PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

Support Contractor

PCHQR Program
FY 2019 IPPS/LTCH PPS Proposed Rule

Presentation Transcript

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Lisa Vinson: Good afternoon and welcome to today's PPS-Exempt Cancer Hospital Quality Reporting Program Outreach and Education event entitled *Fiscal Year 2019 IPPS/LTCH PPS Proposed Rule*. My name is Lisa Vinson and I will be the moderator for today's event. 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. The material 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 [Center for] Clinical Standards and Quality at CMS. As the title indicates, we will be discussing the Fiscal Year 2019 IPPS/LTCH PPS Proposed Rule. Today's event is specific for participants in the PCHQR Program. Although the proposed rule contains content that addresses the Hospital Inpatient Quality Reporting, or IQR, 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 Hospital IQR or LTCH Program, please contact your program lead to find out when there will be a presentation on your section of the Fiscal Year 2019 proposed rule. Next slide, please.

As slide 6 indicates, during this presentation, our presenter will be discussing the areas of the Fiscal Year 2019 proposed rule related to the PCHQR Program. As noted, during this time, the presenter cannot address any rule-related questions. All rule-related questions must be submitted to CMS using the comment process. CMS wants to hear from all of you. As participants in the PCHQR Program, you have valuable input regarding what is being proposed. Step-by-step instructions will be provided later in this presentation on how to submit comments to CMS regarding the proposed rule. Your knowledge and expertise in the cancer care setting is invaluable and CMS highly regards your feedback. So, with this background and introductory remarks, let's move to our next slide, slide 7, to take a look at some of the abbreviations and acronyms that you will hear and see during today's event.

Here is the acronyms and abbreviations list. Acronyms and abbreviations that you will hear and see today include C4QI for Comprehensive Cancer Center Consortium for Quality Improvement, CY for calendar year, FY for fiscal year, HAI for Healthcare-Associated Infection, HHS for US Department of Health and Human Services, IPPS for Inpatient Perspective Payment System, LTCH for Long-Term Care Hospital, and PPS for Prospective Payment System. Slide 8,

please.

The purpose of today's event is to provide an overview of the Fiscal Year 2019 IPPS/LTCH PPS Proposed Rule with a focus on the possible impact of the proposed changes on the PCHQR Program. On slide 9, we will take a look at the objectives.

There are three main objectives for today's webinar. Program participants should be able to locate the Fiscal Year 2019 IPPS/LTCH PPS Proposed Rule, identify the proposed changes possibly impacting participants in the PCHQR Program, and describe how and when to submit written comments to CMS regarding the proposed rule. Next slide, please.

Here is an outline of the publication dates for the Fiscal Year 2019 proposed rule. The public inspection document or display copy was published on April 24, 2018. The link provided on this slide will take you directly to where this document is located. Please note information on the proposed changes and details specific to the PCHQR Program can be found on pages 1271 through 1309 of this document. The official *Federal Register* version was published on May 7, 2018. This version can be accessed via the *Federal Register* link provided here as well. The PCHQR Program section begins on pages 20500 through 20510. At this time, I would like to turn the presentation over to Caitlin who will further discuss the proposed changes and how these changes may impact the PCHQR Program. Caitlin?

Caitlin Cromer: Thanks, Lisa. I'd like to start our discussion today with an introduction for our new Meaningful Measures Initiative. Regulatory reform and reducing regulatory burden are high priorities for CMS right now. To reduce regulatory burden on the healthcare industry, lower health care costs, and enhance patient care, in October 2017, we launched the Meaningful Measures Initiative. This initiative is one component of our agency-wide patients-over-paperwork initiative which is aimed at evaluating and streamlining regulations with a goal to reduce unnecessary cost and burden, increase efficiency, and improve beneficiary experience. Next slide, please.

The Meaningful Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes. This initiative represents a new approach to quality measures that will foster operational efficiencies and will reduce costs, including collection and reporting burden, while producing quality measurement that is more focused on

meaningful outcomes. Slide 13, please.

The Meaningful Measures Framework is a strategic tool for putting patients over paperwork by reducing measure reporting burden in alignment with the national healthcare priorities. On our next slide, we'll look at the Meaningful Measures Framework objectives. Slide 14, please.

The goal of the Meaningful Measures Initiative is to focus everyone's effort on the same quality areas and lend specificity which can help identify measures that address high impact measure areas that safeguard public health; are patient centered and meaningful to patients, clinicians, and providers; are outcome-based where possible; fulfill each program statutory requirements; minimize a level of burden for healthcare providers; identify significant opportunity for improvement; address measure needs for population-based payment through alternative payment models; and finally, align across programs or with other payers. In order to achieve objectives, we have identified 19 Meaningful Measures areas and mapped them to the six overarching quality priorities as shown on our next two slides. Slide 15, please.

This table, which is continued on the next slide as well, highlights the six quality priorities along with the related Meaningful Measures areas. There is a total of 19 areas. Next, please.

By including Meaningful Measures in our programs, we believe that we can also address the following cost cutting measure criteria: eliminating disparities, tracking measurable outcomes and impact, safeguarding public health, achieving cost savings, improving access for rural communities, and reducing burden. Furthermore, we believe that the Meaningful Measures Initiative will improve outcomes for patients, their families, and healthcare providers while reducing burden and cost to clinicians and providers, as well as promoting operational efficiencies. Slide 17, please.

As you are aware, the measure development selection and implementation process is an ongoing cycle. One of the key events is the publication of the proposed rule. As Lisa stated previously, we will be discussing the Fiscal Year 2019 IPPS/LTCH PPS Proposed Rule. The reason the publication of the proposed rule is considered a significant event is that it is an extremely important time for you, the participants in the PPS-Exempt Cancer Hospital Quality Reporting Program, to provide us at CMS your input on the proposed changes to the program in this document. We want your input and consider it while developing the final rule. So, with that as background,

let's start with the proposed new policies for the PCHQR Program on slide 18.

In this proposed rule, we are proposing a number of new policies for the PCHQR Program. We developed these proposals after conducting an overall review of the program under the new Meaningful Measures Initiative that we previously discussed. The proposals reflect our efforts to ensure that the PCHQR Program measure set continues to promote improved health outcomes for our beneficiaries while minimizing the reporting burden associated with submitting or reporting quality measures, the burden associated with complying with other programmatic requirements, and/or the burden associated with compliance to other federal and state regulations, if applicable. We aim to reduce beneficiary confusion by reducing duplicative reporting, thereby streamlining the process of analyzing publicly reported quality measure data. These newly proposed policies also reflect our efforts to improve the usefulness of the data that we publicly report in the PCHQR Program which are guided by the following two goals: to improve the usefulness of CMS quality program data by providing providers with adequate measure information from one program and to improve consumer understanding of the data publicly reported on *Hospital Compare* or other web sites by eliminating the reporting of duplicative measure data in more than one program that applies to the same provider setting. Slide 19, please.

In the Fiscal Year 2017 final rule, we adopted policies for measure retention and removal. We generally retain measures from the previous year's PCHQR Program measure set for subsequent years' measures sets except when we specifically propose to remove or replace a measure. 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. For the purposes of considering measures for removal from the program, we consider a measure to be topped-out if there is statistically indistinguishable performance at the 75th and 90th percentiles and the truncated coefficient of variation is less than or equal to .10. 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 programs but continue to bring value. These factors are outlined on the next slide, slide 20.

These factors, once again previously outlined in the Fiscal Year 2017 final rule, 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, are the measure alliance with other CMS

and HHS policy goals; the measure alliance with other CMS programs, including other quality reporting programs; and finally, if the measure supports efforts to move PCHs towards reporting electronic measures, then we will consider retaining these measures in the program. Slide 21, please.

In this proposed rule, we are proposing to adopt a new measure removal factor in addition to the other factors identified earlier which are considered when evaluating potential measures for removal from the PCHQR Program measure set. We are proposing to consider factor eight, the cost associated with the measure outweigh the benefit of its continued use in a program. We are engaging in efforts to ensure that the PCHQR measure set continues to promote improved health outcomes for beneficiaries while minimizing the overall costs associated with the program. We believe these costs are multifaceted and include, not only the burden associated with reporting, but also the costs associated with implementing and maintaining the program. We have 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 cost associated with complying with other programmatic requirements, the provider and clinician cost associated with participating in multiple quality reporting programs, the cost to CMS associated with the program oversight of the measure (including measure maintenance and public display), and the provider and clinician cost associated with compliance with other federal and state regulations if applicable. For example, it may be needlessly costly and/or of limited benefit to retain measures which our analysis shows are no longer meaningfully supporting program objectives. It may also be costly for healthcare providers to track the confidential feedback, preview reports, and publicly reported information on a measure where we use the measure in more than one program. CMS may also have to extend unnecessary resources to maintain specifications for the measure, as well the tools we need to collect, validate, analyze, and publicly report the measure data. Furthermore, beneficiaries may find it confusing to see public reporting on the same measure in different programs. While these costs outweigh the evidence supporting the continued use of a measure in the PCHQR Program, we believe it may be appropriate to remove the measure from the program. We are proposing that we would remove measures based on this factor on a case by case basis. 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 are inviting public comment on our proposal to adopt this additional measure removal factor, 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 final rule. Slide 22, please.

The PCHQR Program was established by Section 3005 of the Affordable Care Act. In the Fiscal Year 2013 final rule, we finalized a total of five quality measures, including two healthcare-associated infection measures (CAUTI and CLABSI), and three cancer-specific treatment measures for the Fiscal Year 2014 Program Year and subsequent years. The Fiscal Year 2014 final rule saw the addition of one HAI measure (surgical site infection), along with 12 new quality measures, five Oncology Care Measures, six surgical care improvement project measures, and the incorporation of the HCAHPS Survey. The next year, Fiscal Year 2015, there was the addition of one clinical effectiveness measure, EBRT, which is External Beam Radio Therapy for Bone Metastases. Next slide, please.

The fourth rule impacting the program, Fiscal Year 2016, saw the addition of three more HAI measures (MRSA, CDI, and HCP), and the six SCIP measures were removed effective October 1, 2016. In the Fiscal Year 2017 final rule, a new claims-based measure was added, Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy. The diagnosis cohort for NQF Number 0382, Radiation Dose Limits to Normal Tissues, was expanded to include patients with a diagnosis of breast cancer and rectal cancer. Last year, in the Fiscal Year 2018 final rule, we finalized the removal of the three CST measures effective January 1, 2018, and four new end-of-life claims-based measures were added for the Fiscal Year 2020 program and subsequent years. Based upon the factors for removal and retention of measures from the PCHQR Program and considering the measures currently utilized in the program, we are proposing to remove a total of six measures as outlined beginning on the next slide, slide 24.

We are proposing to remove the four web-based structural measures, which are four of the five Oncology Care Measures, or OCMs, from the program, beginning with the Fiscal Year 2021 Program Year because they are topped-out. The four OCMs proposed for removal are 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, finally, the Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients, or NQF Number #0389. Next slide, please.

We are also proposing to apply the newly proposed measure removal factor 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 have 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 (CAUTI), or NQF #0138, and Central Line-Associated Bloodstream Infection (CLABSI), or NQF Number #0139. We will discuss the rationale for these recommendations on the next three slides. Slide 26, please.

The rationale for recommending the removal of these web-based structural measures is that we have concluded that they are topped-out based on the analysis of data from January 1, 2015, through December 31, 2016. This analysis evaluated data sets and calculated that the 5th, 10th, 25th, 50th, 75th, 9[0]th, 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. Slide 27, please.

Given that the performance of these measures is so high and unvarying, meaningful distinctions and improvements in program 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 US Department of Health and Human Services, or 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 effort to develop electronic clinical quality measure reporting for PCHs. If we determine at a subsequent point in the future that PCH returns to the aforementioned HHS and CMS policy goals, the aforementioned program efforts, and the standard of care established by the measure has unacceptably declined, we may propose to readopt these measures in future rulemaking. We are inviting public comment on our proposal to remove these four measures from the program beginning with the Fiscal Year 2021 Program Year. Slide 28, please.

We are proposing to remove two measures from the PCHQR Program beginning with the Fiscal Year 2021 Program Year if the measure factor, the cost associated with the measure outweigh the benefit of its continued use of the program, proposed for adoption is finalized. We have concluded that the costs associated with these measures outweigh the benefit of their continued use in the program. These measures are Catheter-Associated Urinary Tract Infection (or the CAUTI outcome measure), NQF #0138, and the Central Line-Associated Bloodstream

Infection (or the CLABSI outcome measure), NQF # 0139. CAUTI and CLABSI were adopted for the Fiscal Year 2014 Program Year in 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 in forming 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 continued use the program. As a result of these costs, it has become difficult to publicly report these measures due to the low volume of data produced and reported by the small number of facilities participating in this program and the corresponding lack of an appropriate methodology to publicly report this data. Therefore, if our proposal to adopt the new measure removal factor described previously is finalized as proposed, we are proposing that, under that new factor, we would remove the CAUTI and CLABSI measures from the PCHQR Program. We are inviting public comment on our proposal to remove these two measures from the PCHQR Program beginning with the Fiscal Year 2021 Program Year. Slide 29, please.

The Fiscal Year 2013 rule outlines the principles taken into consideration when developing and selecting measures for 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 Inpatient Quality Reporting Program. In this proposed rule, we discussed the Meaningful Measures Initiative and its relation to how we assess and select quality measures for the PCHQR Program. As you may recall, 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 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 1865 [1866] (k)(3)(b) of the Act is at that 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 are proposing one new measure for inclusion into the program. We will begin our discussion of this measure with a general overview on the next slide, slide 30.

In an effort to expand the PCHQR measure set to include measures that are less burdensome to report to CMS but provide valuable information for beneficiaries,

we are proposing to adopt the 30-Day Unplanned Readmissions for Cancer Patients measure, or NQF #3188, 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 1890(a) of the Act, currently the National Quality Forum. This measure aligns with recent initiatives to incorporate more outcome measures and quality reporting programs. It also aligns with the Promote Effective Communication and Coordination of Care domain of our Meaningful Measures Initiative and would fill an existing gap area of readmission measures in the PCHQR Program. This measure was included in the 2017 Measures Under Consideration, or MUC, list and reviewed by the Measure Applications Partnership, or MAP, hospital work group. Slide 31, please.

Cancer is the second leading cause of death in the United States with nearly 600,000 cancer-related deaths expected this year. Oncology care contributes greatly to Medicare spending and accounted for an estimated $125 billion in healthcare spending in 2010, and this figure is projected to rise between $173 billion and $207 billion by 2020. 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 of lowering health care cost and improving outcomes of care. Research suggests that between nine percent and 48 percent of all hospital readmissions are preventable owing to inadequate treatment during the patient's original admission or after discharge. Unnecessary hospital readmissions often negatively impact cancer patients by compromising their quality of life, placing them at risk for health-acquired infections, and increasing the 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. Slide 32, please.

Readmission rates have been developed for pneumonia, acute myocardial infection, and heart failure. However, the development of validated readmission rates for cancer patients lagged. In 2012, the Comprehensive Cancer Center Consortium for Quality Improvement, or C4QI, a group of 18 academic medical centers that collaborate to measure and improve quality and cancer care in their centers, started developing a cancer-specific unplanned readmissions 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 are more accurately reflective of the quality of care delivery when compared with broader readmission measures. Likewise, this measure addresses gaps in existing readmissions measures related to the evaluation of hospital readmissions associated cancer patients. Through adoption in the PCHQR Program, it can increase transparency around the quality of care delivered to patients with cancer. This proposed readmission measure fits within the Promote Effective Communication 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 33, please.

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 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 July 1 of the year three years prior to the Program Year to June 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 July 1, 2018, through June 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 and public reporting. This outcome measure utilizes claims data to demonstrate the rate at 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 from 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 principal or secondary diagnosis, but is not an admitting diagnosis, within the defined measurement period. The measure excludes readmissions 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. Slide 34, please.

This measure is risk-adjusted based on a comparison of observed versus expected readmissions rates. The probability of unplanned readmission has been summed over the index admission for each hospital to calculate the expected unplanned readmission rate. Subsequently, the actual or observed unplanned readmission for each hospital are summed and used to calculate the ratio of observed unplanned readmission through expected unplanned readmissions for each hospital. Each hospital's ratio is then multiplied by the national or standard unplanned readmissions rate to generate the risk-adjusted 30-Day Unplanned Readmissions for Cancer Patients rate as illustrated by the formula on this slide. We are inviting public comment on our proposal to adopt the 30-Day Unplanned Readmissions for Cancer Patients measure, or NQF #3188, for the Fiscal Year 2021 Program Year and subsequent years. Slide 35, please.

The table on this slide and the next two slides summarize the previously finalized and newly proposed PCHQR Program measures. We are not including the two HAI measures and four OCM measures since we are proposing to remove them from the program. This slide displays the four healthcare-associated metrics that are part of the PCHQR Program. SSI, CDI, and MRSA are outcome measures. The other, Influenza Vaccination Coverage Among Healthcare Personnel, is a process measure. Slide 36, please.

Here we see the Oncology Care Measure, or NQF #0383, that has been part of the program and two end-of-life program measures, NQF #0210 and #0215, which were finalized for inclusion in the program in last year's Fiscal Year 2018 final rules. 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. Slide 37, 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 a part of the program and we are recommending to retain. The last measure listed is the newly proposed readmission measure, the 30-Day Unplanned Readmissions for Cancer Patients. These tables combined summarize what the PCHQR Program measure set would look like for the Fiscal Year 2021 Program Year if we finalized our measure removal proposal and our proposal to adopt the new readmission measure. Slide 38, please.

We at CMS understand the importance of improving beneficiary outcomes including reducing health disparities. We also understand that social risk factors such as income, education, race and ethnicity, employment, disability, access to community resources, and social support play a major role in health. Among our core objectives, we aim to improve health outcomes, obtain health equity for all beneficiaries, and ensure that complex patients, as well as those with social risk factors, receive equally excellent care. As indicated on 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 risk factors is appropriate for these measures. The trial period ended April 27, 2017, and the final report is available by accessing the link on this slide. 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 have extended the social economic status, or SES, trial by 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 eliminating differences and outcome rates among patient groups within hospitals or providers that would allow for comparison of those differences/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 might affect outcome. There is additional feedback listed on this slide as well. 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 obtaining health equity for all beneficiaries and minimizing unintended consequences. On slide 39, we will take a look at possible new quality measures for future program years. Next, please.

As discussed in the preamble of this proposed rule, we have begun analyzing our program measures using framework we developed for the Meaningful Measures Initiative. Additionally, in the Fiscal Year 2015, 2016, 2017, and 2018 final rules, we have discussed measure topics and quality domain areas, specifically measure topics addressing making care affordable, communication and care coordination,

and working with communities to permit best practices and healthy living. We welcome public comment and specific suggestions for measure topics that we consider for future rulemaking, including considerations related to risk adjustment and the inclusion of social risk factors and risk adjustment for any individual performance measures. We are again seeking public comment on the types of measure topics we should consider for future rulemaking. Next slide, please.

We are seeking public comment on two measures for potential future inclusion in the PCHQR Program, Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer, or NQF #1790, and Shared Decision Making Process, or NQF #2962. On our next slide, we'll provide an overview of the Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer measure.

The Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer measure is an outcome measure. It assesses the postoperative complications and operative mortality which are important negative outcomes associated with lung cancer resection surgery. Specifically, it assesses the number of patients 18 of age and older undergoing elective lung resection for lung cancer who developed 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 these outcomes as listed on the slide. Knowledge of these predictors informs clinical decision making by enabling physicians and patients to understand the association between individual patient characteristics and outcomes. Also, with continuous feedback of performance data over time, knowledge of these predictors and their relationships 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 are requesting public comment on possible inclusion of this measure in future years as a program. Slide 42, please.

The Shared Decision Making Process, or NQF #2962, is a patient-reported outcome measure. This measure asked patients who have any of the seven preference-sensitive surgical interventions to report on the interaction they had 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 intervention and not to have the intervention; and three, asking for patient input, were all a part of the patient's interactions with

providers when the decision was made to have the procedure. Furthermore, what does shared decision-making mean? When faced with a medical problem, for which there is more than one reasonable approach to treatment and management, shared decision-making means providers should outline for patients that there is a choice to be made, discuss the pros and cons of all available options, and ensure patients have input into the final decision. The result will be decisions that align better with patient goals, concerns, and preferences. Next slide, please.

This measure aligns with the recent initiatives to include patient-reported outcomes and experience of care into quality reporting programs, as well as to incorporate more outcome measures in general, along with the Strengthen Person and Family Engagement as Partners in their Care domain of the Meaningful Measures Initiative. This measure will fill an existing gap of care aligned with the person's goals in the PCHQR Program. We are requesting public comment on the possible inclusion of this measure in future years as a program. Slide 44, please.

CMS intends to review and assess the quality measures that we collect and store in our quality program. We are continually evaluating the existence of the PCHQR measures portfolio and identifying gap areas for future measure adoptions or and/or development. We have conducted a measure environmental scan. By staying abreast of the cancer measurement environment and staying in communication with the cancer measurement development community are vital to ensure that the PCHQR Program measure portfolio remains aligned with 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 welcomes public comment and specific suggestions on the inclusion of measures that examine general cancer care versus cancer-specific clinical conditions in future rulemaking. Slide 45, please.

As program 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 the Fiscal Year 2015 final rule, we adopted a policy under which we can use the sub regulatory process to make non-substantive changes to the program measures. We are not proposing any changes

to this policy. Slide 46, 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 the data before the data is made public would be approximately 30 days in length. We recognize the importance of being transparent with stakeholders and keeping them abreast of any changes that arise at the PCHQR measure set. In this proposed rule, we address some recent changes affecting the timetable for the public displaying of data for specific PCHQR measures. Slide 47, please.

Currently, all PCHs are reporting SSI, MRSA, CDI, and HCP data to the NSHN under the PCHQR Program. However, performance for these measures is narrow and does not span a long enough measurement period to draw conclusions about its statistical significance at this point. As you may recall, in 2016, the CDC announced that HAI data reported to NHSN for 2015 would be used as the new baseline serving as a 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 are proposing to delay the public reporting of data for the SSI, MRSA, CDI, and HCP measures until Calendar Year 2019. We invite public comment on our proposal to delay the public reporting of these four measures until Calendar Year 2019. Slide 48, please.

In the Fiscal Year 2015 final rule, we finalized that PCHs would begin reporting the External Beam Radiotherapy for Bone Metastases, or EBRT, measure beginning with January 2015 discharges and for subsequent years. We finalized that PCHs would report this measure to us 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 to display the 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 H*ospital Compare* data are published four times each year — April, July, October, and December. As such, we anticipate an update of EBRT measure data to be

available in December 2018. Next slide, please.

A summary of the proposed public display requirements for the Fiscal Year 2021 Program Year is shown here on this slide. Currently, the HCAHPS Survey data are publicly reported and are refreshed on a quarterly basis. The one OCM measure retained, NQF #0383, and the 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 Calendar Year 2019. Slide 50, please.

Current data submission requirements and deadlines for the PCHQR Program are displayed on the *QualityNet* Resource page. Data reporting for the proposed 30-Day Unplanned Readmissions for Cancer Patients measure, as this is a claims-based measure, there is no data submission requirement for PCHs. The data will be obtained from Medicare claims data. We are proposing that the annual data collection period would be from July 1 from the Program Year three years prior to the Program Year to June 30 from the two years prior to the Program Year; therefore, for the Fiscal Year 2021 Program Year, we would collect data from July 1, 2018, through June 30, 2019. We are inviting public comment on this proposal. Slide 51 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 a natural disaster. 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 Exceptions, or ECE, policy to extend the deadline for a PCH to submit a request for an extension or an exception from 30 days following the data that the ECE occurred to 90 days following the date that the extraordinary circumstance occurred and to allow CMS to grant an exception or extension due to CMS data systems issues which effect data submission. In addition to ensure transparency and understanding of our process, we clarified that we will strive to provide a response to an ECE request within 90 days of receipt. Next slide, please.

I'd like to thank you all in advance for your attention. We here at CMS truly value

and appreciate your input concerning the proposed rule. Lisa will review the comment submission process next, but, keep in mind, your comments on this proposed rule must be received by June 25, 2018. As always, we will seriously consider your comments in preparation of the final rule. So now I'll turn the slides back over to Lisa.

Lisa Vinson: Thank you, Caitlin. I will now review the areas that CMS is requesting comments and input specific to the Fiscal Year 2019 proposed rule, as well as walk you through the process to electronically submit your comments. Next slide, please.

During Caitlin's presentation on the proposed rule, there are six specific areas highlighted that CMS has requested public comment on this year, which include: the new measure removal factor, removal of six measures beginning with Fiscal Year 2021 Program Year, one new quality measure for inclusion beginning with Fiscal Year 2021 Program Year, two measures for potential future inclusion, future measure topic areas, and the data collection period for the new proposed measure. So, now that you are aware of which topic CMS is requesting for public comment, you may be wondering exactly, "How do I start this process?" On the next series of slides, we will discuss acceptable methods of submission. I will show you where to locate the comment section and how to begin the comment submission process. Slide 55, please.

As indicated on this slide, there are three ways you can submit comments on the Fiscal Year 2019 proposed rule: electronically, via regular mail, or express or overnight mail. Unfortunately, due to staff and resource limitations, CMS is not able to accept comment submissions via fax. Specific details such as the address and addressee can be found in the proposed rule. Slide 56, please.

To electronically submit your comments, you may begin this process on the *Federal Register* site, as illustrated on this slide by the top image, or via the *Regulations.gov* site, which is shown as the bottom image. Please remember that the comment period on the proposed rule closes June 25, 2018. For the purpose of this presentation, we will access the *Regulations.gov* site by clicking on Comment Now, which is denoted by the red box in the lower right-hand corner on this slide. You will be taken to the screen on slide 57.

So, here on the right-hand side, you will see the box to click to enter your comments along with the due date of June 25, 2018. Clicking on Comment Now will take you to the screen on our next slide, number 57.

This is where you will enter your comments. Since you are commenting, this is obviously a required field as indicated by letter A. You are able to enter up to 5000 characters and, on this slide as indicated by the B, you can see the number of characters remaining. Slide 58, please.

First of all, as indicated by the letter A on the slide, notice that you can upload files. Secondly, indicated by the letter B, is where you will enter your personal information. Note that only the state or province, ZIP Code, and country are required. On slide 59, we will hone in on the bottom of this particular screen.

This is where you would note if you were or were not submitting on behalf of a third party, such as the ADCC. If you are submitting on behalf of a third party, you are required to enter the organization's name. If not, uncheck the box and the box containing the organization's name will disappear. Then, you will click Continue to go on to the next screen, as shown on slide 60.

Here is the preview page. It will show how your comment will appear on *Regulations.gov*. Additionally, your country and state and any uploaded files will appear also. Your first and last name (if supplied), organization, and ZIP Code will not appear on *Regulations.gov*. You do have the opportunity to edit the content at this point. Lastly, read the statement that, "You are filing a document into an official docket. Any personal information included in your comment and/or uploaded attachments may be publicly viewable on the web." You must select or click the box acknowledging that you read and understand this statement. Then, you can click on the Submit Comment button. This will take you to the screen shown on our next slide, 61.

Lastly, this is your comment receipt. You are provided a comment tracking number, as indicated on the slide in the red box. If you would like, you can take a screenshot of this page or save your tracking number. So, that wraps up your tour of entering your comment. Slide 62, please.

We will conclude today's event, as always, by reviewing important upcoming dates for the PCHQR Program, beginning on slide 63. Our next educational event will be held Thursday, June 28. As always, we will communicate the title, purpose, and objectives for this event with you via ListServe, starting approximately two weeks prior to the event. The upcoming data submission deadlines are listed here as well. May 15 closes the data submission period which opened April 1, during which time you are submitting the CST data, the CDC will also be submitting your fourth quarter 2017 HAI measures, along with the 2017

through 2018 influenza season data for the healthcare provider vaccinations. The deadline to complete the NHSN Agreement to Participate and Consent has been extended to June 15 of 2018. Please be sure to complete this task as your NHSN access may be negatively affected. Then, on July 5, the quarter one 2018 HCAHPS Survey data is due. Slide 64, please.

Here are the dates for public reporting for the PCHQR Program data. The April data listed on the slide was refreshed as of April 25. For the July 2018 refresh, the preview period, which is currently underway, as it opened May 4 and will continue through June 2 with public posting tentatively scheduled for July 25, 2018. Slide 65, please.

Finally, here is 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 this first time. Now, I will 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. Thank you for joining us today. We hope you learned something. All questions will be answered and posted on our *QualityReportingCenter.com* web site on a later date.

Caitlin Cromer: Hi, its Caitlin again. I'd like to thank everybody for being patient and listening to this long presentation. We look forward to hearing all of your comments on the proposed rule this year. I hope everybody has a wonderful spring. Thank you.