PPS-Exempt Cancer Hospital Quality Reporting Program

Support Contractor

PCHQR Program
FY 2018 IPPS/LTCH 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 *PCHQR Program: FY 2018 IPPS/LTCH Proposed Rule*. My name is Lisa Vinson, and I will be the moderator for today’s event. I serve as the Project Manager for the PPS-Exempt Cancer Hospital Quality Reporting, or PCHQR, Program within the Hospital and Inpatient Value, Incentives, and Quality Reporting, or VIQR, Outreach and Education Support Contractor. The material for today’s presentation was developed by our team in conjunction with our CMS Program Lead, Caitlin Cromer, who will be the main speaker for today’s event. Caitlin is a Social Science Research Analyst working for CMS in the Quality Measures and Value Incentives Group, or QMVIG, within the Center for Clinical Standards and Quality at CMS. As the title indicates we will be discussing the Fiscal Year 2018 IPPS/LTCH Proposed Rule. Today’s event is specific for the participants in the PCHQR Program. Although the Proposed Rule contains content that addresses the Hospital Inpatient Quality Reporting, or HIQR, in the Long-Term Care Hospital, or LTCH, Quality Reporting Programs, we will only be focusing on the PCHQR Program. If your facility is participating in the HIQR or LTCH Programs please contact your Program Lead to find out when there will be a presentation on your section of the FY 2018 Proposed Rule.

As the slide indicates, during this presentation our presenter will be discussing the areas of the FY 2018 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 slide number seven to
take a look at some of the abbreviations and acronyms that you will hear and see during today’s event.

As usual, here is the acronym and abbreviations list. Acronyms and abbreviations that you will hear and see today include CY for Calendar Year, EOL for end-of-life, ECE for Extraordinary Circumstances Exception, FY for Fiscal Year, IPPS for Inpatient Prospective Payment System, LTCH for Long-Term Care Hospital, and NQF for National Quality Forum. Please use this slide as a reference as we go through this presentation. Next slide, please.

The purpose of today’s presentation is to provide a review of the FY 2018 IPPS/LTCH Proposed Rule with the focus on how the proposed changes could impact the PCHQR Program. Now, let’s move to the next slide, slide nine, to take a look at today’s objectives.

There are three main objectives for today’s webinar. Program participants should be able to locate the FY 2018 IPPS/LTCH Proposed Rule text, identify proposed changes impacting the participants in the PCHQR Program, and illustrate how and when to submit written comments to CMS regarding the FY 2018 Proposed Rule. Next slide, please.

Here we have an outline of the publication dates for the FY 2018 Proposed Rule. The Public Inspection Document or displayed copy was published on the April 14, 2017. The 2018 Proposed Rule – Public Inspection link, will take you directly to where this document is housed. Please note, information on the proposed changes and details specific to the PCHQR Program can be found on pages 1149–1187 of this document. The official Federal Register version will be published on the April 28, 2017. Once published, this version can be accessed via the Federal Register link provided here as well. 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. As you are aware, the measure development, selection, and implementation process is an ongoing cycle. One of the key elements is the publication of the Proposed Rule. As Lisa noted, today we will be discussing the FY 2018 IPPS/LTCH Proposed Rule. The reason the publication of the Proposed Rule is a significant event is that it is a very 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 Proposed Rule. We want your input and consider it while developing the Final Rule. With that as a background, let’s begin to look at this year’s Proposed Rule, beginning with the Criteria for Removal of PCHQR Program Measures on slide 12.

This slide lists the seven criteria that are taken into consideration in potentially removing a measure from the Program. These remain unchanged from last year’s Final Rule. You can see that they range from performance being topped-out to changes in clinical practice to the emergence of better measures to issues with implementation. As you will see in a couple of slides the issue of a measure’s performance being topped-out is very pertinent to this year’s Proposed Rule. The term ‘topped-out’ refers specifically to the circumstance that the measured performance among the PCHs is so high and unvarying that meaningful distinctions and improvements can no longer be made. 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 0.10. While these criteria for removal are certainly important, there are other overriding factors that, even if one or more of these criteria are met, may lead to CMS retaining a measure in the Program. These criteria are outlined on our next slide, number 13.

These criteria, once again previously outlined in the FY 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 criteria for removal from the Program are: the measure aligns with other CMS and HHS policy goals; the measure aligns with other CMS Programs including other Quality Reporting Programs – an example of this would be NQF #1822, which is in both the PCHQR Program and the Hospital Outpatient Quality Reporting Program; finally, if the measure supports efforts to move the PCHs towards reporting electronic measures we will consider keeping these measures in the Program. The next slide, number 14, outlines the history of the selection, implementation, and in one case, the removal of measures from the PCHQR Program since its inception in FY 2013.

The PPS-Exempt Cancer Hospital Quality Reporting, or PCHQR, Program was established by Section 3005 of the Affordable Care Act. In the first year of the program the FY 2013 Rule established five quality measures for the Program, including three Cancer-Specific measures and two Healthcare-Associated Infection, or HAI, measures – CLABSI and CAUTI. The next year saw the addition of another HAI measure, Surgical Site Infections and the addition of 12 new quality measures. These new measures included the five process-oriented Oncology Care Measures, six Surgical Care Improvement Project or SCIP measures, and the incorporation of HCAHPS Survey data. FY 2015 was relatively quiet with the addition of one measure, EBRT or NQF #1822, which is External Beam Radiotherapy for Bone Metastases. The fourth rule impacting the Program, FY 2016, saw the addition of two more HAI measures – Methicillin-resistant Staphylococcus aureus Bacteremia and Clostridium difficile Infections, as well as the inclusion of the Healthcare Personnel Influenza Vaccination measure. Of note the FY 2016 Rule removed six SCIP measures as of October 1, 2016. And last year, in the FY 2017 Final Rule a new claims-based measure, Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy, was added and the diagnosis cohort for NQF #382, Radiation Dose Limits to Normal Tissues, was expanded to include the diagnoses of breast and rectal cancer. Based upon the criteria for removal and retention of
measures from the PCHQR Program, and considering the measures currently utilized in the Program, we have proposed to remove three measures as outlined beginning on slide number 15.

We are proposing to remove the three Cancer-Specific Treatment measures: 1) adjuvant chemotherapy for stage 3 colon cancer, NQF #0223; 2) combination chemotherapy for hormone-receptor-negative breast cancer, NQF #0559; and 3) adjuvant hormone therapy for hormone-receptor-positive breast cancer, NQF #0220. We will discuss the rationale for these recommendations on our next slide, number 16.

The rationale for recommending the removal of these three measures is that we have concluded that these three measures are topped-out. Therefore, collecting PCH data on these measures does not further Program goals as the measured performance is so high and unvarying. Also, meaningful distinctions and improvements between hospitals can no longer be made. Statistical analysis performed by the HCQIS Reports and Analytics Team on data from 2014 and 2015 shows that the truncated coefficient of variation is less than 0.10. Furthermore, we believe that these measures do not meet the requirements to measure retention as they do not align with other HHS and CMS policy goals, they do not align with any other CMS programs, and they are chart abstracted and do not support the movement to electronic clinical quality measures. Therefore, we are proposing to remove these three measures from the PCHQR Program beginning with the FY 2020 program year. We are inviting public comment on this proposal.

The FY 2013 Final Rule outlined the principles taken into consideration when developing and selecting measures for inclusion into the PCHQR Program. There are no proposed changes to these principles, which are consistent with the principles used for measure selection in the Hospital IQR Program. You may recall that there are two legislatively committed means of selecting measures for inclusion in the Program. The first is that
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PCHQR Program measures can be chosen from the set of metrics endorsed by an entity with a contract under Section 1890(a) of the Act, which means those currently endorsed by the National Quality Forum, or NQF. The second provision, as specified in Section 1866(3)(B) of the Act, is that the Secretary may select measures not endorsed by NQF as long as due consideration is given to existing endorsed or adopted measures. Using these principles, we are proposing four new measures for the inclusion, inclusion, in the Program. We will begin a discussion of these measures with a general overview on the next slide, slide 18.

There are four measures that we are proposing for inclusion in the PCHQR Program beginning with the FY 2020 program year. These measures are NQF endorsed and include two clinical process measures and two intermediate outcome clinical outcome quality measures. The proposed measures are: 1) the Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 days of life, or NQF #0210; 2) the Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 days of Life. Or NQF #0213; 3) the Proportion of Patients Who Died from Cancer Not Admitted to Hospice, or NQF #0215; and finally 4) the Proportion of Patients Who Died from Cancer Admitted to Hospice for Less than Three Days, or NQF #0216. These measures were included on the 2016 Measures Under Consideration and were reviewed by the MAP Hospital Workgroup which supported the inclusion of these measures in their February 2017 report to HHS and CMS. The overall ideas considered in proposing these measures for inclusion in the Program are discussed in our next slide, slide 19.

The NQF has identified quality of end-of-life care as an area of care that continues to need improvement. End of life may be defined as, “a comprehensive care that addresses medical, emotional, spiritual, and social needs during the last stages of a person’s terminal illness.” This may include palliative care, which is generally defined as multi-faceted, holistic care that anticipates, prevents and alleviates suffering. Both
palliative and end-of-life care can be provided when a patient is receiving hospice services, but it is not necessary to be admitted to hospice to receive such care. End-of-life care to patients and caregivers has been associated with both higher quality and financial cost benefits. Despite the benefits attributed to these services and their increased availability, the NQF and others have noted that these services remained underutilized. By adding these measures to the Program our intent is to assess the quality of end-of-life care provided to patients in the PCH setting. Participants are referred to the link on this page to access the National Quality Forum’s Technical Report, Palliative and End of Life Care 2015 – 2016, for a more in-depth discussion on the topic as well as the measures to assess specifications for these four measures. Next, we’ll take a look at each of these four measures, beginning with NQF #210 on slide 20.

NQF #210 is the Proportion of Patients Who Died From Cancer Receiving Chemotherapy in the Last 14 Days of Life measure. The abbreviation for this measure, or short name, is EOL-Chemo. Chemotherapy is typically used to treat cancer, but in patients with incurable cancer it may also be administered with the goal of easing symptoms and improving survival. However, studies have shown that administering chemotherapy to terminally ill patients may not be beneficial as it may result in a higher rate of interventions without any increase in survival. Also such patients are more likely to die in an intensive care unit and are less likely to die at home or in a location they have expressed a preference to die. Other work has shown that some patients at end-of-life are still receiving chemotherapy for treatment rather than palliation. While the impetus for continuing treatment may vary from case to case, the available evidence indicates that continuing to receive chemotherapy, for palliation or treatment towards the end-of-life, is associated with increased hospitalization and may be associated with a decreased experience of care. This process measure, based on Medicare administrative claims data, addresses the National Quality Strategy domains of Communication and Care Coordination as well as Affordable Care. This measure was also
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included in the FY 2017 Merit-Based Incentive Payment System (MIPS). The numerator is all cancer patients who received chemotherapy, for either treatment or palliative purposes, in the last 14 days of life. The denominator is patients who died of cancer. There are no exclusions, risk adjustments, or risk stratifications because the measure is intended to evaluate the quality of care provided for all cancer patients at the end of their life. We are inviting public comment on our proposal to adopt this measure.

We are proposing to add the Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 days of Life Measure, or NQF #0213, to the Program for FY 2020 and subsequent years. A number of studies have shown that cancer care can become more aggressive at the end of life, which can result in low quality care and lower quality of life. One such type of aggressive care is admission to an intensive care unit, or ICU. Unfortunately, these ICU admissions have been shown to be costly and have a negative impact on patients, families and caregivers. As with NQF #210, this measure addresses the National Quality Strategy domains of Communication and Care Coordination as well as Affordable Care, as well as addresses several CMS Quality Strategy goals. This is an intermediate clinical outcomes measure that assesses whether cancer patients who were admitted to the ICU in the last 30 days of their lives. We recognize that in some cases an ICU admission may be appropriate and note that this measure broadly assesses how many patients are admitted to the ICU close to death, without excluding admissions for specific reasons. As with the other newly proposed measures, this measure is based upon administrative claims data to derive the numerator, which is the number of patients who died from cancer and who were admitted to the ICU in the last 30 days of their lives, and the denominator, which is the patients who died from cancer. There are no exclusions, risk adjustments, or risk stratification. We are inviting public comment on the proposal to add this measure to the Program for the FY 2020 program year and subsequent years.
The third new measure we are proposing to add to the program is NQF
#215, the Proportion of Patients Who Died From Cancer Not Admitted to
Hospice. As we discussed with NQF #213, research has shown that care
can become more aggressive at the end of life resulting in lower quality of
care and quality of life. Such aggressive care has been identified to
include the underutilization of hospice, which is either lack of referral or
late referral to hospice services. Studies have shown that cancer patients
enrolled in hospice were hospitalized less frequently, received fewer
procedures, and demonstrated significant cost savings. This measure, like
the others, supports both National Quality Strategy domains and CMS
Quality Strategy goals. This measure is a process measure, once again
based on Medicare administrative claims data that assesses the proportion
of patients who died from cancer who were not admitted to Hospice. The
measure ties into the following measure, Proportion of Patients Who Died
from Cancer Admitted to Hospice for Less Than Three Days. This
measure seeks to simply evaluate whether patients were admitted to
hospice or not. The following measure assesses whether those patients
who were admitted to hospice in a timely manner to derive maximum
benefit from hospice services. Note that we do not expect PCHs to
achieve perfect rates for this measure as some patients will refuse hospice
or there may be other mitigating factors. The denominator is patients who
died from cancer. The numerator is the proportion of patients not enrolled
in hospice. We are inviting public comment on the proposal to include
this measure. We will now look at the final measure we are proposing for
addition on our next slide, slide number 23.

As discussed on the previous slide, this measure is tied to NQF #215.
NQF #216 is the Proportion of Patients Who Died from Cancer Admitted
to Hospice for Less Than Three Days, with the short name of EOL-3DH.
All the studies have shown, while there has been an increasing trend to
admit cancer patients to hospice, the number of patients admitted close to
death was also increasing. This has led to some to surmise that hospice
care was not being used to mitigate symptoms but only used to manage
death. Cancer patients have been identified as the largest users of hospice, but are also the cohort with the highest rates of hospice stays less than three days. Because research indicates that earlier discussions with patients about palliative care can positively impact the care received at end of life, including timely admission to hospice, we believe that including the proposed EOL-3DH measure will incentivize timely discussions and admissions to hospice in the PCH setting. This in turn may lead to improving the quality of care for cancer patients at PCHs. As with other end of life measures, this measure also addresses important areas of emphasis for CMS. This is an intermediate outcome measure derived from Medicare claims data in which the denominator is patients who died from cancer who were admitted to hospice. The numerator is the number of patients who died from cancer and spent fewer than three days in a hospice. As with the other three end of life measures, we are inviting public comment on the inclusion of this measure to the PCHQR Program. On the next few slides, 24 – 27, we will review the previously finalized and newly proposed measures for the Program for the FY 2020 program year and subsequent years.

Slide 24 displays the six Safety and Healthcare-Associated metrics that are currently part of the PCH Quality Reporting Program. The first five – CLABSI, CAUTI, SSI, CDI and MRSA – are outcomes measures. The other, Influenza Vaccination Coverage Among Healthcare Personnel, is a process measure. Of note, this measure is being reported for the PCHQR Program for the first time in the data submission closing on May 15, 2017. Please note that on this slide and the other two slides summarizing the finalized and newly proposed measures for the Program, we are not including the three Cancer-Specific Treatment measures that we are proposing to remove from the Program in this Proposed Rule.

Here we see the five Oncology Care Measures that have been part of the Program: NQF #382, #383, #384, #389 and #390. Note the “star” next to NQF #382, Radiation Dose Limits to Normal Tissues. This is denoting
the expansion of the diagnosis cohort to include breast and rectal cancers that was finalized last year. We then see, under Clinical Process/Oncology Care Measures two of the new measures we are proposing for inclusion in the Program: NQF #210, the Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life and NQF #215, the Proportion of Patients Who Died from Cancer Not Admitted to Hospice. Next, on the bottom of the slide is the new category, Intermediate Clinical Outcome Measures. Here you see the other two measures that we are proposing for inclusion in the Program: NQF #213, the Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life and NQF #216, Proportion of Patients Who Died from Cancer Admitted to Hospice for Less than Three Days.

And here, we see three measures: HCAHPS, EBRT, and the claims-based measure, Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy, that are all currently part of this Program and that we are recommending the routine. CMS welcomes your comments on the previously finalized and newly proposed measures to the PCHQR Program.

We at CMS understand that social risk factors such as income, education, race and ethnicity, employment, disability, community resources and social support play a major role in health. One of our core objectives is to improve beneficiary outcomes including reducing healthcare disparities and ensure that all beneficiaries achieve high quality care. To this end we have been reviewing reports prepared by the Office of the Assistant Secretary for Planning and Evaluation, and the National Academy of Sciences, Engineering, and Medicine. Also of note then, NQF has undertaken a two-year trial period to assess risk adjustment for selected social risk factors is appropriate for various measures. As this process unfolds we continue to seek public comment on accounting for social risk factors in the PCHQR Program and, if so, what measures are most appropriate, which social risk factors may be most appropriate for
reporting stratified measure scores and/or potential risk adjustment for a particular measure or measures in the Program, and finally any operational considerations that should be taken into consideration when evaluating such adjustments. We note that any such changes would be proposed through future notice and comment rule making. On our next slide, slide number 28, we will begin to look at possible new quality measures for the Program for future years.

In the FY 2015, 2016, and 2017 Final Rules, we discussed future measure topics and quality domain areas. Specifically, we discussed topics and measures related to the CMS Quality Strategy domains listed on this slide. We welcome public comment and specific suggestions for measure topics that we should consider for the future rulemaking. Specifically, we are seeking public comment on six measures for potential future inclusion in the PCHQR Program. They are listed on this slide. You can see that the first five are localized prostate cancer measures, while the sixth is a 30-day unplanned readmissions for cancer patients measure. Our next slide, slide 29, provides an overview of proposed prostate cancer measures.

These five measures are related, patient reported outcomes, measures obtained from administering the Expanded Prostate Inventory Composite, or EPIC, survey. This survey gathers input from patients based on their experiences. The survey questions are intended to be administered to all non-metastatic prostate cancer patients undergoing radiation or surgical treatment at the reporting facility. This is the denominator. The numerator is patients with clinically significant changes in each of the listed areas from baseline to follow-up. The goal is to identify issues of variation, suboptimal performance, and disparities in care. This measure aligns with the priorities of incorporating more outcome measures, specifically patient reported outcome measures into quality reporting programs. While these measures were included in the 2016 MUC, they were not reviewed by the MAP. We do anticipate that they will be on a future list of Measures Under Consideration for MAP review. We are
requesting public comment on possible inclusions of these measures in future years of the Program.

This measure would measure the number of hospitals-specific 30-day unscheduled and potentially avoidable readmission following hospitalization among diagnosed malignant cancer patients. This would assess the total number of unscheduled readmissions within 30 days of the index admission. The basic concepts of the numerator and denominator are shown on the slide and the link is provided for further information on this measure. We are requesting public comment on the possible inclusion of this measure in future years of the Program.

As participants are aware we maintain the technical specification for the PCHQR Program on QualityNet, specifically, on the Data Collection page where you can find the measure information forms, algorithms, paper data collection tools and other references. Also, note that in 2015 we adopted a policy under which we can use a sub-regulatory process and make non-substantive changes to the Program measures. We are not proposing any changes to this policy.

This slide outlines the public display requirements for the Program. Note that the PCH must have the opportunity to review the data prior to such data being made available to the public. This is the purpose of the Preview Reports that you are provided. Also, we strive to make the data available to the public as soon as possible or feasible. An example of this is the publication of the EBRT for the first time this summer with the July Refresh. Furthermore, we will continue to propose in rulemaking the first year for which we intend to publish data for each measure. Lastly, and I know that the Support Contractor has received questions regarding this topic, we propose to continue to defer the public display of the CAUTI and CLABSI data until collaboration with the CDC allows identification of an appropriate time and analytic method to be used in the public
reporting of CLABSI and CAUTI data. Slide 33 shows the previously finalized and newly proposed public display requirements.

Currently, the CST measures are reported publicly and are refreshed on a quarterly basis. Note that we are proposing the removal of three of these measures from the Program beginning in the FY 2020 program year. The five current OCM measures were first reported publicly last winter and will be updated on an annual basis. Note that beginning in the FY 2019, for care delivered in calendar year 2017, NQF #382 data will reflect the expanded diagnoses cohort. As previously mentioned we are proposing to continue to defer the public reporting of CLABSI and CAUTI data at this time. And lastly, as finalized in last year’s Rule, EBRT will be publicly reported for the first time this summer with the July Refresh and then will be updated annually each December.

The current data admission requirements for the Program are displayed on the Resources page for the Program on QualityNet. We are not proposing any changes to these requirements. Data reporting for the proposed four new, end-of-life measures is discussed on this slide. As these are all claims-based measures there is no data submission requirement for the PCHs. The data will be obtained from Medicare claims data. We are proposing annual reporting with a data collection period from July 1 from the year three years prior to the program year to June 30 from the two years prior to the program year. For example, for the FY 2020 program year, data would be collected from the July 1, 2017, through June 30, 2018. We are inviting public comment on this proposal. On our next slide, slide 35, we will look at the proposed changes to the Extraordinary Circumstances Exceptions, or ECE, policies for this Program.

The ECE process for the PCHQR Program was established in the FY 2014 Rule. To better align the ECE process for the PCHQR Program with other CMS quality programs we are proposing the following modifications to this policy. First, we propose to extend the deadline to request an
exception or exemption from 30 days to 90 days. Secondly, we propose to specify that CMS will strive to provide a formal response of our decision within 90 days of the receipt of the request. And thirdly, we propose to allow CMS to grant an exception or extension due to CMS data systems issues that affect data submission. We are inviting public comments on this proposal. I will conclude my comments in the didactic portion of the presentation on slide 36.

I would like to thank you in advance for your attention in providing comments concerning the Proposed Rule. We here at CMS truly value and appreciate your input. Lisa will review the comment submission process next, but keep in mind that your comments on this Proposed Rule must be received by no later than 5:00 pm Eastern Time on the June 13, 2017. And, as always, we will seriously consider your comments in our preparation of the Final Rule. So, at this point, I will turn the presentation over to Lisa.

**Lisa Vinson:** Thank you, Caitlin. I am now going to review the areas that CMS is requesting comments and input specific to the FY 2018 Proposed Rule, as well as walk you through the process to electronically submit your comments.

As indicated on this slide, there are four ways you may submit comments on the Proposed Rule: electronically, via regular mail, express or overnight mail, or hand or courier delivery. Electronic submission is the preferred method; however, this method will not be available until April 28, 2017 when the Federal Register version is published. Specific details such as the address, addressee, and hand or courier delivery instructions can be found in the Proposed Rule. Next slide, please, slide 39.

During Caitlin’s presentation on the Proposed Rule there were six specific areas highlighted that CMS has requested public comment on this year. These are:
• Removal of three CST measures beginning with the FY 2020 program year
• Inclusion of four new measures for the FY 2020 program year and subsequent years
• Input addressing accounting for social risk factors
• Six measures for potential future inclusion
• Data collection period for four new proposed measures, and
• Modifications to the Extraordinary Circumstances Exception or Extension policy

So, now that you are aware of which topics CMS is requesting for public comment, you may be asking yourself, “Where do I start this process?” On the next slide, slide 40, I will show you where to locate the comment section and how to begin the comment submission process.

As today’s information is being provided prior to the Federal Register publication date, we are unable to provide actual screenshots of what you will see when submitting your comments electronically. As we move through the next few slides, the images you will see were captured from the FY 2017 Proposed Rule published last year. 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 13, 2017. Clicking on “Comment Now!” takes you to the screen on slide number 41.

This is where you can enter your comments. Since you are commenting, this is obviously a required field as indicated by the letter ‘a’. You can enter up to 5,000 characters, and on the slide, indicated by letter ‘b’, you can see the number of characters remaining. On our next slide, slide 42, please direct your attention to the bottom of this page.

First of all, indicated by the letter ‘a’ on the slide notice that you are able to upload files. Secondly, indicated by the letter ‘b’, this is where you will enter your personal information. Note that only the state or province, zip code and country are required. On slide 43 we will look at the very bottom of this screen.
This is where you would note if you were or were not submitting on behalf of a third party, such as the ADCC or ASCO. 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 click “Continue” to go on to the screen shown on slide 44.

This is the preview page. It will show how your comments will appear on Regulations.gov. Additionally, your country and state and any uploaded files will appear. 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 click the box acknowledging that you read and understand the statement above, and then you can click on “Submit Comment.” This will take you to the screen shown on slide 45.

And lastly, this is your comment receipt. You are provided a comment tracking number as indicated on this slide, labelled letter ‘a’. If you would like you can take a screenshot of this page or save your tracking number otherwise. So, that wraps up your tour of entering a comment. Next slide, please.

We will conclude today’s event, as always, by reviewing important upcoming dates for the PCHQR Program, beginning on slide number 47.

Here you see a list of the upcoming PCHQR Program webinars. These are currently scheduled for the fourth Thursday of each month, but that is subject to change. As always, we will communicate the exact dates, title, purpose, and objectives for these events with you via ListServe starting approximately two weeks prior to the event. In May and July, we will have presentations on best practices. And in between, in June, we will have a follow-up to March on the Web-Based Data Collection Tool
focusing on the OCMs and EBRT. August is the bookend event to today’s event in what we are scheduled to discuss the FY 2018 Final Rule. Slide 48, please.

This slide lists the upcoming data submission deadlines. May 15 closes the data submission period, which opened April 1, during which you are submitting the CST data, as discussed last month, via the Web-Based Data Collection Tool. The CDC will also be submitting your quarter four 2016 HAI measures at this time. Please do not forget that this will be the first time that you are required to report your 2016–2017 influenza season data for the healthcare provider vaccinations. Then in August, there will be another entry of the CST data, more HAI information, and the annual submission of your OCM and EBRT data via Web-Based Data Collection Tool.

And lastly, here are the updates for public reporting for the PCHQR Program data. The April data was refreshed on the April 26. And for the 17th July Refresh, note that the Preview Period opened April 6 and will continue through May 5, with public posting currently scheduled for July 26. This will contain a refresh of the CST measures and HCAHPS, as well it will be the first public reporting of the EBRT data. In October, you can see that once more the CST and HCAHPS data will be refreshed. The Preview Period for this time period is now anticipated to be July 14 through August 13, with a refresh tentatively occurring on October 12. Please remember that all dates for public reporting are subject to change. As we get closer to the Preview Periods and refresh dates, we will always notify you of the exact dates via ListServe. With that I’m going to turn the event over to Deb Price to review the CE information for today’s event and then Caitlin will have a few closing remarks. Deb?

**Deb Price:** Well, thank you very much. 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 report
their own credits to their boards using the national provider number 16578. It is your responsibility to submit this number to your own accrediting body for your credits.

We now have an online CE certificate process. You can receive your CE certificate two ways. First way, if you registered for this webinar through ReadyTalk®, a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate. We will also be sending out the survey link in an email to all participants within the next 48 hours. If there are others that are listening to the event that are not registered in ReadyTalk®, please pass the survey to them. After completion of the survey, you notice at the bottom right-hand corner a little grey box that says “Done.” You will click the “Done” box, and then another page opens up. That separate page will allow you to register on our Learning Management Center. This is a completely separate registration from the one that you did in ReadyTalk®. Please use your personal email for this separate registration, so you can receive your certificate. Healthcare facilities have firewalls that seem to be blocking our certificates from entering your computer.

If you do not immediately receive a response to the email that you signed up with the Learning Management Center, that means you have a firewall up that’s blocking the link into your computer. Please go back to the “New User” link and register a personal email account. Personal emails do not have firewalls up. If you can’t get back to your “New User” link, just wait 48 hours because remember you’re going to be getting another link and another survey sent to you within 48 hours.

Okay, this is what the survey will look like. It will pop up at the end of the event and will be sent to all attendees within 48 hours. Click “Done” at the bottom of the page when you are finished.
This is what pops up after you click “Done” on the survey. If you have already attended our webinars and receive CEs, click “Existing User.” However, if this is your first webinar for credit, click “New User.”

This is what the new user screen looks like. Please register a personal email, like Yahoo or Gmail or AT&T, since these accounts are typically not blocked by hospital firewalls. Remember your password, however, since you will be using it for all of our events. Notice you have a first name, a last name, and the personal email. And, we’re asking for a phone number in case you have some kind of back side issues that we need to get in contact with you.

This is what the existing user slide looks like. Use your complete email address as your user ID, and of course the password you registered with. Again, the user ID is the complete email address including what is after the @ sign.

Okay, now I’m going to pass the ball back to your team lead to end the webinar, and to go over any questions that came in. Thank you for taking the time spent with me.

Caitlin Cromer: Thank you, everybody, for listening to the presentation. And, we look forward to reviewing your comments and including them for consideration for our Final Rule. Have a nice day everyone.