PCHQR Program: FY 2016 IPPS/LTCH Final Rule

Minutes

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Matt McDonough: Good afternoon and welcome to this afternoon's webinar. My name is Matt McDonough and I'm going to be your virtual host for today's event.

Before we turn things over to our presenters today to get started, I do want to cover some housekeeping items with you so that you understand how today's event is going to work and how you can interact with our presenters throughout today's event. I'd also like to share with you some troubleshooting tips in case you do get stuck on some audio issues during the event.

As you can see on this slide, audio for this event is available via Internet streaming, and if you're hearing my voice right now, then you know that

is the case. You don't need to have a telephone to listen to today's audio feed, but computer speakers or headphones are necessary.

Now, if you do encounter audio issues that you can't resolve, limited dial-in lines are available. Please just send us a Chat message if you need one of those lines. We'll get that information out to you as quickly as we can.

Also, this event is being recorded.

Now, let's talk a little bit on how to troubleshoot audio. If you're streaming audio and you're speakers start breaking up or your audio suddenly stops, you can usually resolve that issue yourself. Click the "Pause" button, which is located in the upper left side of your screen, wait about five seconds, and then click the "Play" button. Your audio feed should restart. Also, you can just click the "F5" button and refresh your browser, and the event should reload right in your browser.

Now, if you hear a very bad echo on the call right now, it's usually because you're connected multiple times to this event, and that means you're hearing my voice twice. So what you should do is close all but one of those browsers or tabs, and the echo will clear up because you'll only be hearing one audio feed at that point.

Now, all of our attendees are in a listen-only mode today, but you can still submit questions to our subject matter experts on the line. On the left side of your screen, you'll notice that there is a "Chat with Presenter" box. Simply type your question into that box and click the "Send" button to the right. When you send your question in, all of our presenters online today will see your question, and as time and as resources allow, we'll answer select questions throughout today's events.

Henrietta Hight: All right, thank you.

Matt McDonough: Well, that's going to do it for my brief introduction. So without further ado, I would like to start today's meeting – but if you'll hold one moment, I do believe that we have a technical issue here that we need to resolve. If

you'll give me one moment, we will get that resolved for you momentarily, and I apologize for that.

And I'm sorry. Tom, could you please send me the most recent slide deck for today?

And for those of you who are on the line, you should have seen your screen just go blank. That's all right. We stopped sharing slides for the moment. Again, we'll start sharing slides here in just a bit.

Also, if you do have any issues with your audio at any point during today's event, even while we're waiting for this to resume, please do send a Chat message to us. We do have a limited amount of dial-in lines we can use for you as well. Also, let me go ahead and while we're waiting for that to load up, we're going to go ahead and send out a link in our Chat window, and this is going to provide you with a downloadable link that you can use to access today's slide deck right now while we're waiting for this slide deck to load up.

All right, thanks, Tom. I just got that in here. So if you'll give me just a moment, we'll get started here. And again, I appreciate everybody's patience while we do resolve this technical issue. That's going to take me about a minute to get this loaded and started.

Again, if you look in your Chat window on the left side of your screen, if you'd like a link to today's presentation, it should be posted. You can actually click right on that link. It will launch a new tab or a new browser which will bring up the page that you're clicking on. It will not disconnect you from your event that you're currently connected to, as well. So you can go over to that page, get what you need, and still remained connected to today's event. And I'll give you just another 20 seconds or so, and I'll let you know when our slides are ready to go.

Tom Ross: At this time Matt, let's ask Henrietta to move forward with the introductions of our speakers while that loads up, which she will just now do. Henrietta?

Henrietta Hight: Okay, thank you, Matt. Thank you, Tom.

Hello. We would like to welcome everyone to today's webinar entitled, FY2016 IPPS/LTCH PPS Final Rule. This is the Final Rule for year 2016. In the webinar today, we will be focusing on the Final Rule section regarding the PPS-Exempt Cancer Hospital Quality Reporting Program.

Our main speaker today is Caitlin Cromer. Ms. Cromer is a Social Science Research Analyst with the Centers for Medicare & Medicaid Services or CMS. As you can see on the slide, Ms. Cromer is associated with several groups at CMS. And again, we always have these acronyms. One of the groups is CCSQ, which is the Center for Clinical Standards and Quality; QMVIG, which is the Quality Measurement and Value-Based Incentives Group; and DVIQR, which is the Division of Value Incentives and Quality Reporting.

Also speaking today will be Tom Ross, the PCHQR Lead Project Coordinator here at the VIQR, the Inpatient Quality Incentives and Quality Reporting Outreach and Education Support Contractor.

We would like to remind the registrants that today's webinar will cover the section of the Fiscal Year 2016 Final Rule and it applies only to the PPS-Exempt Cancer Hospital Quality Reporting Program. This Final Rule also has sections covering the Inpatient Perspective Payment System, IPPS hospitals; and the Long-Term Acute Care, LTCH hospitals. If you're associated with one of these two programs, please note we will not be including information regarding your program. Therefore, please check with the Support Contractor team for your respective programs regarding the Fiscal Year 2016 Final Rule educational webinar.

And now, to begin the webinar, let's look at the next slide.

We live by acronyms, and don't you love these acronyms? To help us out for now and later, this slide will help you translate the rest of the presentation. So keep this page handy.

At this time, I would like to turn this webinar over to Tom to discuss the next couple of slides addressing our upcoming webinar plans, as well as the purpose and objective of today's presentation. Tom?

Tom Ross: Thank you, Henrietta.

As you can see, we have two future webinars in the works specific to the PCHQR. The first is scheduled for September 24th. We'll delve more detail into a topic that will be addressed today, the oncology measures assessment of pain and plan for the treatment of pain. As the participants are aware, these are paired metrics, and there's been a lot of discussion about sampling and reporting of these metrics. We'll provide guidance on this process, as well as share overall results from the first submission of data, which completed on August 15th. We'll look at the frequency of pain that was reported and quantified, and then compare the results to the literature. We'll then have two guest speakers from PCH-participating hospitals share their insight on the topic, Sarah Thirlwell from Lee Moffitt Cancer Center and Steve Flaherty from the Dana-Farber Cancer Institute. Then in October we are tentatively planning a deep dive into the three new NHSN measures for the PCHQR that Caitlin will be introducing to us today.

Next slide please, Deb.

The purpose of today's presentation is two-fold. First, we'll summarize the final updates to the PCHQR program in the Rule, and this will drive the majority of our discussion today. Secondly, we will review some comments you submitted to CMS and the responses to these. This is important because each and every comment was reviewed and addressed.

Next slide please.

So the overall objective for today's presentation is for you to understand the finalized changes to the PCHQR Program that will take effect January 1, 2016. In order for you to be able to do that, you will be able to need – you will need to be able to, first of all, find the Rule; secondly, know what

the finalized changes are and discuss the Final Rule measures as part of a process improvement strategy, [and understand] why are these measures [were] selected for implementation of PCHQR.

At this point in time, it is my privilege to turn the presentation over to Caitlin Cromer from the Quality Measures and Value Incentives Group at CMS.

Next slide please, and welcome Caitlin. Thank you for taking your time today to share the Fiscal Year 2016 Final Rule with us.

Caitlin?

Caitlin Cromer: Thank you, Tom and Henrietta.

I really appreciate the opportunity today to discuss the Fiscal Year 2016 Inpatient Prospective Payment System, Long Term Care Hospital Prospective Payment System Final Rule with a focus on the PPS-Exempt Cancer Center Hospital Quality Reporting Program of PCHQR.

Next slide please.

The finalized Rule impacts the PCHQR program in four major areas, including the removal of six Surgical Care Improvement Project measures or SCIP measures; the addition of three new quality measures which are aimed at improving patient safety; the consideration of quality measure topics beyond Fiscal Year 2016; and the implementation of some administrative changes, including but not limited to technical classifications for quality measures, public display requirements.

Tom Ross: So technical specifications for quality measures, the public display requirements, and the form, manner, and timing of data submission.

Next page please, as we wait for Caitlin to rejoin.

A summary of the finalized PCHQR program measures beginning with the Fiscal Year 2018 program – the six items you see

highlighted in blue are previously finalized measures which you've already been working on and have already been reporting. The three highlighted areas in yellow are new measures for Safety and Healthcare-Associated Infections, or HAIs, and HCP [Influenza Vaccination Coverage Among Healthcare Personnel]. All three of these measures are from the Centers for Disease Control and Prevention or CDC, National Healthy Safety Network, NHSN, that have been finalized for the Fiscal Year 2018 program and subsequent years. They include, first of all, NQF 1717, which is the CDC NHSN Facility-wide Inpatient Hospital-onset *Clostridium difficile* infection or CDI outcome measures; NQF 1716, which is the Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* or MRSA Bacteremia Outcome Measure; and NQF 431, the CDC NHSN Influenza-Vaccination Coverage Among Healthcare Personnel.

Next slide please, Deb.

This slide continues to review the matters to be reported during the Fiscal 2018 program year. Once again, these seven items are previously finalized measures which you have been working on and which you have been reporting on, or will soon report.

And there is [are] three areas of the major categories of NQF measures. These being Clinical Process, which has the sub-categories of Cancer-Specific Treatment and Oncology Care Measures; the second being the Patient Engagement/ Experience of care or HCAHPS; and Clinical Effectiveness.

Next slide please, Deb.

So why change? Needless to say most of us do not like change. However, change is needed as we deal with a dynamic and constantly evolving healthcare environment. The high level view is quite simple. First of all, legislative changes occur and CMS is required to implement them; and secondly, some measures get topped-out, or everybody gets pretty close to

the best practices, so we shift focus to areas that need more improvement. So basically if a measure changes, a new requirement is added, or an item is deleted, there must be change.

So, on the next slide, we take a look at a statutory approval for this. There are no changes here, Henrietta was happy to remind me.

As a reminder, the establishment of a quality reporting [program]for hospitals was described first in 1886(d)(1)(B)(v) of the Act referred to as the PPS-Exempt Cancer Hospitals, or PCHs, that specifically applies to PCHs that meet the requirements under 42 Code of Federal Register 412.23(f). Then Section 3005 in the Affordable Care Act or ACA added new sections to the Act. And lastly, as you can see, Section 1866(k)(1) required that, starting in Fiscal Year '14, PCHs had to submit data to the Secretary in accordance with the section listed in respect to such a fiscal year.

Next slide, please.

And this really gives you an overview from starting 2013 to today where the PCH-related statutory authority was delineated with Fiscal Year 2013 being the First Rule. And now, we have finalized the Fourth Rule for Fiscal Year 2016.

This slide indicates the Federal Register locations for the newest in each of the previous three Final Rules. There's a hyperlink in this slide to assist you in accessing the CMS Fiscal Year 2016 IPPS LTCH Final Rules as published in the final register.

Next slide please.

So final measure removal – Henrietta told me this slide should bring a smile to everyone's face – removal of a measure set.

Next slide please.

So as is proposed in the finalized Rule, SCIP reporting will end with the last reporting being the reporting of Quarter two and three discharges during the July 1 to August 15, 2016 submission period. This slide indicates the measure removal schedule. So starting with quarter four of 2015 discharges, no further data submission will be required.

Next slide please.

We'll take a look at the six measures that were [finalized] for removal. We won't take any time to delve into these, but these are the three antibiotic: the urinary catheter, the VTE prophylaxis, and the beta-blocker metrics.

Next slide please.

So the logic for the finalized removal of SCIP measures is summarized in this slide. First of all, SCIP measures were topped-out in the Inpatient Quality Reporting or IQR program and, as a result, were removed in the IQR submission requirements. Secondly, as CMS moves toward aligning programs, the removal of the SCIP measures in the IQR program makes removing them from the PCH program not only feasible but practical. Furthermore, from a systems perspective, IT specifically, keeping the SCIP measures only solely for the PCHQR program is not operationally feasible. And then, an added bonus, removal of these measures reduces administrative burden and maintenance costs. And lastly, and I think most significant for patient care, removal of these six measures will allow the PCHQR and the CMS information technology systems to focus more in the future on actual outcomes and other measures that are more closely linked with clinical outcomes.

On the next slide, we will address some of the comments received about this proposal.

There were a total of five comments received pertaining to the removal of the SCIP metrics. In general, these were very supportive of the removal, noting the reduction in data collection burden. There were further comments about the timing and reporting of the SCIP measures for the

total of three quarters. Lastly, comments [were] received requesting clarity of this proposal from the PCHQR and how it relates to the IQR. Attendees are asked to refer to the Federal Register for the complete comments and responses.

And at this time, I'll ask Caitlin to take back over on the summary of the SCIP status on slide number 22.

Caitlin Cromer: Thanks, Tom.

It seems like today is the afternoon of technical difficulties.

As Tom said, this slide summarized – we have finalized a proposal to remove the six SCIP measures from the PCHQR program beginning with the fourth quarter of 2015 discharges. We will now move and do a review of the new measures finalized for the PPS-Exempt Cancer Hospital Quality Reporting program.

Next slide please.

There are three new measures focused on improving or reducing the rate of hospital-acquired infections in all of our hospitals that are included in the Fiscal Year 2015 Final Rule for the PCHQR.

Next slide.

Finalized for [the] Fiscal Year 2018 program year and subsequent years, these new NHSN HAI measures include NQF #1717, which addresses CD infections or CDIs; and NQF 1716, which addresses – excuse me right here, methicillin-resistant *Staphylococcus aureus*, or more familiarly and more easily pronounced, MRSA. Both of these are outcome measures with the rates of the entire hospital being monitored and reported.

The third measure, NQF 0431, Influenza Vaccination Coverage Among Healthcare Personnel measure or HCP, is the first HCP measure in the PCHQR program. It, too, is an Outcome measure.

Next slide.

We use a lot of acronyms in the next few slides. Please refer to the acronym page in the beginning of the presentation to assist you, if need be.

So let's be aware in how these finalized new measures originated.

First of all, these measures are currently reported under the Hospital IQR Program. Implementation of these measures came about through a vetting and publishing process, which included public posting in a list of measures being considered for the Quality Reporting Program. The published list is called the List of Measures Under Consideration or MUC list. These particular measures, the ones proposed for addition in the Fiscal Year 2016 Proposed Rule, were posted on December 1, 2014. The MUC list meets the legislative requirements to publicize all measures under consideration. Following the public posting of the Measures Under Consideration, they were submitted to the Measure Applications Partnership or MAP. The MAP is a public-private partnership. It was convened by the National Quality Foundation, NQF, providing input to the Secretary of the Department of Health and Human Services, or HHS, on the selection of certain quality and efficiency measures. All three proposed measures for the PCHQR program received approval from the MAP – on the MAP.

Next slide please.

Why are the finalized new HAI measures important? HAIs can have devastating emotional, financial, and medical consequences, and their impact is widespread. Both CDI and MRSA significantly contributed to the morbidity and mortality amongst hospitalized patients. Tens of thousands lives each year in the United States are lost. Nearly one in every 25 inpatients develops an infection related to hospital care. These HAIs HAIs cost the U.S. healthcare system billions on an annual basis.

And while CDI is primarily causally related to the provision of healthcare, MRSA occurs in all in all public environments, not just in hospitals or

related care facilities. That being said, we still want to reduce our MRSA nosocomial incidents in our hospitals.

On the next slide, we will discuss some of the specific rationale for the inclusion of these measures in the program.

An adoption of new HAI measures reinforces CMS' commitment to increasing patient safety, and in the case of many cancer patients, meeting their increased safety needs related to infection.

It is a given that your cancer patients are at an increased risk for hospital-acquired infections. Their serious underlying illnesses or immunocompromised condition increases the risk of CDIs. Prolonged antibiotic exposure [adds] to their risk. Additionally, cancer-patients' long-term involvement in a healthcare setting, as well as their transition throughout the entire spectrum of the healthcare delivery process due to their various treatment regimens increases the risk of acquiring an HAI.

As a key part of CMS's quality programs, patient safety and any opportunity to improve it, is an opportunity to improve patient care. To that end, CMS actively partners with patients via the *Partnership for Patients*. Through the Partnership, CMS and over 3,700 participating hospitals are focused on making hospital care safety, more reliable, and less costly by reducing preventable hospital-acquired conditions and improving care transitions.

Next slide please.

Tom Ross: Caitlin, this is Tom. We're having a lot of trouble with the audio breaking up. Let's see if I can take over for a couple of slides, and then if you can maybe get in on a different line. Will that be acceptable?

Caitlin Cromer: That sounds great. I'll try again. Thank you.

Tom Ross: Okay, thank you.

So, the CDI measure is, similar to the other HAI measures. CDI data reported – report the standardized infection ratio or SIR of hospital-onset CDI laboratory-identified events among all patients in the facility.

The NHSN defines SIR as a statistic used to track healthcare-associated infections, HAIs, over time at a national, state or facility level. The SIR compares the actual number of HAIs at each hospital to the predicted number of infections. The predicted number is an estimate based on national baseline data and it is risk-adjusted. Risk-adjustment takes into account that some hospitals treat sicker patients than others. Sicker cancer patients are factored into this calculation.

The numerator is the total number of observed hospital-onset CDI LabID events among all patients in the facility. This number excludes well-baby nurseries and neonatal intensive care units. The denominator is the total number of predicted events. It is calculated by multiplying the number of inpatient days for this facility by the hospital-onset CDI LabID event rate for similar types of facilities obtained from a standard population.

Next slide please.

So, in other words, as baseline of SIR would be performances as expected. So, in 2010 through 2011 there's a national baseline SIR established of 1.0 and the national goal was to reduce the incidence of all facility onset CDI overall by 30 percent, which would be a resulting SIR of 0.7 by no later than 2013. Has this been achieved? It's not attained yet, and progress has been minimal, unfortunately. Facility onset CDI decreased by only two percent as of the end of calendar year 2012, resulting in a SIR of 0.98.

Now, the baseline was being reset in 2015 to a goal of 1.0 with the revised national goal to reduce facility onset CDI by 30 percent to 0.7 by no later than 2020. And of course, was this achieved? As Henrietta pointed out, not until 2020 will we know the answer.

Next slide please.

The MRSA measure addresses the National Quality Forum Patient Safety domain. MRSA causes approximately 18,000 deaths per year during hospital stays and is especially dangerous to cancer patients who are at increased risk, especially older adults with weakened immune systems. As you can see here in the slide, MRSA data reports the SIR of hospital-onset unique blood source MRSA events among all inpatients in a facility. Once again, the numerator is the total number of observed hospital-onset unique blood source MRSA LabID events among all patients in the facility. While similar to [the] CDI metric, the denominator is the total number of predicted hospital-onset unique blood source MRSA LabID events.

In the same as we did with the CDI, on the next slide, Deb, let's take a look at the MRSA goals then and now.

The baseline of 1.0 in 2009, the goal was to achieve a reduction of 50 percent by no later than 2020. Certainly, we weren't there yet but we're unable to asses reaching this goal. The progress, once again, has been slow. And by the end of calendar year 2012, we saw the SIR decreased to 0.97. The new goal has to take a baseline SIR of one again, in 2015, and to reduce facility-onset infections by 50 percent to a SIR of 0.5 by no later than 2020.

Next slide please.

So once again, why is it important to implement the HAI measures for the PCH? There are a number of sound reasons for implementing these measures within the hospitals of [the] PCHQR. Collection of data and adoption of these measures will help focus attention on areas of known risks to patients. This is in direct support of Health and Human Services' "National Action Plan to Prevent Healthcare-Associated Infections."

Collection and evaluation of data will allow hospitals to assess and identify areas for improvement with the intent of reducing preventable harm to patients.

The next slide shows even more reasons for implementing the HAI measures.

Other [key] reasons to implement the HAI measures in the PCHQR include the mortality associated with MRSA infections; the fact that cancer patients are as susceptible or even more so to these infections. The CDC reports that, "Cancer patients have an increased risk for MRSA infections, specifically older adults with weakened immune systems who are receiving hospital inpatient care."

Next slide, please.

The CDC and MRSA data will be tracked and reported using the CDC's NHSN database. This should be advantageous for the PCHQR as they are already using the NHSN database to report CAUTI, CLABSI, and the SSI measures. Therefore, the use of the NHSN for these measures will not require a lot of training.

The NHSN reports enable the PCH staff to evaluate their infection control efforts and identify opportunities for improvement. For example, the tracking of infections by specific locations enables the identification of areas or units in the hospitals that are doing well and others that may have opportunity for improvement.

Next, we will take a look at the third newly proposed measure for this program.

Next slide please, Deb.

The third proposed new measure is the tracking and reporting of influenza vaccination of healthcare personnel. Higher vaccination coverage among healthcare personnel is associated for lower incidence of nosocomial influenza. The CDC estimates that in the US each year an average of five to 20 percent of the population gets influenza, and more than 200,000 people are hospitalized for seasonal influenza-related complications.

Over a period of 30 years, estimates of influenza-associated death range from a low of approximately 3,000 to a high of approximately 49,000 people. Due to the impact on patients, the Advisory Committee on Immunization Practices recommends that all healthcare personnel and persons in training for healthcare professions receive an annual influenza vaccination. The numerator for this metric is delineated on the next slide.

The numerator reports the percent of healthcare personnel who, during the flu season, meet one of four criteria: one, they received the influenza vaccination at the PCH or provide documentation that it was received elsewhere such as at a physician's office or pharmacy; number two is, people have medical reason for not receiving a vaccination such as are listed on the slide; the third is personnel who declined; and the fourth are personnel with an unknown vaccination status.

Next slide please.

The denominator includes all personnel working in the hospital setting, regardless of clinical responsibility or contact for at least one working day between October 1st and March 31st of the following year. Even hospital personnel who do not have direct patient contact are included in the influenza vaccination numbers since these people can interact with patients and visitors in the cafeteria and other non-patient care areas. This includes employees, licensed independent practitioners, and adult students/trainees, and volunteers.

The overall goals are listed on the next slide.

If you look in the 2012 through 2103 flu season, [the] vaccination rate for healthcare personnel is about 72 percent. In the following year, it was up to 75.2. One of the *Healthy People* 2020 goals is to achieve a vaccination rate among healthcare personnel of 90 percent nationally by the year 2020.

So why was this measure selected for the exempt cancer hospitals? Next slide.

First and foremost, this measure was selected to increase patient protection and safety, to prevent adverse outcomes for high-risk cancer patients including premature death due to the influenza-acquired in the PCH setting. Furthermore, vaccination is proven to be an effective preventative measure against the influenza virus and it can prevent untimely illness, death, and loss in employee productivity.

Another benefit is that it supports CMS' efforts to prevent unnecessary additional or prolonged hospitalizations and the costs associated with these events.

One the next slide, we're going to take a look at the HCP data collection and reporting.

PCHs are already using the NHSN database for HAI reporting. Using the same system to submit HCP measured data will provide the PCHs with a known reporting mechanism requiring [very] little learning curve. Additionally, the HCP measure only requires completion of a summary data once during the flu season, as opposed to monthly [as] with other measures.

Next slide please.

So, as stated earlier, comments were reviewed and responded to in the Final Rule. There were total of nine comments for healthcare-associated infections and HCP measures. Note that the current plan is to discuss these measures in a little bit more detail in the October 22, 2015 webinar entitled *New NHSN Measures for the PCHQR*.

Overall, comments were supportive of the addition of *C. difficile* and MRSA measures to the program and immunization of healthcare practitioners. Some of the commenters mentioned issues regarding differences in cancer patients versus other hospitalized patients and even within specific types of cancer patients. In responding, it was noted that PCHQR data was displayed separately from the data reported by other healthcare settings.

All comments and responses are documented in the Final Rule to which attendees are directed for specific comments and responses.

Next slide please.

This slide and the next three slides provide a summary of adopted and newly finalized PCHQR program measures beginning with the Fiscal Year 2018 program. First, we see the six metrics in the Safety and Healthcare-Associated Infection domain.

Next slide please.

This slide is a continuation of the previous slide. Here, we see the three Cancer-Specific treatment measures and the five Oncology Care Measures which had previously been added to the PCHQR.

Next slide please.

And in conclusion, continuing from the previous slide, completing the summation of the 16 measures for the Fiscal Year 2018 Program for the PCHQR where we see the addition that we already have, the Patient Engagement/Experience of Care measure and the Clinical Effectiveness measure, NQF 1822, which will be first reported during next summer's data collection period.

We will now take a look at potential ideas and domains for future Rules based upon comments received.

Next slide please.

CMS is continually trying to develop new quality measure topics, and measure domains with the potential to decrease care cost, increase care coordination, and increase communication within and between care communities, including the sharing of best practices. They welcome your suggestions for measure topics and/or domains that support these areas. In this month's – in this year's rule-making process, we received excellent ideas we will summarize on the next slide.

There were a total of nine comments received pertaining to future measure selection. You can see from the slide that the majority of comments were directed towards measures, especially patient-reported measures that focus on outcomes and quality of life. Consideration of data collection burden was also mentioned; consideration of risk adjustment, and further clarification on how metrics are deemed to be topped-out.

CMS is appreciative of this input. For a comprehensive review of the specific comments and responses, once again, please refer to the Final Rule. As with all of the programs, CMS is fully committed to engage in the partnering with all stakeholders to ensure success, and most importantly, improve quality of care.

Next slide please Deb.

The technical specifications for the PCHQR program measures are periodically updated on the website on this slide, located on the *QualityNet* website. Note that the Final Rule does not include any changes to the sub-regulatory process found in the Fiscal Year 2015 rule.

Next slide please.

The Affordable Care Act requires the Secretary to establish procedures for making the data submitted under the PCHQR program available to the public. Such procedures must ensure that the PCH has the opportunity to review the data that are to be public prior to the data's display and on the *Hospital Compare* website. PCHs are provided with a preview period of 30 days.

Next slide please.

This slide details the previous, current, and future measures of measured data – or excuse me, future schedule of measured data to be displayed on *Hospital Compare*. Initially, for Fiscal Year 2014, two cancer-specific measures, the colon and breast chemotherapy measures were displayed on *Hospital Compare*.

Starting with October 2015, *Hospital Compare* will release a third cancer specific measure, NQF #220 Adjuvant Hormonal Therapy for ER-positive breast cancer will be added to the publicly reported data. Not later than 2017, two of the HAI measures, CLABSI and CAUTI, will also be displayed on *Hospital Compare*, making a total of five PCHQR measures that will be publicly be displayed.

Next slide please.

The Fiscal Year 2016 Finalized Rule specifies the additional display of five oncology care measures or OCMs, as well as the HCAHPs survey measure data on *Hospital Compare*. Reporting of the OCM measures' data for first quarter 2015 began with the data submission period ending on August 15, 2015. HCAHPS has been reported since October 2014. These metrics are slated for public reporting beginning 2016.

Next slide please.

So what comments were received and what was the response? There were a total of eight comments related to public display published and responded to in the Final Rule. Once more, several commenters were supportive. Specific comments were received regarding the public reporting for CLABSI and CAUTI metrics.

One of the comments received are the questions related to NQF 382, Radiation Dose Limits to Normal Tissues. This measure, limited to lung and pancreas cancers in the PCHQR, was expanded to include breast and rectal cancer patients by the measure steward, and this was accepted by the NQF last November. At this time, the measure remains limited to lung and pancreas cancer patients for the purposes of the PCHQR. CMS intends to address the expanding cohort issue in next year's rule-making process. So we'll continue to monitor this and have an opportunity to provide feedback, as always.

A last comment was in regards to Pain Intensity Quantified and Plan of Care for Pain. Note that these are paired metrics. That means for any

cancer patients that are reporting pain and their pain is quantified, these cancer patients should have a care plan for pain management. Cancer patients that qualify for the numerator of the pain assessment metric, NQF 384, are also sampled to account for the Plan of Care for Pain, NQF 383, Denominator.

As with the other sections' comments and responses, please always refer to the Final Rule for the full text.

Next slide please.

So the summation for the public display requirements, the data, the table displayed on this data – on the slide, summarizes the previously adopted and newly finalized public display requirements arranged by measure and public reporting years. I think this should be a great reference.

NQF 223 and 559 are already publicly reported. The Adjuvant Hormonal Therapy will begin to be publicly reported in actually two months, in October 2015. Then in 2016, you can see the addition of the OCM and HCAHPS measures, and lastly, the planned reporting of CLABSI and CAUTI beginning in 2017. We will close by looking at the timing of the measure submission for these new measures.

Next slide please.

Please note that this slide represents program year 2018 reporting. Two of the CDC measures, CDI and MRSA have quarterly requirements. For discharges starting January 1, 2016, data will be reported quarterly starting [in] August 2016, for the CDI and MRSA metrics. This is similar to what you're familiar with the CLABSI, CAUTI, and SSI reporting.

Next slide please.

The HCP influenza vaccination measure has an annual reporting requirement, as indicated on this slide. For the influenza season starting

with October 1, 2016 running through March 31, 2017, the data will be submitted by [a] deadline of May 15, 2017.

I thank you for your attention and time. I apologize for the technical difficulties we had. But [at] this time we're going to ask Deb Price to describe the continuing education process, and then we'll have a period of questions-and-answers, if time allows.

Once again, please remember that today's presentation of the Final Rule is specific to the PPS-Exempt Cancer Quality Reporting Program for those 11 hospitals with the PPS exemption.

Deb?

Deb Price: Thank you, Tom.

Today's webinar has been approved for one continuing education credit by the Boards listed on this slide. We are now a nationally accredited nursing provider, and as such, all nurses will report their own credits to the Boards using our National Provider Number listed on this slide, 16578.

We have an online CE certificate process. You can receive the CE certificate in two separate ways: the first way is, if you're listening to this webinar and you registered for it, as soon as it ends, a survey will pop up. And then you take the survey and click it. And then that – the next page will take you through your certificates. If, however, you're listening in a room and only one person was able to register, you can also get your certificate with a survey that we send out in 48 hours. This is what the survey looks like, the end of the survey. And you notice on the bottom, there's a little rectangular gray box that says "Done." When you click the "Done" and a page opens up – yes, page opens up, and you will register as a "New User" or as an "Existing User."

If you are a "New User," that means that you have not gotten a – have not received a CE certificate from us before. You put your first and last name. Use a personal email like Yahoo or Gmail or AT&T or any of your home

email addresses, because those addresses do not have firewalls up like the hospitals do. So again, this is a separate registration than the one that you used to get the webinar. The webinar was through ReadyTalk®. If, however, you have received our certificates before, go ahead and click on "Existing User," and the "Existing User" page – this is what it looks like. Your username is your entire email address, and of course, your password.

And now, I'm going to turn the ball back over to Tom to get into the questions and possibly give some answers for today's event. Thank you everyone.

Tom Ross: Thank you, Deb.

Depending upon technology availability, we'll now have Jim Poyer, Program Lead for the PCHQR, also from the Quality Measures and Value Incentives Group at CMS, joining Caitlin for [a] questions and answers period.

Please note that all questions that are submitted during the webinar will be researched, answered, and posted at qualityreportingcenter.com within 10 business days of the conclusion of our webinar.

So, the first question that we have is, "I'm assuming that since the SCIP measures will be retired, reporting of (pop-sampling) counts would also stop after submitting quarter two and quarter three 2015 discharges?"

Jim Poyer: Hi. This is Jim Poyer from CMS.

That is correct. We would no longer be requiring the submission of (pop-and-sample) counts effective – the last quarter would be third calendar quarter 2015 discharges. The due date, I believe, is February 15, 2016. After that, it would cease.

Tom Ross: Thank you.

Another question which came up right at the end of the program, Jim, was – "Is today's webinar applicable to all – all the programs covered inside

the IPPS rule, LTCH rule, or is it specific only to the participants in the PPS-Exempt Quality Reporting Program?"

Jim Poyer: Thanks, Tom.

As you previously alluded to, these measures and reporting requirements are specific only to the 11 hospitals billing Medicare under the – as PPS-Exempt Cancer Hospitals. They are – I would refer readers to the applicable section of the Federal Register IPPS Rule for – for example, inpatient care hospitals building under IPPS, LTCH, long-term care hospitals, and other types of providers billing Medicare. This is specific only to the 11 PPS-Exempt Cancer Hospitals.

Thank you.

Tom Ross: Thank you very much.

And that summarizes the questions that we received during the webinar today. Once again, feel free to submit your questions via the – other questions and clarifications via the *QualityNet* Hospital Inpatient function, and we'll respond to those in a timely manner.

I thank you for your time and attention. I apologize for the technical challenges, but we covered the information. And as always, thank you for the care that you provide to our patients.

Have a great afternoon everyone.

Jim Poyer: And CMS thanks you. Take care.

Bye.

Tom Ross: Thank you.

END