PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

Support Contractor

PCHQR Program Measure Overview: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy (PCH-30 and PCH-31)

Presentation Transcript

Speakers

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Lisa Vinson: Good afternoon and welcome to today's presentation entitled, *PCHQR Program Measure Overview: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy (PCH-30 and PCH-31).*

My name is Lisa Vinson, and I am the program lead for the PPS-Exempt Cancer Hospital Quality Reporting, or PCHQR, Program with the Hospital Inpatient Value, Incentives, and Quality Reporting, or VIQR, Outreach and Education Support Contractor. I will be the moderator for today's event. As the Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy, also known by its short name Outpatient, or OP, Chemo measure, has also been added to the Hospital Outpatient Quality Reporting Program, I would like to emphasize that the specific content for today's webinar is only applicable to the participants in the PPS-Exempt Cancer Hospital Quality Reporting Program as it relates to participation and reporting in CMS Quality Reporting Programs. Please be sure to refer to information regarding this measure provided by the support contractor for your program. As a reminder, the slides for today's event were posted on *QualityReportingCenter.com* prior to the event. The questions and answers, transcript, and recording of today's event will be posted on the same web site and *QualityNet.org* in the near future. Lastly, if you have questions as we go along through today's presentation, please type your question in the chat window. At the end of this event, we will have a question-and-answer session. For the speakers to best answer your question, we ask that, at the beginning of your question, please reference the slide number along with your question in the chat window. Questions that are not addressed during this question-and-answer session will be posted to the *QualityReportingCenter.com* web site at a later date. Next slide, please.

Our guest speakers for today are from the Mathematica Policy Research, or MPR, team, which is the measure developer for the Outpatient Chemotherapy measure. I would like to welcome both Mario Marchesi and Jessica Ross, who are both chemotherapy measure leads with MPR.

However, before I turn the presentation over to our first guest speaker, I would like to cover a few of our standard slides and provide some background information on the Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy measure. We will begin with our list of acronyms and abbreviations. Next slide, please.

Here's a list of acronyms and abbreviations you may hear during today's presentation. These are quite familiar to the participants in the program and regular attendees of our events. Acronyms and abbreviations you may hear today include: ED, for Emergency Department; FFS, for Fee-for-Service; FSR, for Facility-Specific Report; RSAR, for Risk-Standardized Admission Rate; and RSEDR, for Risk-Standardized ED Visit Rate. Next slide, please.

The purpose of today's presentation is to provide a review of the Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy measure for the PCHQR Program. Our guest speakers will be providing an overview of how the measure is specified and calculated, an overview of the upcoming confidential reporting period via distribution of the Facility-Specific Reports, or FSRs, and information on how to interpret measure results. Next slide, please.

We hope that today's presentation will assist you with understanding how the chemotherapy measure is specified and calculated in the PCHQR Program, provide you with information on how to interpret measure results for the upcoming confidential reporting of PCH-30 and PCH-31 via the Facility-Specific Reports, and that you will be able to answer questions related to the measure calculation and confidential reporting. Next slide, please.

As stated earlier, I will now provide a brief background on the Outpatient Chemotherapy measure. This claims-based outcome measure was adopted into the PCHQR Program in the Fiscal Year 2017 IPPS/LTCH PPS Final Rule which was published on August 22 of 2016. By clicking on the link provided on this slide, you will be taken directly to the *Federal Register* publication of this rule, and the specific page numbers pertaining to the

OP Chemotherapy measure are provided here as well. This measure was effective for the Fiscal Year 2019 Program Year, and the data collection period was finalized for July 1, 2016 through June 30, 2017. Then, the measure will be calculated for subsequent years using data from July 1 through June 30. Since it is claims-based, there are no additional data submission requirements for the PCHs for this measure. Next slide, please.

As cited in the Fiscal Year 2017 final rule, this measure aims to assess the care provided to cancer patients and encourages quality improvement efforts to reduce the number of unplanned inpatient admissions and ED visits among cancer patients receiving chemotherapy in a PCH outpatient setting. Improved PCH management of the potentially preventable symptoms, including anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis could reduce unplanned admissions and ED visits for these conditions. Measuring unplanned admissions and ED visits for cancer patients receiving outpatient chemotherapy would provide PCHs with an incentive to improve the quality of care for these patients by taking steps to prevent and better manage side effects and complications from treatment. In addition, the Outpatient Chemotherapy measure meets the two National Quality Strategy priorities listed on this slide: promoting effective communication and coordination of care and promoting the most effective prevention and treatment practices for the leading causes of mortality. Next slide, please.

It is important to note that this measure does not target a specific symptom but rather assesses the overall management of ten important symptoms that studies have identified as frequent reasons for ED visits and inpatient admissions in this population, and it assesses the care outcomes that matter to patients, rather than measuring processes to detect and treat these conditions. Other important key points about this measure are it is risk standardized; it includes patients who are 18 years or older and receiving outpatient chemotherapy at a PCH for all cancer types, except for leukemia; qualifying diagnosis on the admission or ED visit claim must be the primary diagnosis or a secondary diagnosis accompanied by a primary diagnosis of cancer; the window for identifying events is limited to 30

days following the PCH outpatient chemotherapy treatment encounters; and this measure identifies outcomes separately for the inpatient admission and ED measures. At this time, I would like to turn the presentation over to Mario Marchesi. Mario, the floor is yours.

Mario Marchesi: Thank you, Lisa. My name is Mario Marchesi. I'm an analyst at Mathematica Policy Research and will be providing an overview of PCH measures 30 and 31, the Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy measure, which I'll refer to as the Chemotherapy measure for the remainder of the presentation. The goal of today's presentation is to provide a foundational understanding of the measure, its specifications, and how to interpret measure results. In order to achieve this goal, I will provide a high-level summary of the measure, walk through the measure specifications, describe measure calculation and risk standardization, provide an overview of how the measure will be confidentially reported and how to interpret measure results, and, finally, go over how to access additional measure resources.

The Chemotherapy measure is a claims-based outcome measure which estimates hospital-level risk-adjusted rates of inpatient admissions and ED visits for cancer patients 18 years of age or older for at least one of ten potentially preventable diagnoses within 30 days of hospital-based outpatient chemotherapy treatment. The measure's results are intended to assess the care provided to cancer patients and encourage quality improvement efforts to reduce the number of potentially avoidable hospital admissions and ED visits among cancer patients receiving chemotherapy in a hospital outpatient setting. The ten qualifying outcome diagnoses (anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, and sepsis) are commonly cited reasons for hospital visits among cancer patients receiving outpatient chemotherapy treatments and are potentially preventable through appropriately managed outpatient care and increased communication with the patient. Improved hospital management of these potentially preventable symptoms could reduce admissions and ED visits and increase patient quality of care and quality of life. The goal of this measure is not to achieve zero admissions

or ED visits, but rather, the measure focuses on relative performance across hospitals. CMS will confidentially report results to facilities starting in October of 2018 and use Medicare claims data for chemotherapy treatments performed from July 1, 2016 through June 30, 2017 as a performance period. Because this is a claims-based measure, there's no requirement for facilities to provide any additional data, as all measure calculation will be done using existing claims data. All facilities in the PCHQR Program with at least one patient who receives a qualifying chemotherapy treatment during the performance period will be included in measure calculation. The next round of confidential reporting is scheduled for spring of 2019 using a performance period of July 1, 2017 through June 30, 2018.

The measure cohort, or denominator, includes Medicare Fee-for-Service patients 18 years of age or older with a diagnosis of cancer receiving outpatient chemotherapy treatment. The measure includes all adult patients, rather than only those age 65 or older, to assess a broader population and more comprehensively evaluate the quality of care provided. The measure has three exclusion criteria. First, patients with a diagnosis of leukemia at any point during the performance period are excluded from the measure. Given the high toxicity of treatment and recurrence of disease, admissions among this population do not reflect poorly managed outpatient care. Patients with leukemia have a higher expected admission rate due to frequent relapse, which is not the type of admission the measure intends to capture. Second, patients who are not enrolled in 12 months of continuous Medicare Fee-for-Service Parts A and B prior to their first chemotherapy treatment during the performance period are excluded. The measure excludes these patients to ensure that complete patient diagnosis data will be available for the risk adjustment model which uses the year before the first chemotherapy treatment during the period to identify comorbidities. Finally, number three, patients who are not continuously enrolled in Medicare Fee-for-Service Parts A and B in the 30 days after any chemotherapy treatment during the performance period, the measure excludes these patients to ensure that full data will be available for outcome assessment.

The measure assesses two separate but related outcomes for this population, so the measure has two rates. The first rate measures whether one or more inpatient hospital admissions occurred within 30 days of an outpatient chemotherapy treatment with at least one of the ten potentially preventable qualifying diagnoses, and these diagnoses qualify for the outcome if they are either in the primary diagnosis, signaling that they were the reason for the admission, or are present as a secondary diagnosis with a primary diagnosis of cancer. The second rate measures whether one or more ED visits occurred within 30 days of an outpatient chemotherapy treatment with the same ten qualifying diagnoses. Some important details are that, if someone experiences both an inpatient hospital admission and ED visit, we count the inpatient hospital admission but not the ED visit, and, if someone has multiple inpatient hospital admissions, only the first one counts. In this respect, it's a patient-level measure assessing whether at least one of these outcomes occurred, not an event- or a case-level measure. Finally, both of these two rates are risk adjusted using age, sex, chemotherapy exposure, and a number of comorbidities that I won't go through here but are listed in Appendix B of the measure's technical report, which can be found on the measure's *QualityNet* page.

On the slide, you'll see the equation used to calculate both risk-standardized rates used in the measure. We divide a facility's predicted outcomes by expected outcomes and then multiply it by the national observed rate. Estimates of the expected number of outcomes for each hospital are calculated using the hospital's patient mix and the average hospital-specific intercept. That is the average intercept among all hospitals in the sample. The measure estimates the predicted number of outcomes for each hospital using the same patient mix but an estimated hospital-specific intercept. For more detailed information on the measure's risk-adjusted model, please review Appendix B of the measure's technical report, which can be found on the measure's *QualityNet* page.

CMS will create and distribute Facility-Specific Reports, also known as FSRs, for each facility included in the measure calculation and provide the FSRs to facilities during the confidential reporting period. The FSR is a

read-only document which prevents users from unintentionally altering its content. If you wish to make changes to the file, you may use the Save As option to create a new version under a different name. The FSR contains the following five worksheets: Worksheet Number 1, titled Chemotherapy Measure Workbook, is a cover page with a link to the measure page on *QualityNet* and the measure inbox for directing questions. Link [Worksheet] 2, Table 1 Performance Results, includes each facilities risk-standardized rate and associated performance category. This page displays your facility's results for the Chemotherapy measure and also displays the observed rate at your facility and for the 11 PCH facilities in the nation. There are two separate columns which show the information for the inpatient admission outcome and the ED visit outcome. Tab [Worksheet] 3, titled Table 2 Distribution of Facility Performance, is a table that presents the distribution of PCH facilities by performance category at all 11 PCH facilities across the nation. Again, there are separate columns to show information for the inpatient admissions outcome and the ED visit outcome. Tab [Worksheet] 4, titled Table 3 Patient Information, [patient] level data for all eligible patients at your facility that met the inclusion criteria for the Chemotherapy Measure. The table includes each patient at your facility who met inclusion criteria and also those who were excluded from the measure, and the reason for exclusion will be denoted in column F of the table. Tab [Worksheet] 5, Table 4 Case Mix and Comparison, case mix information for patients at your facility and across all PCHs in the nation will be displayed on this table. With the data in this worksheet, you can assess your facility's case mix compared with other facilities' case mixes. The case mix information presented in these tables may help you understand differences between the observed rate and the risk-standardized rate in Table 1 in this workbook. Finally, please note that there's also an FSR user guide available on the measure's *QualityNet* page which provides a more in-depth explanation of each section of the FSR.

As noted earlier, for each facility CMS calculates two rates: a Risk-Standardized Admission Rate and a Risk-Standardized Emergency Department Rate that adjusts for differences in case mix across facilities and a facility-specific effect. To categorize facility performance, CMS

also calculates a corresponding 95% interval estimate for each facility's risk-standardized rates. The interval estimate represents the range of probable values for the rate. A 95% interval estimate indicates that there's a 95% probability that the true value of the risk-standardized rate lies between the lower limit and the upper limit of the interval.

CMS assigns facilities to performance categories by comparing each facility's interval estimate to the national observed hospital admission rate and national observed ED visit rate, respectively. Comparative performance for facilities with a sufficient number of patients is classified as follows: A facility is considered to have a performance worse than a national rate if the entire 95% interval estimate of the facility's rate is higher than the national observed outcome rate. A facility is considered to have a performance no different from the national rate if the 95% interval estimate of a facility's rate includes the national observed outcome rate. A facility is considered to have a performance better than the national rate if the entire 95% interval estimate of the facility's rate is lower than the national observed outcome rate. Finally, if a facility has fewer than 25 patients, CMS assigns the facility to a separate category called Number of Facilities in the Nation That Had Too Few Cases. Results will still be provided to these facilities in their FSRs.

And, finally, although CMS provides information to facilities on performance categories, the measure results will not be publicly reported during the January 2019 or spring 2019 *Hospital Compare* releases. These results will be reported confidentially.

There are several resources available on the Chemotherapy measure's PCHQR [Program] *QualityNet* page, including a frequently-asked-questions document, measure fact sheet, methodology document (such as a technical report and the measure data dictionary), and the FSR user guide. The link on this page will take you to the PCHQR [Program] *QualityNet* page. Additionally, if you have specific questions in the future, please feel free to use the *QualityNet* Questions and Answers Tool. This will direct your question to the measure's Help Desk, which will provide you which a detailed response to your question. The second link on this

slide will take you to that Help Desk. Thank you again, and I'm going to turn the presentation back over to Lisa.

Lisa Vinson: Thank you, Mario, for providing this valuable information on the Outpatient Chemotherapy measure. I am sure our program participants have found this to be very beneficial. Now, we will review some important key dates and reminders that pertain to the PCHQR Program. Next slide, please.

First, the dates for our next two Outreach and Education Events have been tentatively scheduled for November 29 and December 19. As always, we will provide the topic, purpose, and objectives starting at least two weeks in advance of the scheduled date. As future events for the upcoming year are in the process of being developed, please consider providing feedback on topics you would like to see presented. You can always provide your suggestions via the post-event survey, specifically question number 11 and the *QualityNet* Q&A tool, or Questions and Answers Tool, which I will review shortly. Second, our upcoming data submission deadline dates and data contained within that period have been provided to you as well here on this slide. Next slide, please.

The October 2018 *Hospital Compare* refresh of the data displayed on this slide is tentatively scheduled for October 31, 2018, which is in a few days. Then, the January 2019 *Hospital Compare* Preview Period is tentatively scheduled for November 17 through December 16, and the refresh is anticipated to occur on January 30, 2019. Please remember that all dates for public reporting are subject to change. As we get closer to the preview periods and refresh dates, we will always notify you of the exact dates via ListServe communication. Next slide, please.

As a support contractor, we are available to answer questions you may have, and the *QualityNet* Questions and Answers Tool can assist you with this task. As illustrated on this slide by the red box on the right-hand side, this is the *QualityNet* Questions and Answers Tool for the PPS-Exempt Cancer Hospitals, which is found on the *QualityNet* home page. Also, remember that if you are a first-time user you will need to complete the registration process to establish your login credentials. Next slide, please.

Once you click the PPS-Exempt Cancer Hospitals link on the *QualityNet* home page, as shown previously, you will be taken to this screen where you will be able to select your program topic. The red box on this slide denotes what your selection should be if you wish to submit an inquiry to the PCHQR Program queue. Next slide, please.

Lastly, as Mario referenced earlier during this event, you will be able to submit your inquiry directly to the OP Chemotherapy measure Help Desk by selecting the PCH-30/31: Admissions and ED Visits for Patients Receiving OP Chemotherapy link as indicated by the red circle on this slide. This link will be a new addition to the PCHQR Program Select an Answer Category section once it becomes available. Again, you can also provide suggestions regarding future webinar topics via this tool as well. Next slide, please.

Now, we will begin our question-and-answer session. Mario, along with Jessica Ross, will be addressing the questions submitted as time allows. We will not be asking questions in any particular order as to how they were received in the chat box. Please remember: If we do not address your question today, all questions and answers will be posted to *QualityReportingCenter.com* in the near future. So, let's get started. Our first question is: Why are only patients with leukemia excluded and not those with other hematologic cancers?

Mario Marchesi: Hi, Lisa. It's Mario from Mathematica. To answer your question, CMS specified the measure to be as inclusive as possible, and so, therefore, CMS excluded only those patient groups which hospital visits were not typically a quality signal or for which risk adjustment would not be adequate. CMS decided during the development to limit the exclusion criteria to only those patients with leukemia based on feedback from earlier public comments suggesting that exclusions for all patients with a hematologic malignancy would be too broad. Analyses showed that patients with lymphoma and multiple myeloma have similar rates of admissions and ED visits when compared with patients with other non-leukemia cancer types. In addition to this, we decided to risk adjust for both lymphoma and multiple myeloma in the risk model.

Lisa Vinson: Thank you. Next question: My facility does not have an emergency department. How can the measure capture ED visits for patients receiving outpatient chemotherapy in my facility?

Mario Marchesi: Well, patients receiving outpatient chemotherapy at your facility are not required to visit your emergency department in order to be captured in the outcome. Outpatient chemotherapy patients at your facility who visit any emergency department for a qualifying diagnosis within 30 days of chemotherapy will be considered. Using Medicare Fee-for-Service claims, we're able to review the patient experience across all facilities.

Lisa Vinson: Thank you. Next question: How does CMS account for differences in the patient characteristics of PCHs and non-PCHs?

Mario Marchesi: The measure uses risk-standardized rates of hospital visits to account for the fact that patient characteristics may vary by facility type. The risk adjustment models account for patient-level factors that affect the probability of having a hospital visit. So, that ensures fair treatment of all facilities that see different kinds of patients regardless of whether they're a PCH or a non-PCH facility. Furthermore, since the measure's calculation is separate for PCHs and non-PCHs, the risk adjustment models also have different co-efficients for identified risk factors. So, therefore, while the same set of risk factors are applied in both programs, only information from the patients seen at the 11 PCHs are used to determine the numerical value of the risk factor co-efficiencies for the PCHQR Program.

Lisa Vinson: Thank you. Next question: How are multiple ED visits or hospitalizations weighted in the measure calculation?

Mario Marchesi: Hi, Lisa. Thank you. So, if a patient has multiple ED visits, we really only capture that first ED visit. So, we're just looking at a patient level if one or more outcomes occurred.

Lisa Vinson: Okay. Thank you very much, Mario, for addressing the questions we received today during our presentation. Please remember that if your question was not addressed, a transcript of the questions and answers will

be posted on *QualityNet.org* and *QualityReportingCenter.com* at a later date. Next slide, please.

In closing, as always, we would like to thank everyone for their time, attention, and participation during today's event. We do hope that this information was beneficial to you. Thank you so much and enjoy the remainder of your day.