PPS-Exempt Cancer Hospital Quality Reporting Program

Support Contractor

PCHQR Program
FY 2018 IPPS/LTCH 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 2018 IPPS/LTCH (PPS) Final Rule*. My name is Lisa Vinson and I serve as the Project Manager for the PPS-Exempt Cancer Hospital Quality Reporting, or 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 event. Caitlin is a social science research analyst working for CMS in the Quality Measures and Value Incentives Group, or QMVIG, within the Center for Clinical Standards and Quality at CMS. As the title indicates, we will be discussing the Fiscal Year 2018 IPPS/LTCH (PPS) Final Rule. Today's event is specific for the participants in the PCHQR Program. Although the final rule contains content that addresses the Hospital Inpatient Quality Reporting, or HIQR, and the 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 HIQR or LTCH programs, please contact your program lead to find out when there will be a presentation on your section of the fiscal year 2018 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, transcript, and questions and answers will be posted following today's event on Quality Reporting Center and *QualityNet*. Next slide please.

As usual, here is the acronyms and abbreviations list. Acronyms and abbreviations that you will hear and see today include C-Y for calendar year; E-O-L for end-of-life; E-C-E for extraordinary circumstances exception; F-Y for fiscal year; I-P-P-S for inpatient prospective payment system; L-T-C-H for long-term care hospital; and N-Q-F for National Quality Forum. Please use this slide as a reference as we go through this presentation. Next slide, please.

The purpose of today's presentation is to provide a review of the Fiscal Year 2018 IPPS/LTCH (PPS) Final Rule with the focus on how the changes will impact the PCHQR program. We will also be addressing the comments that were received during the rulemaking process. Now, let's move onto the next slide, slide 8, to take a look at today's objectives.

At the conclusion of today's presentation, there are three main objectives that you as participants will be able to do:

1. Locate the Fiscal Year 2018 IPPS/LTCH (PPS) Final Rule.
2. Identify changes to the PCHQR program as specified in the final rule.
3. Summarize CMS responses to comments received during the rulemaking process.

Slide 9 please.

To set the table for Caitlin's discussion of the fiscal year 2018 final rule, which will be the sixth rule finalized that will impact the PCHQR program since its formation as a result of the Affordable Care Act, I want to recap briefly 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 rule established five quality measures for the Program including the three Cancer-Specific Measures and two Healthcare-associated Infection, or HAI, measures, CLABSI and CAUTI. The next year was the addition of another HAI measure, Surgical Site Infections, and the addition of 12 new quality measures. These new measures included five process-oriented Oncology Care Measures, six Surgical Care Improvement Project, or SCIP, measures, and incorporation of the HCAHPS Survey data. Fiscal year 2015 saw the addition of one measure, EBRT, or NQF 1822, which is External Beam Radiotherapy for Bone Metastases. The fourth rule impacting the program, fiscal year 2016, saw the addition of two more HAI measures, Methicillin-resistant *Staphylococcus aureus* Bacteremia and *Clostridium difficile* Infections, as well as the inclusion of the Healthcare Personnel Influenza Vaccination measure. Of note, the fiscal year 2016 rule removed the six SCIP measures as of October 1, 2016. And last year, in 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 382, Radiation Dose Limits to Normal Tissues, was expanded to include patients with a diagnosis of breast or rectal cancer. You certainly have this slide for informational purposes, but, keep in mind, if you are ever looking for a brief history of the Program and the measures, a list of the final rules with their key changes to the Program, as well as hyperlinks to PDF versions of the final rule is available in numerous locations including *QualityNet,* on the PCHQR Program overview page, *QualityReportingCenter* on the PCHQR tab, and in the Program Manual, which is posted on both Quality Reporting Center and *QualityNet*. As an informational note, the latest version of the manual was recently posted during June, on both *QualityNet* and *Quality Reporting Center*. Slide 10 please.

This slide lists the publication dates for the fiscal year 2018 final rule. On August 2nd, the fiscal year 2018 final rule display copy was made available at the Office of the Federal Register Public Inspection Desk. The display copy link shown on this slide will take you directly to the document. The final rule information pertaining to the PCHQR Program can be found on pages 1678 through 1735 of the display copy. The official Federal Register version was published on August 14th. This version can be accessed via the Federal Register provided on the slide (Fiscal year 2018 IPPS/LTCH PPS Final rule) and the pages specific to the PCHQR Program are 38411 through 38425. At this time, I would like to turn the presentation over to Caitlin who will further discuss the changes that have been made and how they will impact the PCHQR Program. Caitlin?

Caitlin Cromer: Thanks, Lisa. As we've discussed previously, most notably during the webinar titled *Development and Selection of Quality Metrics for the PCHQR (*Development and Selection of Quality Metrics for the PCHQR Program*)*, which was presented in March 2016 by Elizabeth Bainger, representatives from the Alliance of Dedicated Cancer Centers and myself, the measure development, selection, and implementation process is an

ongoing cycle. The work culminates each year in the publication of the final rule, which we will be discussing today. Back in April, Lisa and I presented to you the proposed fiscal year 2018 rule. There was a period of public comment. We at CMS highly value this input and today, while we are we reviewing the contents of the fiscal year 2018 final rule, I will share with you a summary of the comments we received and our responses to these comments. The final rule for the PCHQR Program consists of ten sections, which I will highlight for you on the next slide, slide 12.

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 Background and Maintenance of Technical Specifications, so we will not address those sections in detail during today's presentation. In summary, the background for the PCHQR Program remains unchanged. The 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. Previously, final rules have been published from fiscal year 2013 through this year, fiscal year 2018, to guide the Program. 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 *QualityNet* under the PCHQR Program. Updates to the Program occur during the annual publication of the final rule and there is a sub-regulatory process to allow nonsubstantive updates to measures in the Program. On the next slide, slide 13, we will briefly look at the criteria for removal, and on slide 14, criteria for retention of measures within the Program. Next slide.

This slide lists the criteria that are taken into consideration in potentially removing a measure from the Program. These remain unchanged from last year's final rule and there were no comments received, hence no changes from what we discussed in the proposed rule webinar. Basically, keeping in mind the reason for the PCHQR Program to empower and

inform patients and providers to improve healthcare quality and value, you will see that the criteria for removal are such as when the performance of a measure has been maximized, it is no longer consistent with best practices or has been supplanted by a better measure, or one that is not feasible to implement, collect, or report. Next slide.

These criteria, once again previously outlined in fiscal year 2017 final rule, are consistent with those developed for Hospital Inpatient Quality Reporting Program. The specific reason for retaining a measure in the Program, even if it meets some of the criteria for the removal, are: the measure aligns with other CMS and HHS policy goals, the measure aligns with other CMS programs, including other quality reporting programs. An example of this would be NQF #1822, which is in both the PCHQR Program and the Hospital Outpatient Quality Reporting Program. And finally, the measure supports efforts to move the PCHs towards reporting electronic measures. Once again, these criteria remain unchanged from the previous final rule. Beginning on the next slide, slide 15, we will look at the retention and removal of previously finalized quality measures from the Program.

On slide 9, Lisa reviewed the history of the final rules impacting the Program, highlighting measures that have been historically added and, in some cases, removed from the Program. In last year's rule, the fiscal year 2017 final rule, we delineated 17 measures for the program effective for program year 2019. These were six Safety and Healthcare-associated Infection measures, three Cancer-Specific Treatment measures, five Oncology Care Measures, the HCAHPS Survey to assess patient experience, EBRT, and the Clinical Effectiveness Measure, Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy, a claims-based measure. In the fiscal year 2018 proposed rule, we proposed to remove the three Cancer-Specific Treatment measures: adjuvant chemotherapy for stage 3 colon cancer, or NQF #0223; combination chemotherapy for hormone receptor negative breast cancer, or NQF #0559; and adjuvant hormonal therapy for hormone receptor positive

breast cancer, or NQF #0220. On slide 16, we will review the rationale for the removal of these measures from the Program.

The rationale for recommending the removal of these three measures is that we have concluded that these measures are topped out. Therefore, collecting PCH data on these measures does not further Program goals, as the measure performance is so high and unvarying. Meaningful distinctions and improvements can no longer be made. Statistical analysis performed by the HCQIS Reports and Analytics Team on data from 2014 and 2015 show that the truncated coefficient of variation is less than 0.10. We believe that these measures do not meet the requirements for measure retention; they do not align with other HHS and CMS policy goals; they do not align with other CMS programs; and they're also chart abstracted — they do not support the movement to electronic clinical quality measures. Next slide please.

Overall, commenters were in support of removal of these three measures from the Program as performance is topped out. The measures no longer add value to the Program and removing them would ease the burden on collecting and submitting data. We are appreciative of these supportive comments. One comment suggested that the measures be removed as quickly as possible to more rapidly decrease the data burden on PCHs. We understand that continuing to submit performance data on measures that meet topped out criteria while the measures are being removed is burdensome. At this time, we expect to begin removing these measures with diagnoses occurring as of January 1, 2018, which will result in the last reporting of these measures in February 2019, when the quarter four 2017 hormone therapy data is reported. Other comments were received as well. One comment was that the removal of CSTs creates a gap in the clinical process domain for the Program, while another was that, if CSTs are removed, two common cancers, breast and colon cancers, would no longer be addressed. We thank these commenters for this input. We believe that, as these measures are topped out and their reporting is burdensome, their removal is appropriate. We will continue to evaluate the entire measure set on an annual basis to assess the overall

appropriateness of the measure set for the Program. Another commenter noted that in their data registry, these measures indicated disparities in measure performance. We appreciate these commenter's views. We note that our analysis indicated that performance for these measures is topped out for the participants in the PCHQR Program, and that their performance is not surprisingly different than that in much larger population of providers. As noted in the proposal, we will continue to monitor performance in this area and reserve the option to propose to reintroduce these measures if we will feel that the performance merits such reintroduction. Lastly, one comment suggested retaining the measures as a composite measure to continue to measure compliance. As before, we have found the measure performance to be topped out and as performance is too high to yield meaningful data distinctions, and, given the burden of data reporting, it is not practical to retain these measures in the Program as a composite measure. After consideration of all the public comments we received, we are finalizing our proposal to remove the three Cancer-Specific Treatment measures from this Program. Next slide please.

The fiscal year 2013 rule outlines the principles taken into consideration when developing and selecting measures for the inclusion in the PCHQR Program. There are no proposed changes to these principles, which are consistent with the principles used for measure selection in the Hospital IQR Program. You may recall that there are two legislatively permitted means of selecting measures for inclusion in the Program. The first is that the PCHQR measures can be chosen from a set of metrics endorsed by an entity with a contract under Section 1890(a) of the Act, which means those currently endorsed by the National Quality Forum, or NQF. The second provision, as specified in Section 1866(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, notably, this year the first measures endorsed by the National Quality Forum, we proposed four new measures for inclusion in the Program. Slide 19 please.

There are four end-of-life measures that, to encourage participants to further the goal of improving care for patients in the PCHQR Program, we proposed for inclusion beginning with the fiscal year 2020 program year. These NQF endorsed measures include two clinical process measures and two intermediate clinical outcome quality measures:

1. The Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (NQF #0210)
2. The Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (NQF #0213)
3. The Proportion of Patients Who Died from Cancer Not Admitted to Hospice, or NQF #0215
4. The Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (NQF #0216)

We will briefly recap the rationale for our proposal to include these measures on the next slide, slide 20.

The NQF has identified quality of end-of-life care as an area of care that continues to need improvement. End of life may be defined as comprehensive care that addresses medical, emotional, spiritual, and social needs during the last stages of a person's terminal illness. This may include palliative care, which is generally defined as multifaceted, holistic care that anticipates, prevents, and alleviates suffering. Both palliative and end-of-life care can be provided when a patient is receiving hospice services, but it is not necessary to be admitted to hospice to receive such care. End-of-life care to patients and caregivers has been associated with both higher quality and financial cost benefits. Despite the benefits attributed to these services and their increased availability, the NQF and others have noted that these services remained underutilized. By adding these measures to the Program, our intent is to assess the quality of end-of-life care provided to patients in the PCH setting. Participants that refer to the link on this page to access the National Quality Forum's Technical Report, Palliative and End-of-Life Care 2015–2016, for a more in-depth discussion of the topic, as well as measure specifications for these four

measures. Several comments that we received address end-of-life measures in general and we review these slides on the next slide, slide 21.

Overall, commenters were supportive of the inclusions of these measures in the program. While some commenters recommended that measures be adopted that focus on the care planning process and others wanted to ensure that patient and family engagement occur, we believe that the adoption of these four measures will lead to more, not less, patient and family engagement because the measures draw attention to the need to understand and clarify a patient's wishes regarding end-of-life care. Instead of resulting in unintended consequences, end-of-life care with more patient and family involvement should result in care that adapts to the patient experience and shapes the care pursuant to changing patient needs and the incorporation of patient's wishes. Also, we note that these measures are a first step in assessing what is happening in PCHs at the end of life and will provide a baseline of the existing end-of-life care at these hospitals. We will continue to consider other measures for future introduction into the Program and we welcome stakeholder input as we do so. Our next slides will take a closer look at each of the four end-of-life measures individually. Next slide please.

The Proportion of Patients Who Die from Cancer Receiving Chemotherapy in the Last 14 Days of Life, otherwise known as NQF #0210, or EOL-Chemo. This measure assesses the percentage of patients who received chemotherapy within the last 14 days of their life. As with all of the end-of-life measures proposed for addition into the Program this year, this is an administrative claims-based measure meaning that CMS will calculate the measure results from claims data that you submit, so no data submission is necessary. This measure was also included in the fiscal year 2017 Merit-Based Incentive Payment System, or MIPS. The numerator is all cancer patients who received chemotherapy for either treatment or palliative purposes in the last 14 days of life. The denominator is patients who died of cancer. There are no exclusions, risk adjustments, or risk stratifications because the measure is intended to evaluate the quality of care provided to all cancer patients at the end of

life. Many commenters supported the addition of EOL-Chemo measure to the PCHQR Program. It will improve care for patients by encouraging providers to have difficult, but necessary conversations with their patients and it addresses treatments that could lead to unnecessary and futile care. It will also promote accountability and drive improvement because it addresses a measurement gap. Some commenters, as you see on the slide, recommended modification of the measure to account for patient preference, enrollment in clinical trials and palliative chemotherapy — noting that a performance rate of zero is not the goal of the measure. CMS intends this measure to gather information on the proportion of patients who received chemotherapy at the end of their life regardless of the purpose of chemotherapy. We agree that a performance rate of zero is not a reasonable goal and, as with all measures adopted in the PCHQR Program, we will continue to monitor the measure and continue to assess if used in the Program over time. After consideration of the comments received, we are finalizing our proposal to adopt NQF #0210. On our next slide, slide 23, we will take a look at the end-of-life measure that was proposed for addition into the Program, NQF #0213. Next slide please.

We propose to add the Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life measure, NQF #0213, to the Program for fiscal year 2020 and subsequent years. A number of studies have shown that cancer care can become more aggressive at the end of life, which can result in low quality of care and lower quality of life. One such type of aggressive care is admission to an intensive care unit, or ICU. ICU admissions have been shown to be costly and have negative impact on patients, families, and caregivers. As with other newly proposed measures, this measure is based upon administrative claims data to derive the numerator. The number of patients who died from cancer and who are admitted to ICU in the last 30 days of life, and the denominator, patients who died from cancer. Once again, there are no exclusions, risk adjustments, or risk stratifications. As with NQF #0210, positive comments were received for this measure, citing similar benefits. Several comments were received suggesting that specific exclusions be incorporated, including patients receiving a bone marrow transplant with

curative intent. Another commenter recommended that this data not be publicly reported or introduced in the quality programs tied to payment until adjustments for patient characteristics are taken into account. We appreciate these comments, but note that our intent is to gather information about admission to the ICU regardless of the reason. As data is gathered, we can further evaluate the need for the measure to evolve. We also note that the PCHQR Program is not tied to payment. Lastly, a suggestion was made to provide confidential PCH performance data compared to non-PCH providers. At this present time, we are unable to provide such reports due to operational concerns with collecting and providing this data. After consideration of the public comments received, we are finalizing our proposal to adopt the EOL-ICU measure, or NQF #0213, for the fiscal year 2020 Program and subsequent years. Next slide.

Also known as EOL-Hospice, NQF #0215 is the Proportion of Patients Who Died from Cancer Not Admitted to Hospice. As noted on the slide and discussed in the proposed rule presentation, research has shown that care can become more aggressive at the end of life resulting in lower quality of care and quality of life. Such aggressive care has been identified to include underutilization of hospice, which is either lack of referral or late referral to hospice services. Studies have shown that cancer patients enrolled in hospice were hospitalized less frequently, received fewer procedures, and demonstrated significant cost savings. Another claims-based measure, this process measure assesses the proportion of patients who died from cancer who are not admitted to hospice and is linked to the next measure we will discuss, Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days. This measure seeks to simply evaluate whether patients were admitted to hospice or not. Once again, many commenters in support of this measure were received. One suggestion was to expand the denominator of the measure to include referral to hospice-based palliative care services in the denominator. While we recognize the importance of palliative care in alleviating symptoms during the disease process, we are seeking with this measure to assess whether or not patients in PCHs are admitted to hospice prior to death because admission to hospice has been

shown to be an indicator for the aggressiveness of care at the end of life, and also if discussions are being held with patients to discuss end-of-life choices and preferences. We do welcome recommendations as to possible measures related to palliative care for potential inclusion in the Program in the future. The other comment listed on this slide was to adopt a process measure to assess if and when terminally ill patients are given the opportunity to consider hospice. We agree with the commenter that it is important to gauge when patients are alerted to their prognosis and presented with end-of-life choices. We intend to take this commenter's suggestion under advisement; however, we do not see it as an alternative to this measure. After consideration of the comments received, we are finalizing our recommendation to add NQF #0215, Proportion of Patients Who Died from Cancer Not Admitted to Hospice for the 2020 program year and subsequent years. On the next slide, slide 25, we will look at the final measure, which was proposed for inclusion in the PCHQR Program this year. Next slide please.

NQF #0216, the Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days, or EOL-3DH, is linked to the measure we just discussed, NQF #0215. The difference is that this measure is assessing, once again through the use of Medicare claims data, those patients who died of cancer and spent fewer than three days in hospice. While NQF #0215 is assessing the important process of being admitted to hospice, this intermediate clinical outcome measure is assessing the timeliness of admission to hospice, specifically reported as those patients who died of cancer care who were admitted to hospice, but spent fewer than three days there. Once again, many supportive comments were received. As with NQF #0215, one commenter suggested including palliative care services in the measure, while another suggested addressing for social risk factors and co-morbidities. Once again, we appreciate the comments received and want to emphasize that we are adopting measures that allow us to assess current hospice admitting practices at PCHs. We do recognize the importance of palliative care and welcome recommendations as to additional measures related to palliative care, as well as those related to other aspects of the measure specifications

that could be revised or incorporated in a future rulemaking. As with other end-of-life measures, after consideration of public comments received, we are finalizing the proposal to adopt NQF #0216, the Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days, into the PCHQR Program, for the fiscal year 2020 program year and subsequent years. Our next slides will recap the measures finalized for fiscal year 2020 program year and subsequent years. Slide 26 please.

Slide 26 displays the six Safety and Healthcare-associated (Infection) metrics that are currently part of the PCHQR Program — CLABSI, CAUTI, SSI for both colon and abdominal hysterectomy, CDI, MRSA, and Influenza Vaccination Coverage Among Healthcare Personnel. Please note that on this slide and other slides summarizing the fiscal year 2020 finalized measures for the Program, the three Cancer-Specific Treatment measures, NQF #0223, #0559, and #0220 have been removed. Slide 27 please.

Here we see the five Oncology Care Measures that have been part of the Program, NQF #0382, #0383, #0384, #0389, and #0390. Remember that for care delivered in the calendar year 2017 and attributed to the fiscal year 2019 program year, the diagnosis cohort for NQF #0382, Radiation Dose Limits to Normal Tissues, is expanded to include the diagnoses of breast and rectal cancers. We then see, under Clinical Process/Oncology Care Measures, two of the new measures we are proposing for inclusion to the Program, NQF #0210 — the Proportion of Patients Who Die from Cancer Receiving Chemotherapy in the Last 14 Days of Life, and NQF #0215 — the Proportion of Patients Who Die from Cancer Not Admitted to Hospice. On the bottom of this slide is a new category, Intermediate Clinical Outcome Measures. Here you see the other two measures we are proposing for inclusion in the Program this year, NQF #0213 — Proportion of Patients Who Died from Cancer Admitted to ICU in the Last 30 Days of Life, and NQF #0216 — Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days. Next slide please.

And here we see three measures, HCAHPS, EBRT, and the claims-based measure, Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy, that are currently part of the Program and that we are recommending to retain. So that wraps up the discussion of the new quality measures beginning with the fiscal 2020 program year. We will take a brief look at the next portion of the final rule that pertains to the section on accounting for social risk factors in the Program on slide 29.

We at CMS 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. One of our core objectives is to improve beneficiary outcomes including reducing healthcare disparities and to ensure that all beneficiaries receive high quality care. To this end, we have been reviewing reports prepared by the Office of the Assistant Secretary for Planning and Evaluation and the National Academies of Science, Engineering, and Medicine. Also note that NQF has undertaken a two-year trial period to assess its risk adjustment for selected social risk factors as appropriate for various measures. As this process unfolds, we continue to seek public comment and work with stakeholders in this process. Specific input that we have been requesting include accounting for social risk factors in the PCHQR Program and, if so, which methods are most appropriate, which social risk factors might be most appropriate for reporting stratified measure scores and/or potential risk adjustment for a particular measure or measures in the Program and any operational considerations that should be taken into consideration when evaluating each adjustment. We at CMS appreciate the interest in and comments received in this topic. We intend to consider all suggestions as we continue to assess each measure and the overall Program. We appreciate the comment about the need for risk adjustment with the potential for an increased data burden of collecting additional data required to perform such adjustment. Future proposals will be made after further research and continued stakeholder engagement. Slide 30 please.

In the fiscal year 2015, 2016, and 2017 final rules, we discuss future measure topics and quality domain areas. Specifically, we discuss topics and measures related to the CMS Quality Strategy domains of Making Care Affordable, Communication and Care Coordination, and Working with Communities to Promote Best Practices of Healthy Living. Specifically, in the proposed rule we saw input on six potential measures for future inclusion in the program, five measures for localized prostate cancer and one 30-day unplanned readmissions for cancer patient measure. Let's take a look at slide 31 to briefly review the prostate measures and comments received.

These five prostate measures are related to patient-reported outcome measures obtained from administering the Expanded Prostate Inventory Composite, or EPIC, Survey. This survey gathers input from patients based upon their experiences. The survey questions are intended to be administered to all non-metastatic prostate cancer patients undergoing radiation or surgical treatment at the reporting facility. This is the denominator. The numerator is patients with clinically, significant changes in each of the listed areas from baseline to follow-up. The goal is to identify issues of variation, suboptimal performance, and disparities in care. A number of commenters expressed their support noting the importance to patients of measures that effect quality of life as well as support meaningful comparisons between providers. Such information would also allow patients to make informed decisions. We appreciate these views and support. Another commenter asked if the tool mentioned for data collection, the Expanded Prostate Inventory Composite, or EPIC, would be the only tool allowed. While the measures are being developed based upon a single data collection tool, we understand that other tools could potentially collect this information and we will monitor the measure's development and testing to determine the best means for collecting this data. Lastly, one commenter asked how the use of this tool would support the move to electronic quality reporting. We cannot at this time say with certainty if this tool would support this evolution. We thank the commenters and will consider their views as we develop further measures for their use in the PCHQR Program. Slide 32 please.

This measure would measure the number of hospital specific 30-day unscheduled and potentially avoidable readmissions following hospitalization among diagnosed malignant cancer patients. This would assess a total number of unscheduled readmissions within the 30 days of the index admission. A link to the full measure specifications were supplied during the webinar on the proposed rule and is also included in the final rule. Once again, several commenters generally supported the future inclusion of such a measure in the Program noting that it addressed a gap in the measurement of cancer care, it meets the criteria for inclusion in the Program, the measure has been shown to be reliable and valid, several PCHs are currently using the measure for internal performance improvement or other payment programs, and, lastly, one commenter supported the future of adoption of this measure and also encouraged additional consideration and evaluation of a measure that would report a five-year survival rate for cancer. We thank the commenters and will consider their views as we develop further measures for use in the Program. Next slide please.

As participants are aware, we maintain the technical specifications of 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 2015, we adopted a policy under which we can use a sub-regulatory process to make non-substantive changes to the Program measures. We did not propose any changes to this policy. Slide 34 please.

This slide outlines the public display requirements for the Program. Note that the PCH must have the opportunity to review the data prior to such data being made available to the public. This is the purpose of the preview reports that you were provided. Also, we strive to make the data available to the public as soon as possible or feasible. An example of the publication of the EBRT that was recently reported for the first time in the July refresh of the PCH data on *Hospital Compare*. Furthermore, we will continue to propose in rule making the first year for which we intend to publish data for each measure. Lastly, as was finalized in the fiscal year

2017 final rule, we will continue to defer the public display of the CAUTI and CLABSI data until collaboration with the CDC allows identification of an appropriate time and analytic method to be used in the public reporting. Slide 35 shows the finalized public display requirements, which remain unchanged.

You will see the removal of the public reporting of the Cancer-Specific Treatment measures beginning with the fiscal year 2020 program year. The five original OCM measures and HCAHPS data will continue to be reported publicly. Note that beginning in the fiscal year 2019 for care delivered in calendar year 2017, NQF #0382 data will reflect the expanded diagnosis cohort, which will contain breast and rectal cancers, in addition to the initial lung and pancreatic cancers. As previously mentioned, we are proposing to continue to defer the public reporting of CLABSI and CAUTI data at this time. Lastly, as finalized in last year's rule, EBRT was publicly reported for the first time this summer with the July refresh and will be updated annually each December at the same time as the original five OCM measures. Next slide please.

The current data submission requirements for the Program are displayed on the resources page for the Program on *QualityNet*. We did not propose any changes to these requirements. The data reporting schedule that we proposed for the four new end-of-life measures are displayed on this slide. As these are all claims-based measures, there is no data submission requirement for the PCHs. The data will be obtained from Medicare claims data. We propose annual reporting with a data collection period from July 1 from the year three years prior to the program year and to June 30th from two years prior to the program year. For example, for the fiscal year 2020 program year, data would be collected from July 1, 2017, through June 30, 2018. After consideration of the public comments received, which are in the final rule, we are finalizing the data collection period for end-of-life measures as was proposed and displayed on the site. On the next slide, slide 37, we will look at the changes to the Extraordinary Circumstances Exceptions, or ECE, policy for the Program. Next slide please.

The ECE process for the PCHQR Program was established in the fiscal year 2014 final rule. To better align the ECE process for the PCHQR Program with other CMS quality programs, we are proposing the following modification to this policy. First, we clarified that we will strive to provide a formal response to an ECE request within 90 days of the receipt. We proposed to extend the deadline to request an exemption or extension from 30 to 90 days, and secondly, we proposed to allow CMS to grant an exception or extension due to CMS data system issues that are affecting data submission. Commenters generally supported these changes, noting that providing additional time to request an extension or exemption after an event will enable PCHs to focus on patient needs and service recovery. Commenters also noted that, by allowing CMS to allow an exception for CMS data issues, we will avoid unfairly penalizing PCHs for circumstances outside of their control. We wish to clarify that if CMS does not proactively notify PCHs that it plans to provide an exception to the policy after a data systems issue, PCHs may still submit a request for an exemption for CMS consideration. After consideration of public comments received, we are finalizing this proposal to extend the deadline for a PCH to request an extension or exemption within 30 to 90 days after the extraordinary circumstance occurred and we are finalizing our proposal to allow CMS to grant an exception or extension due to CMS data systems issues, which affect data submission. And that concludes my overview of the fiscal year 2018 final rule. I thank you all for the comments you submitted during the rulemaking process and for your time, patience, and attention during today's event. I will now pass the presentation back to Lisa on slide 38. Lisa?

Lisa Vinson: Thank you, Caitlin. We will conclude today's event as always by reviewing important upcoming information and dates for the PCHQR Program. Slide 39 please.

The measure developer, responsible for the initial analysis and conducting the dry run, provided the information on this slide and the next two. This is the same information that was presented during last month's webinar, but, as this is the first claims-based measure for the PCHs, we feel it is

important enough to review again so that everyone is engaged and on the same page. Over the past month or so, all of you who are subscribed to the PCHQR Program notifications have received several ListServe communications detailing the information on these slides, as well as how to access the details of the dry run on *QualityNet*. As you are aware, the National Confidential Reporting Period, or dry run, for the PCHQR Program, is currently underway, having started on August 15th and concluding on September 14th. The purpose of this dry run is to familiarize the PCHs with this measure in advance of the calculation of their actual performance data and in anticipation of the future public reporting of the measure results. This is also a very important time to be sure that all the PCHs understand the measure in detail, the calculations that are performed with the administrative data, and for you to ask questions of the measure development team. The dry run information will be calculated based upon claims data that was submitted for patients who had received outpatient chemotherapy at a PCH between October 1, 2015, through September 30, 2016. Once fully implemented, the first actual performance data for the PCHs will be analyzed for those patients receiving chemotherapy between July 1, 2016, and June 30, 2017. This will then occur annually. Please note that the initial public reporting timeline for this measure has not yet been announced. Next slide please.

By now, those of you who are designated as the Security Administrator for your facility should have already received your Facility-Specific Report, or FSR, via the *QualityNet Secure Portal*. This document contains the information as to the calculation of results, as well as facility-specific and benchmark performance for the entire PCH population. Remember, as has been communicated, as these FSRs contain patient-specific and identifiable information, it is very important that you do not send this information to others without observing the proper safeguards to protect protected health information. If, for some reason, you have not yet received your FSR, please feel free to reach out to us as soon as possible and let the measure developer know. Their contact information is in the ListServe that you have received, as well, as is specified on our next slide.

We hope that you were able to attend the National Provider Call, which took place August 23rd. This event will be archived on *QualityNet* and you can find other helpful information by following the pathway on *QualityNet* delineated on our next slide, slide 41.

Detailed information about the dry run has been posted on *QualityNet* under the PCHQR Program tab on the Measures page. On this page, you will see in the upper left hand corner a box entitled "Chemotherapy Measure Dry Run." Clicking on this link will allow you to access a number of key documents, including a fact sheet, frequently asked questions, timeline for the dry run, methodology, and other helpful information. As mentioned on our previous slide, this is where you will also find the link for the archived materials for the National Provider Call. Also, you see here the address to send your questions about this measure, which is CMSChemotherapyMeasure@yale.edu. Slide 42 please.

Here is a list of the upcoming PCHQR Program webinars. These are currently scheduled for the fourth Thursday of each month, but that is subject to change. As always, we will communicate the exact dates, title, purpose, and objectives for these events with you via ListServe starting approximately two weeks prior to the event. Next month and November, we will be continuing our series on best practices. The month of October will be dedicated to the new program measures that have been discussed during today's event, the end-of-life measures, and we will end the year with a review and look ahead in the month of December. Slide 43 please.

This slide lists the upcoming data submission deadlines. We just closed out our biggest submission period of the year, which was August 15th. Thank you to everyone for successfully submitting your data in a timely manner. Our next requirement is the fiscal year 2018 DACA which is due Thursday, August 31st. Once completed, this form will need to be submitted via fax or email by the deadline. Then, November 15th will be the last data submission for 2017 and the data requirements for this submission are listed on the slide. Next slide please.

For October, the preview period just ended as of August 13th and the anticipated refresh will take place on October 25th. For the month of December, the preview period will take place from October 2nd through October 31st and the anticipated refresh will occur on December 20th. Next slide please.

Now, let us take a few moments to discuss a few questions we have received from our PCH providers. Our first question regarding NQF #0139 — NHSN central-line associated bloodstream infection, or CLABSI, outcome, the provider asked, "Are mucosal barrier injury laboratory-confirmed bloodstream infection events still included in the numerator of the CLABSI data being reported to CMS?" Per the CDC, the answer is yes. For the PCHQR Program, CMS has not opted to use the 2015 NHSN baseline at this time. The CLABSI data for the PCHs will continue to include MBI events as it relates to CMS reporting. Should CMS opt to use the 2015 baseline, the CDC will then remove the MBIs from the CLABSI measures reported going forward. However, there is not information on if or when CMS will opt to use the 2015 baseline. Additional work and discussions are anticipated in the coming months and any changes will be communicated to NHSN users. Next slide, please.

Our next two questions pertain to NQF #0390, or Prostate Cancer Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients measure. In the first scenario, the provider shares that there is a patient on the facility's list that received hormone therapy, but it was given as a subsequent treatment. (Patient was given first round of treatment and was diagnosed at an outside center.) Based on this, the provider asked, "Should this patient be included or excluded, as this wasn't the primary therapy?" The patient should be included in the population, denominator, and numerator. The patient is eligible for the measure if they received EBRT to the prostate at your facility. This is captured via CPT codes for EBRT. The androgen deprivation therapy, or ADT, or hormone therapy, may be prescribed before, during, and/or after the EBRT as specified in the measure information form. This allows for such situations like this when the ADT or hormone therapy is administered outside of the walls of

the PCH. As for the term primary therapy, we are using this synonymously with initial therapy, referring to the treatment of the prostate with EBRT. If a patient has refractory disease, you will see instances in the NCCN guidelines where they may receive EBRT or hormone therapy or a combination of both. This measure is just assessing initial or primary therapy with EBRT to the prostate to ensure hormone therapy was prescribed or administered, regardless of the location of administration. For the second scenario, the provider asked, "Does the denominator for NQF #0390 only include patients who are receiving EBRT to an intact prostate? Do we exclude those that have had a prostatectomy and are receiving EBRT as part of their treatment, not salvage?" This measure only includes patients who received EBRT to the prostate as primary therapy. By definition, included in the measure are those patients with prostate cancer at high or very high risk of recurrence. If they have previously undergone a prostatectomy and then EBRT is administered, it falls into more of the adjuvant treatment, as opposed to primary treatment of the prostate cancer. This is further outlined in detail in the NCCN guidelines algorithm for NQF #0390. Next slide please.

As you all are aware, EBRT, or NQF #1822, is a challenging measure. This question is about sampling. The provider asked, "When sampling for EBRT and following the minimum sample requirements, upon case review there are exclusions. So we move to the next case to abstract until we have a minimum, which is 20 cases, that meet criteria, but more than 20 cases were reviewed. Is this considered oversampling since more than the minimum was reviewed or is it the minimum because we only reviewed cases until we met at least 20 who met criteria?" First of all, in reporting data in the Web-Based Data Collection Tool, there are three options to choose from: sampled quarterly, not sampled, or not applicable/no eligible patients. There is no option to indicate "oversampling." If you sample, you sample in terms of reporting. Furthermore, your initial approximation of your population is based upon two administrative codes, ICD-10 for bone metastasis and CPT for EBRT. Therefore, use this approximate population to determine your minimum sample size. Then, as you begin to review the charts, as you know, you will find people with

exclusions, such as previous EBRT to the same site or surgical stabilization of the site. It is appropriate to supplement the sample population and continue to do so until you have the number of patients who meet the minimum required sample size for the approximate population. Without reviewing every chart, you cannot know the true initial patient population. However, if you reviewed every possible eligible chart from the administrative data, you will lose the benefit of sampling. In reality, you cannot truly determine the exact initial patient population, those meeting all inclusion and exclusion criteria for the denominator for this measure unless you abstract every chart. Now, I would like to turn the presentation over to Deb Price, who will explain the continuing education process. Deb?

Deb 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 have not had any issues getting your credits, use the existing user link. 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.

Caitlin Cromer: Thank you everybody for listening to the presentation. Have a nice day everyone.