019 IPPS/LTCH PPS Final Rule, identify the changes impacting participants and the PCHQR Program, and summarize the CMS responses to comments received during the rulemaking process. Next slide please.

Before Caitlin begins our discussion of the fiscal year 2019 final rule, which will be the seventh rule finalized that will impact the PCHQR Program since its formation as a result of the Affordable Care Act, I would like to briefly review the history of the measures that have been added and, in some cases, removed from the program since its inception. In the first year of the program, the fiscal year 2013 final rule finalized five quality measures for the program including three Cancer-Specific Treatment, or, CST measures, and two healthcare-associated infection, or HAI, measures, CAUTI and CLABSI. The following year saw the addition of another HAI measure, surgical site infection, or SSI, and the addition of 12 new measures. These new quality measures included five Clinical Process/Oncology Care measures, six Surgical Care Improvement Project, or SCIP, measures, and the incorporation of the HCAHP Survey data. The third final rule publication, fiscal year 2015, finalized the addition of one measure, External Beam Radiotherapy for Bone Metastases, or EBRT. Slide 10 please.

The fourth final rule impacting the program, fiscal year 2016, there were two new HAI outcome measures added. Methicillin-resistant *Staphylococcus aureus* bacteremia, or MRSA, and *Clostridium difficile* infection, or CDI, as well as the inclusion of the Healthcare Personnel Influenza Vaccination measure. Also, the six SCIP measures were removed effective October 1, 2016. The fiscal year 2017 final rule, a new claims-based measure, Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy was added and the diagnosis cohort for NQF #0382, Radiation Dose Limits to Normal Tissues, was

expanded to include patients with a diagnosis of breast or rectal cancer. Last year in the fiscal year 2018 final rule, the three CST measures were removed effective for diagnoses occurring January 1, 2018 and there were four new end-of-life, or EOL, claims-based measures added to the program. Please keep in mind that a list of final rules with a summary of the key changes to the program along with the hyperlinks to the PDF versions of the final rules is available on *QualityNet* on the PCHQR program overview page, *Quality Reporting Center* on the PCHQR tab and in the program manual which is posted on both *QualityNet* and *Quality Reporting Center*. Of note, the program manual will undergo its second iteration later this year, reflecting the program changes that we will be discussing today. Slide 11 please.

The official Federal Register version of the final rule was published on August 17, 2018. This version can be accessed via the Federal Register link provided here. The PCHQR program section begins on page 41609 through page 41624. At this time, I would like to turn the presentation over to Caitlin, who will further discuss the finalized changes, how these changes will impact the PCHQR Program, comments received, and responses provided. Caitlin.

Caitlin Cromer: Thank you Lisa. As we have discussed previously, a measure development, selection and implementation process is an ongoing cycle. The work culminates each year with the publication of the final rule which we will be discussing today. Back in May, Lisa and I presented to you the fiscal year 2019 proposed rule. There was a period of public comment. We at CMS highly value this input and today we'll be reviewing the contents of the fiscal year 2019 final rule. I will share with you a summary of the comments we've received and our responses. The final rule for the PCHQR Program consists of ten sections which I will highlight for you on the next slide.

The PCHQR Program portion of the final rule is broken into ten major sections as outlined on this slide. There are no changes to the sections on maintenance of technical specifications or quality measures and extraordinary circumstance exceptions, or ECE policy, so we will not

address those sections in detail during today's presentation. In regards to the maintenance of technical specifications for quality measures, as participants know, materials pertaining to the business of the program are posted on the *QualityNet* under the PCHQR Program. Updates to the program occur during the annual publication of the final rule and there is sub-regulatory process to allow non-substantive updates to measures in the program. As for the ECE policy, under the PCHQR Program, and our experience with other quality reporting and performance programs, we have noted occasions when providers have been unable to submit required quality data due to uncontrollable extraordinary circumstances. We do not wish to increase their burden unduly during these times. Last year in the fiscal year 2018 final rule, we finalized modifications to the ECE policy which have not changed. On Slide 14, we will start with the first section of the final rule which is the background.

The background for the PCHQR Program remains unchanged. This program was legislatively mandated in Section 3005 of the Affordable Care Act. The purpose of this program is to put patients first by allowing them to make data decisions along with their providers using information from data-driven insights. In combination with the other quality reporting programs, the PCHQR Program helps to incentivize hospitals to improve healthcare quality and value. In the Fiscal Year 2019 IPPS/LTCH PPS Proposed Rule, there were a number of new policies to the PCHQR Program. CMS developed these proposals after conducting an overall review of the program under our new Meaningful Measures Initiative. In an effort to continue promoting improved health outcomes and minimizing burden, CMS also aims to minimize beneficiary confusion by reducing duplicative reporting and streamlining the process of analyzing publicly reported quality measure data. Next slide please.

This slide lists the seven factors that are taken into consideration in potentially removing a measure from the program. These remain unchanged from last year’s final rule. We generally retain measures from the previous year's PCHQR Program measure set for subsequent year’s measure sets, except when we specifically propose to remove or replace a

measure. While these factors for removal are important, we recognize there are times when measures may meet some of the outlined factors for removal from the program but continue to bring value to the program. These factors are outlined on the next slide.

The factors for retention are consistent with those developed for the Hospital Inpatient Quality Reporting Program. The specific reasons for retaining a measure in the program, even if it meets some of the factors for removal from the program, are that the measure aligns with other CMS and HHS policy goals, that the measure aligns with other CMS programs, including other quality reporting programs, and if the measure supports efforts to move the PCHs toward reporting electronic measures, then we will consider retaining these measures in the program. Next slide please.

In the fiscal year 2019 proposed rule, we proposed to adopt an additional factor to consider when evaluating potential measures for removal from the PCHQR Program measure set, which is Factor 8 – the cost associated with the measure outweigh the benefit of its continued use in the program – beginning with the effective date of Fiscal Year 2019 IPPS/LTCH PPS Final Rule, which is October 1, 2018. We believe that these costs are multifaceted and include not only the burden associated with reporting, but also the cost associated with implementing and maintaining the program. We identified several types of costs, including but not limited to: provider and clinician information collection burden associated with the submission and reporting of quality measures to CMS; provider and clinician costs associated with complying with other programmatic requirements; the provider and clinician costs associated with participating in multiple quality programs; the cost to CMS associated with the program oversight of the measure including measure maintenance and public display; and the provider and clinician costs associated with compliance with other federal and state regulations when applicable. Our goal is to move the program 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. We invited public comment on our proposal to adopt this

additional measure removal factor and we will review the comments and responses on our next slide.

Overall, commenters were in support of adopting this measure removal factor. One commenter noted that the broad application of this factor helps to streamline CMS' quality programs. Also, the commenter encouraged CMS not to base removing a measure on a previously finalized measure being too difficult to implement, but rather identify ways to gather the appropriate data by different means. We are appreciative of this support. We also want to ensure that it has never been our intent to remove measures solely based on the ease of implementation. The removal of measures under the newly proposed Factor 8 will serve to balance the cost of ongoing maintenance, reporting and collection, and public reporting with the benefit associated with reporting of that data. We intend to be transparent in our assessment of measures under this factor. Other comments were received as well, such as the transparent process being required to weigh the benefit against the cost and assessment of value must be transparent with the clear prioritization of the needs of patients and customers. We intend to evaluate each measure on a case-by-case basis while considering input from a variety of stakeholders, including but not limited to patients, caregivers, patient and family advocates, providers, provider associations, healthcare researcher, data vendors and other stakeholders with insight into the benefits and costs and we will continue to do so in the future when proposing measures for adoption and retention in the PCHQR Program. After consideration of all public comments received, we are finalizing our proposal to adopt the new measure removal Factor 8. The cost associated with the measure outweigh the benefits of its continued use in the program beginning with the effective date of the Fiscal Year 2019 IPPS/LTCH PPS Final Rule. Next slide please.

In the fiscal year 2019 proposed rule, we proposed to remove four web-based structural measures which are part of the Clinical Process/Oncology Care Measures group: Radiation Dose Limits to Normal Tissues, or NQF #0382, Pain Intensity Quantified, or NQF #0384, Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients, or NQF #0390, and

Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients, or NQF #0389. On the next slide we'll briefly review the rationale for the removal of these measures from the program.

The rationale for recommending the removal of these web-based structural measures is that we have concluded that they are topped-out based on an analysis of data from January 1, 2015 through December 31, 2016. This analysis evaluated datasets and calculated the 5th, 10th, 25th, 50th, 70th, 90th and 95th percentiles of national facility performance for each measure. Based on this analysis, we believe that collecting PCH data on these measures does not further program goals. Given the performance of these measures is so high and unvarying, meaningful distinctions and improvements in performance can no longer be made. We believe that these measures also do not meet the criteria for retention of an otherwise topped-out measure as they do not align with the HHS and CMS policy goals to focus on outcome measures. These measures do not align with measures used in other CMS programs and these measures do not support our efforts to develop electronic clinical quality measures reporting for PCHs. If we determine at a subsequent point in the future that PCHs adherence to the aforementioned HHS and CMS policy goals, the aforementioned program efforts and the standard of care established by the measure has unexpectedly declined, we may propose to re-adopt these measures in future rulemaking. We invited public comment on our proposal to remove these four measures from the PCHQR Program beginning with the fiscal year 2021 program year. Next slide please.

There were a few commenters who supported the proposed removal of these four web-based structural measures. Commenters noted that topped-out measures provide little in the way of quality differentiations and cannot incentivize meaningful quality improvement. Also, this removal will help reduce the administrative burden of the PCHQR Program. One commenter recommended retaining the measure in the program until the Core Quality Measure Collaborative, or CQMC, is able to jointly re-evaluate the measures inclusion in the oncology measure set. We are appreciative of this input, however, continued reporting on a topped-out

measure provides limited opportunity for continuing quality improvement, while continuing to incur reporting burden to care providers. Furthermore, the PCHQR Program is not bound to removing a measure solely because they are topped-out, but in this instance the data for this measure demonstrates that meaningful distinctions and improvements in performance can no longer be made. Another commenter indicated that since the Oncology: Medical and Radiation – Pain Intensity Quantified, or NQF #0384, was validated and endorsed by its measure developer and NQF, as a paired measure with the Oncology: Plan Care for Pain, the collection of data for NQF #0384 would continue to be necessary in order to obtain the eligible patient population for the NQF #0383. The commenter recommended that both measures either be included or excluded from PCHQR Program as a pair. While we recognize the pairing of these two measures, NQF #0384 remains statistically topped-out while NQF #0383 is not. We believe that NQF #0383 suffices to assess cancer patient pain treatment and will incentivize continued quality improvement with public reporting in the PCHQR Program. After consideration of the public comments we received, we are finalizing the removal of NQF #0382, #0384, #0390 and #0389 beginning with the fiscal year 2021 program year. Next slide please.

We also proposed to apply measure removal Factor 8, if finalized, to two NHSN chart-abstracted measures, and if that factor is finalized to remove both measures from the PCHQR Program, beginning with the fiscal year 2021 program year because we concluded that the cost associated with these measures outweigh the benefit of their continued use in the program. These measures are Catheter-Associated Urinary Tract Infection, or NQF #0138, and Central-Line Associated Bloodstream Infection, or NQF #0139. We will review the rationale for this recommendation on the next slide.

CAUTI and CLABSI were adopted in the fiscal year 2014 program year and the fiscal year 2013 final rule. We continue to believe that both measures provide important data for patients and hospitals in making decisions about care and informing quality improvement efforts. However,

we believe that removing these measures in the PCHQR Program will reduce program burden and complexity. We believe the cost, coupled with the high-technical and administrative burden on PCHs associated with collecting and reporting this measure data outweigh the benefits to continue use in the program. As a result of these costs, it has become too difficult to publicly report these measures due to the low volume of data produced and reported by the small number of facilities participating in the program and the corresponding lack of an appropriate methodology to publicly report this data. Therefore, we proposed under Factor 8, we would remove CAUTI and CLABSI measures from the PCHQR Program. We invited public comment on our proposal to remove these two measures from the PCHQR Program beginning with the fiscal year 2021 program year. Next slide.

In acknowledgment of the importance of these measures in assessing patient safety in the PCH setting, we want to be cautious not to prematurely remove measures from the PCHQR Program. We are conducting additional data analyses to assess measure performance based on new information provided by the CDC. The data recently submitted by the CDC were not available at the time we proposed the removal of these measures from the program. Therefore, we will reconcile the comments received on the proposed removal of both CAUTI and CLABSI in future 2018 final rule, most likely in the Calendar Year 2019 OPPS/ASC Final Rule, targeted for release no later than November 2018. The deferral will not affect the PCH data submission since we proposed to end data collection beginning calendar year 2019. Slide 25.

The fiscal year 2013 rule outlines the principles taken into consideration when developing and selecting measures for inclusion in the PCHQR Program. There were no changes to these principles which are consistent with principles used for measure selection in the Hospital IQR Program. In the proposed rule, we discussed the Meaningful Measures Initiative and its relation to how we assess and select quality measures for the PCHQR Program. You may recall that there are two legislatively permitted means of selecting measures for inclusion in this program. The first is that

PCHQR Program measures can be chosen from the set of metrics endorsed by an entity with a contract under Section 1890A of the Act, which means those currently endorsed by the National Quality Forum, or NQF. The second provision, as specified in Section 1865(k)(3)(B) of the Act is that the Secretary may select measures not endorsed by the NQF as long as due consideration is given to existing endorsed or adopted measures. Using these principles for measure selection in the PCHQR Program, we proposed one new measure for inclusion in the program which we will discuss on the next slide.

In an effort to expand the PCHQR Program measure set to include measures that are less burdensome to report to CMS, but still provide valuable information for beneficiaries, we proposed to adopt the 30-Day Unplanned Readmission for Cancer Patients, or NQF #3188, measure for the fiscal year 2021 program year and subsequent years. This measure meets the requirement under Section 1866(k)(3)(A) of the Act that measures specified for the PCHQR Program be endorsed by the entity with a contract under Section 1890A of the Act, currently the NQF. This measure aligns with recent initiatives to incorporate more outcome measures and quality reporting programs and will fill an existing gap of risk-adjusted readmission measures in the PCHQR Program. This proposed readmission measure fits within the Promote Effective Communications and Coordination of Care measurement domain and specifically applies to the associated clinical topic of “Admissions and Readmissions to Hospitals” of our Meaningful Measures Initiative. This measure is intended to assess the rate of unplanned readmissions among cancer patients treated at PCHs and to support improved care delivery and quality of life for this patient population. By providing an accurate and comprehensive assessment of unplanned readmissions within 30 days of discharge, PCHs can better identify and address preventable readmissions. Slide 27 please.

Given the current and projected increases in cancer prevalence and cost of care, it is imperative that healthcare providers look for opportunities to lower the cost of cancer care. Reducing admissions after hospital

discharges have been proposed as an effective means to lowering healthcare costs and improving the outcomes of care. Research suggests that between 9% and 48% of all hospital readmissions are preventable, owing to inadequate treatment during the patient's original admission or after discharge. Unnecessary hospital readmissions also negatively impact cancer patients by compromising their quality of life, placing them at risk for health-acquired infections and increasing cost of care. Also, unplanned readmissions during treatment can delay treatment completion and potentially worsen patient prognosis. Preventing these readmissions improves the quality of care for cancer patients. Furthermore, certain readmissions in cancer patients are preventable and should be routinely measured for purposes of quality improvement and accountability. Readmission rates have been developed for pneumonia, myocardial infarction and heart failure. However, the development of validated readmission rates for cancer patients lagged. In 2012, the Comprehensive Cancer Care Consortium for Quality Improvement, or C4QI, which is a group of 18 academic medical centers that collaborate to measure and improve quality of cancer care in their centers, started developing a cancer-specific unplanned readmission measure, hence the 30-day Unplanned Readmissions for Cancer Patients. This measure incorporates the unique clinical characteristics of oncology patients and results in readmission rates that more accurately reflect the quality of cancer care delivery when compared with broader readmissions measures. Likewise, this measure addresses gaps in existing readmissions measures related to the evaluation of hospital readmissions associated with cancer patients. Through adoption in the PCHQR Program, it can increase transparency around the quality of care delivery to patients with cancer. The proposed 30-day Unplanned Readmissions for Cancer Patients measure is claims-based, which means PCHs would not be required to submit any new data for the purposes of reporting this measure. We are proposing to calculate this measure on a yearly basis using Medicare administrative claims data specifically for the data collection period for each program year to span from October 1 of the year three years prior to the program year to September 30 of the year, two years prior to the program year. Therefore, for the fiscal year 2021 program year, we would calculate measure rates

using PCH claims data from October 1, 2018 through September 30, 2019. Statistical analysis indicates that there are opportunities to utilize this measure to reduce unplanned readmissions in cancer patients making it useful for performance improvement in public reporting. This outcome measure utilizes claims data to demonstrate the rate of which adult cancer patients have unplanned readmissions within 30 days of discharge from an eligible index admission. The numerator includes all eligible unplanned readmissions to the PCH within 30 days of the discharge date on an index admission to the PCH that is included in the measure denominator. The denominator includes inpatient admissions for all adult Medicare beneficiaries where the patient is discharged from the PCH with a principle or secondary diagnosis, that is not admitting diagnosis, within the defined measurement period. The measure excludes readmission for patients readmitted for chemotherapy or radiation therapy treatment or with disease progression. Participants are referred to the link on this page to access the National Quality Forum site for additional details on the testing results and measure specifications. We invited public comment on our proposal to adopt the 30-day Unplanned Readmission for Cancer Patients measure for the fiscal year 2021 program year and subsequent years. Next slide.

Comments were generally supportive. Commenters noted that this measure incorporates the unique clinical characteristics of oncology patients and will provide specific readmissions data that more accurately reflects the quality of cancer care delivery that will be hugely beneficial information for patients. This measure also allows hospitals to better identify and address preventable readmissions of cancer patients than current readmission measures. One commenter expressed concern regarding assigning accountability due to severity of illness that many patients experience related to their cancer diagnosis. It would be misguided to assign responsibility and penalize other caregivers for admissions associated with cancer patients. Also, the commenter requested clarification regarding the proposed data collection period for this measure. As always, CMS is appreciative of the comments received. We recognize that there was a discrepancy with the proposed data collection

period in the proposed rules which stated that the collection period for the fiscal year 2021 program year would begin July 1, 2018 through June 30, 2019 while also identifying a date range of October 1, 2018 through September 30, 2019. However, in this final rule we are finalizing that the data collection period for the fiscal year 2021 program year and subsequent years for this measure, will be October 1 through September 30 of the following calendar year for each respective year. Therefore, the data collection period fiscal year 2021 program year will be October 1, 2018 through September 30, 2019. Moreover, the one-year time frame narrows examination period for the assessment of caregivers making it less difficult to evaluate where in the process a readmission could have been preempted and easier to evaluate provider attribution. We understand that there are confounding healthcare factors that contribute to the severity of illness that many patients experience related to their cancer diagnosis. However, we believe that assessing patient readmissions is a proactive method that PCHs can use to hone in on which of these factors could be remedied and are prevented with improved quality of care. After consideration of the public comments received, we are finalizing the adoption of the 30-day Unplanned Readmission for Cancer Patients measure for the fiscal year 2021 program and subsequent years. We are also finalizing that the data collection period for the fiscal year 2021 program year and subsequent years for this measure will be October 1 through September 30 of the following calendar year for each respective year. Slide 29 please.

The table on this slide, and the next two slides, summarizes the previously and newly finalized PCHQR Program measures. CAUTI and CLABSI are included in this table with a footnote denoting that their removal has been deferred in this final rule. The remaining four HAI measures that are part of the PCHQR Program, SSI, CDI and MRSA are outcome measures and the other, Influenza Vaccination Coverage Among Healthcare Personnel, is a process measure. The next slide please.

Here we see the oncology care measure, NQF #0383, that has been part of the program and two end-of-life measures, NQF #0210 and #0215, which

were finalized for inclusion in the program in the last year, fiscal year 2018 final rule. The next category, Intermediate Clinical Outcome Measures has the remaining two end-of-life measures; NQF #0213 and #0216 which were also finalized for inclusion last year. Next slide please.

Here we see four measures: HCAHPS Survey, EBRT and the claims-based measure, Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy, that are all currently part of the program and we are recommending to retain. The last measure listed is the newly finalized readmission measure, 30-day Unplanned Readmission for Cancer Patients, or NQF #3188. These tables combined, summarize what the PCHQR Program measure set looks like for the fiscal year 2021 program year. Next slide please.

We at CMS understand the importance of improving beneficiary outcomes including reducing health disparity. We also understand that social risk factors such as income, education, race and ethnicity, employment, disability, community resources and social support play a major role in health. Among our core objectives, we aim to improve health outcomes, attain health equity for all beneficiaries and ensure that complex patients, as well as those with social risk factors, receive excellent care. As stated in the fiscal year 2018 final rule, the NQF undertook a two-year trial period in which certain new measures and measures undergoing maintenance review have been assessed to determine if risk adjustment for social factors is appropriate for these measures. The trial period ended April 27, 2017 and a final report was made available. The trial concluded that measures with a conceptual basis for adjustment generally did not demonstrate an empirical relationship between social risk factors and the outcomes measured. This discrepancy may be explained in part by the methods used for adjustment and the limited availability of robust data on social risk factors. NQF has extended the socioeconomic status, or SES trial, allowing further examination of social risk factors and outcome measures. We solicited feedback on which social risk factors provide the most valuable information to stakeholders and the methodology for illuminating differences and outcomes rates among patient groups with

hospital or providers that would also allow for comparison of these differences or disparities across providers. Commenters encouraged CMS to explore factors that could be used to stratify or risk adjust the measures. Beyond dual eligibility, explore risk adjusted approaches and consider the full range of differences in patient backgrounds that may affect outcomes. As a next step, CMS is considering options to improve health disparities among patient groups within and across hospitals by increasing transparency and how this work applies to other CMS quality programs. We plan to continue working with ASPE, the public and other key stakeholders on this important issue to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences. Commenters supported CMS' continued efforts to account for social risk factors in its quality reporting programs. Commenters also encourage CMS to provide more transparency in its efforts to address this issue due to the complex and detailed nature of this research being undertaken by ASPE, as well as by the measure stewards through the quality measure development process. We thank commenters for their support, opinions and recommendations and we'll take them into consideration as we continue to work on this issue. On Slide 33, we will discuss new quality measures for the program for future years. Next please.

CMS began analyzing our programs’ measures using the framework we developed for the Meaningful Measures Initiative. Additionally, in the fiscal years 2015, 2016, 2017 and 2018 final rules, we have discussed future measure topics and quality domain areas; specifically measure topics addressing making care affordable, communication and care coordination and working with communities to promote best practices of healthy living. We welcomed further comment and specific suggestions for measure topics that we consider for future rulemaking, including considerations related to risk-adjustments and the inclusion of social risk factors and risk adjustments for any individual performance measures. We sought public comment on two measure topics for potential future inclusion in the PCHQR Program including Risk-Adjusted Morbidity and

Mortality for Lung Resection for Lung Cancer or NQF #1790 and Shared Decision-Making Process or NQF #2962. Next slide please.

So, Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer measure is an outcome measure. It assesses the post-operative complications and operative mortality which are important negative outcomes associated with lung cancer resection surgery. Specifically, it assesses the number of patients 18 years of age or older undergoing elective lung resection for lung cancer to develop one of the listed post-operative complications described in the measure specifications. The lung cancer resection risk model, utilized in this measure, identifies predictors of the outcomes as listed on this slide. Knowledge of these predictors informs clinical decision-making by enabling physicians and patients to understand the associations between individual patient characteristics and outcomes. Also, with continued feedback of performance data over time, knowledge of these predictors and the relationship with patient outcomes will foster quality improvement. This measure aligns with recent initiatives to incorporate more outcome measures in quality reporting programs. It will fill an existing gap in risk-adjusted mortality measures in the PCHQR Program. We have requested public comment on the possible inclusion of this measure in future years of the program. Comments were supportive of the possible inclusion of this measure. One commenter urged CMS to consider whether this measure can be collected in a less burdensome manner before incorporating it into the PCHQR Program and work to clarify the data collection and submission process, measure calculation process and any appropriate risk adjustments. Commenters also expressed concern about the omission of small volume centers in the model that the Society of Thoracic Surgeons, or STS, used to validate the risk adjustment, morbidity and mortality for lung cancer resection metrics as able to sort out high performing versus acceptable versus low performing centers. We intend to collaborate with the measure steward to ensure that the measure calculation and risk adjustment methodologies are thoroughly outlined should we decide to move forward with this proposal. Another commenter noted that this measure may have negative implications for lung cancer care as it may penalize centers that choose to

serve more complex high-risk patients. We acknowledge this concern and note that this measure does incorporate a lung cancer risk adjusted model which accounts for the patient age, smoking status, co-morbid medical conditions and other patient characteristics, as well as operative approach and extent of pulmonary resection. Furthermore, we thank the commenters and will consider their views as we develop future policy regarding the potential inclusion of the Risk-Adjusted Morbidity and Mortality for Lung Resection of Lung Cancer measure in the PCHQR Program. Next slide please.

The Shared Decision Making Process, or NQF #2962, is a patient-reported outcome measure. This measure asks patients who have had any of the seven preference sensitive surgical interventions to report on the interactions they have with their providers when the decision was made to have surgery. Specifically, this measure assesses patient answers to four questions about whether three essential elements of shared decision making - one, laying out options; two, discussing the reasons to have the intervention and not to have the intervention, and three, asking for patient input - were part of the patient's interactions with providers when the decision was made to have the procedure. We requested public comment on the possible inclusion of this measure in future years of the program. Commenters were supportive and indicated that this measure is essential for cancer patients, as it allows for the opinion of the patient to be determinant of their care. Commenters were also appreciative that this measure places a strong emphasis on the quality of dialogue between the patient and physician. Commenters also offered recommendations such as including a question that gauges the patient's assessment of cost, procedure specific questions, and revisions to some of the survey questions. We are appreciative of the comments and feedback received and we'll consider the commenters views as we develop future policy regarding the potential inclusion of the Shared Decision Making Process measure in the PCHQR Program. Next slide please.

CMS intends to review and assess the quality measures that we collect and score in our quality programs. We are continually evaluating the existing

PCHQR measure portfolio and identifying gap areas for future measure adoption and/or development. We have conducted a measure environmental scan and by staying abreast of the cancer measurement environment and staying in communication with the cancer measurement development community are vital to ensure that PCHQR Program measure portfolio remains aligned with the current CMS and HHS goals. Currently, we are assessing whether or not to redefine the scope of new quality metrics implemented in the PCHQR Program in future years. More specifically for the PCHQR Program, we are trying to determine which type of quality measures would be most beneficial - those that examine general cancer care or more measures that examine cancer-specific clinical conditions like prostate cancer, colon cancer or uterine cancer. CMS welcomed public comment and specific suggestions on the inclusion of measures that examine general cancer care versus cancer-specific clinical conditions in future rulemaking. Some commenters expressed support for the development of a balanced scorecard that includes both general cancer care measures and measures that focus on cancer-specific clinical conditions such as breast, colon, prostate, lung and other types of cancers. Other commenters expressed support for moving towards general cancer care measures which are more appropriate to allow more providers to report them and they are more applicable to a larger number of patients, providers and practices and can be utilized in multiple quality programs. We will consider the implications associated with measure implementation feasibility as we examine measures for future inclusion into the PCHQR Program measure set. Also, we will consider performance measures that assess patient experience and engagement and the feasibility of implementing additional end of life measures. Again, we thank the commenters for their input and we'll consider their views as we develop future policy regarding the inclusion of quality measures that examine general cancer care versus the quality measures that examine cancer-specific clinical conditions. Next slide please.

As program participants are aware, we maintain the technical specifications for the PCHQR Program on *QualityNet*, specifically on the data collection page where you can find the measure information forms,

algorithms, paper data collection tools and other references. Also note that in the fiscal year 2015 final rule, we adopted a policy under which we can use the sub-regulatory processes to make non-substantive changes to the program measures. There are no changes to this policy. Next slide please.

This slide outlines the public display requirements for the program. Under Section 1866(k)(4) of the Act, we are required to establish procedures for making the data submitted under the PCHQR Program available to the public. In the fiscal year 2017 final rule, we finalized that, although we would continue to use rulemaking to establish what year we would first publicly report data on each measure, we would actually publish the data as soon as feasible during that year. We also intend to make the data available on at least a yearly basis and that the time period for PCHs to review their data before the data are made public would be approximately 30 days in length. We recognize the importance of being transparent with stakeholders and keeping them abreast and aware of any changes that arise with the PCH measure set. In the proposed rule, we addressed some recent changes affecting the time table for the public display of data for specific PCHQR Program measures. Next slide please.

Currently, all PCHs are reporting SSI, MRSA, CDI and HCP data to the NHSN under the PCHQR Program. However, performance data for these measures is new and does not stand a long enough measurement period to draw conclusions about statistical significance at this point. As you may recall, in 2016 the CDC announced the HAI data reported to NHSN for 2015 would be used as a new baseline, serving as a new “reference point” for comparing progress. These current rebaselining efforts make year-to-year data comparisons inappropriate at this time. However, in fiscal year 2019 we will have two years of comparable data to properly assess trends. We proposed to delay the public reporting of data for the SSI, MRSA, CDI and HCP measure until calendar year 2019. We invited public comment on our proposal to delay public reporting of these four measures until calendar year 2019. One commenter supported the proposal to defer the public reporting of the SSI, MRSA, CDI and HCP measures until statistical significance and reliability can be determined. Another

commenter expressed concern regarding delayed reporting of the HCP measure as vaccinating HCP against influenza has been shown to improve patient safety and reduce disease transmission. This is essential for immunocompromised patients in the cancer hospital setting. CMS is appreciative of the commenters' support. We want to ensure that publicly displayed information is adequate and accurate. Since the performance data is new and does not span a long enough measurement period to draw conclusions about their statistical significance at this point, we will modify our proposal in that we will provide stakeholders with the performance data as soon as practicable. Therefore, we are finalizing a modification to our proposal to delay public reporting of data for SSI, MRSA, CDI and HCP measures until calendar year 2019. Instead, we are finalizing that we will provide stakeholders with performance data as soon as practicable. That is if usable data is available sooner than calendar year 2019. We will publicly report it on *Hospital Compare* via the next *Hospital Compare* release. We will continue to monitor the progress of the current rebaselining efforts made by the CDC. Next slide please.

In the fiscal year 2015 final rule, we finalized the PCHs would begin reporting the External Beam Radiation Therapy for Bone Metastases, or EBRT, measure beginning with January 1, 2015 discharges and for subsequent years. We finalized the PCHs would report this measure via a CMS web-based tool on an annual basis; July 1 through August 15 of each respective year. Then in the fiscal year 2017 final rule, we finalized to begin a display of measure data during calendar year 2017. This data was publicly reported in December 2017. We note that this measure is updated on an annual basis and that new *Hospital Compare* data are published four times each year - April, July, October and December. In this final rule, we do anticipate an update of EBRT measure data to be available in December of 2018. Next slide please.

A summary of the public display requirements for the fiscal year 2021 program year is shown here on this slide. Currently the HCAHP Survey data are publicly reported and refreshed on a quarterly basis. The one OCM for pain, NQF #0383, and EBRT measure, are publicly reported and

updated on an annual basis. As previously mentioned, we are proposing to defer the public reporting of SSI, MRSA, CDI and HCP measures until the calendar year 2019. Next slide please.

Current data-submission requirements and deadlines for the PCHQR Program are displayed on the *QualityNet* resources page. As the 30-day Unplanned Readmission for Cancer Patients measure is claims-based, there is no data submission requirement for the PCHs. The data will be obtained from Medicare claims data. For the fiscal year 2021 program year we will collect data from October 1, 2018 through September 30, 2019. We invited public comment on this proposal and the commenter supported this time frame. After consideration of the public comment received, we are finalizing the proposal to collect data on this measure from October 1, 2018 through September 30, 2019 for the fiscal year 2021 program year. Next slide please.

In our experience with other quality reporting and performance programs, we have noted occasions when providers have been unable to submit required quality data due to extraordinary circumstances that are not within their control, such as natural disasters. We do not wish to increase their burden unduly during these times. In the fiscal year 2014 final rule, we finalized our policy that PCHs may request, and we may grant exceptions with respect to the reporting of required quality data when extraordinary circumstances beyond the control of the PCH warrant. In the fiscal year 2018 final rule, we finalized modifications to the extraordinary circumstances sections, or ECE policy, to extend the deadline for a PCH to submit a request for an extension or exception from 30 days following the date that the ECE occurred to 90 days following the date that the extraordinary circumstance occurred and allow CMS to grant an exception or extension due to CMS data system issues or which affect data submission. These modifications were effective for extraordinary circumstance events that occurred on or after October 1, 2017. In addition to ensure transparency and understanding of our process, we will strive to provide our response to ECE requests within 90 days of receipt. This concludes my overview of the fiscal year 2019 final rule. I will now turn

the presentation back to Lisa and then I will return for a few closing remarks. Lisa?

Lisa Vinson: Thank you Caitlin. We will now take a moment to review important upcoming dates and reminders for the PCHQR Program beginning on Slide 45.

Our next two educational events will be held on September 27 and October 25 respectively. As always, we will communicate the title, purpose and objectives for this event with you via ListServe communication starting approximately two weeks prior to the event. The upcoming data submission deadlines are listed here as well. Our next upcoming deadline is the completion of the fiscal year 2019 DACA which this year, and moving forward, is an electronic process. You will be completing or may have already completed this requirement via the *QualityNet Secure Portal* and the deadline is August 31. Next on October 3, the second quarter 2018 HCAHP Survey data is due, which will be submitted by your facility's vendor. Then the November 15 data submission deadline will include Quarter 3 2017 CST hormone data and Quarter 2 2018 HAI data as indicated on this slide. Slide 46 please.

The October 2018 preview period is currently underway and closes October 25. Please be sure to review your preview report for accuracy, if you have not already done so. You will note that the December refresh has been moved to a January 2019 refresh. The preview period is tentatively scheduled to take place beginning October 26 and will end on November 24. The anticipated *Hospital Compare* refresh date is January 30, 2019. As usual, please remember that all dates for public reporting are subject to change. As we get closer to the preview periods and refresh dates, we will always notify you of the exact dates via ListServe communication. Slide 47 please.

Finally, here's how to access the PCH Questions and Answers tool via the *QualityNet* homepage. You can access this tool by clicking the

PPS-Exempt Cancer Hospitals link as indicated by the red box on this slide to start the process. Please keep in mind that there is a first-time registration required if you are accessing this tool for the first time. Now I will turn the presentation over to Deb Price who will explain the continuing education process. Deb?

Deborah Price: Thank you. This event has been approved for one continuing education credit. You must report your own credit to your respective boards. Complete your survey and then register for your certificate. Registration is automatic and instantaneous, therefore, if you do not get a response right away, there is a firewall blocking your link. You will need to register as a new user using your personal email and phone number.

If you are a new user or have had any problems getting your credits, use the New User link. If you had not had any issues getting your credits, use the Existing User link. Okay, now I'm going to pass the ball back to your team lead to end the webinar and to go over any questions that came in. Thank you for taking the time spent with me.

Caitlin Cromer: Thank you all for attending our webinar on the fiscal year 2019 final rule. We thank you for all of your comments and support during the rulemaking period. Have a great day.