PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

Support Contractor

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

Presentation Transcript

Speaker

Mario Marchesi, MPA
Chemotherapy Measure Lead, Mathematica

Moderator

Lisa Vinson, BS, BSN, RN
PCHQR Program Lead
Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor

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Lisa Vinson: Good afternoon and welcome to today's presentation entitled, *PCHQR Program Measure Update: Admissions and Emergency Department 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 Inpatient Value, Incentives, and Quality Reporting, or VIQR, Outreach and Education Support Contractor. I will be the moderator for today's event. Our guest speaker for today is Mario Marchesi, who serves as the Chemotherapy Measure Lead for Mathematica. Of note, and as you may be aware, Mathematica is the measure developer for the Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy measure. As this measure is also included in the Hospital Outpatient Quality Reporting, or OQR, 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. Along the same lines, we felt that this topic and the information we will be providing today will be beneficial to the PCHs as they recently received their Facility-Specific Reports, or FSRs, about two months ago, back in April. We received feedback that information pertaining to the measure refinements would be helpful to the PCHs in gaining a better understanding of the measure results found in their FSRs. If you have questions as we go through today's presentation, please type your question in the chat window. At the end of this event, there will be a questions-and-answers session. For our speaker to best answer your question, we ask that, at the beginning of your question, to please reference the slide number, along with your question in the chat window. Questions that are not addressed during the questions-and-answers session will be posted to *QualityNet* and *Quality Reporting Center* websites at a later date. Furthermore, the slides for today's event were posted on *QualityReportingCenter.com* prior to the event. The transcript and recording of today's event will be posted on the same website and *QualityNet* in the near future as well.

Here's a list of acronyms and abbreviations you may hear during today's presentation. These are quite familiar to participants in the program and regular attendees of our event. Acronyms and abbreviations you may hear today include ED for Emergency Department, FFS for fee for service, FSR for Facility-Specific Report, OP for outpatient, RSAR for Risk-Standardized Admission Rate, and RSEDR for Risk-Standardized ED Visit Rate.

The purpose of today's event is to review the refinements made to the measure specifications for PCH-30 and PCH-31 for the April 2019 measure calculations. We will also review measure calculation, risk standardization, and ways to interpret measure results for the April 2019 Facility-Specific Reports, or FSRs.

At the culmination of today's event, we hope that you will be able to identify pertinent refinements made to the measure specifications, understand the measure results provided in the FSRs, and locate PCH-30 and PCH-31 tools and resources on the *QualityNet* website.

Before I hand the presentation over to our guest speaker, I would like to provide an overview of today's event as you see listed on this slide, and I will also delve into some of the background information on the Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy measure. So, for today, our discussion points will include a summary of the chemotherapy measure; a summary of the measure refinements, which were recently made for the April 2019 measure calculation; the measure specification, calculation, and risk standardization; the confidential reporting or review of the chemotherapy measure via the FSRs; interpretation of the measure results; and questions related to the measure calculation and confidential reporting, which will be addressed during the questions-and-answers segment towards the end of today's presentation.

The Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy measure was adopted for inclusion in the PCHQR Program in the Fiscal Year 2017 IPPS/LTCH PPS Final Rule. On this slide, you

will find a hyperlink that will direct you to the *Federal Register* version of the final rule, and the page citation is noted here as well. This measure was effective for the PCHQR Program for the fiscal year 2019 program year, and the data collection period was finalized for July 1, 2016 through June 30, 2017. You may recall that the national confidential dry run was conducted in 2017, and the purpose of this dry run, as with any dry run, was to prepare the PCHs for public reporting of the measure results prior to the public display of this information on *Hospital Compare*. Subsequently, the measure results were then confidentially reported in October 2018 for the July 1, 2016 through June 30, 2017 performance period and most recently in April 2019 for the July 1, 2017 to June 30, 2018 performance period. We would like to point out that the version of the measure reported in October 2018 used the same specifications as the dry run due to production timeline restraints. Furthermore, the April 2019 version includes refinements, which is one of the main discussion points of today's presentation. Future confidential reports, such as for calendar year 2020 and forward, will include further refinements which are being or will be explored in measure re-evaluation. Lastly, this measure was recommended for endorsement by the NQF Cancer Committee in February of this year.

Here is more background information on the OP chemotherapy measure, some of which will be discussed further during today's event. First, this measure is a risk-standardized measure, which includes patients who are 18 years or older, receiving outpatient chemotherapy in a PCH for all cancer types, except for leukemia. Second, this measure uses one year of Medicare FFS Parts A and B administrative claims data. Therefore, it is a claims-based measure and there are no additional submission requirements by the PCHs. Third, this measure requires that the qualifying diagnosis on admission or the ED visit claim, be the primary diagnosis or a secondary diagnosis accompanied by a primary diagnosis of cancer. Fourth, this measure has a 30-day window after PCH outpatient chemotherapy treatment encounters for identifying events. And lastly, this measure identifies outcomes separately for the inpatient and emergency department visits. So, if a

patient experiences both outcomes during the performance period, then the outcome is counted towards the inpatient admission outcome.

To add, overall, this measure aims to assess care provided to cancer patients and encourage quality improvement efforts to mitigate the occurrence of the 10 potentially preventable symptoms, which include anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis. Ultimately, this could reduce unplanned admissions and ED visits in PCH outpatient settings for these conditions. It is important to note that unplanned admissions have negative impacts on patients, caregivers, and clinical resources. As we have discussed in a few of our earlier education events this year, CMS has made a concerted effort to align program measures with their current aims and goals. Therefore, this measure does address two National Quality Strategy priorities: promoting effective communication in coordination of care and promoting the most effective prevention and treatment practices for the leading causes of mortality. Now, I would like to turn the presentation over to Mario. Mario?

Mario Marchesi: Thank you, Lisa. My name is Mario Marchesi. I'm an analyst at Mathematica and will be providing an overview of PCH measures 30 and 31, the Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy, which I will refer to as the "chemotherapy measure" for the remainder of this presentation. The goal of today's presentation is to provide a foundational understanding of the measure, its specification, and how to interpret measure results. In order to achieve this goal, I'll provide a high-level summary of the measure, walk through of the measure's refinements made during re-evaluation in 2018, 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 access to additional measure resources. The chemotherapy measure is a claims-based outcome measure, which estimates hospital-level, risk-adjusted rates of inpatient admissions and repeat visits for cancer patients 18 years of age or older per at least one of 10 potentially

preventable diagnoses within 30 days hospital-based outpatient chemotherapy treatment. The measure 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 10 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 patients' quality of care and quality of life. The goal of this measure is not to achieve zero admissions or ED visits. Rather, the measure focuses on relative performance across hospitals. CMS confidentially reported results for facilities in the PCHQR Program in April 2019 using Medicare claims data for chemotherapy treatments performed from July 1, 2017 through June 30, 2018, as the performance period. Because this is a claims-based measure, there are no additional requirements for a facility to provide any data, as all measure calculation was done using existing claims. All facilities in the PCHQR Program with at least one patient who received a qualifying chemotherapy treatment during the performance period were included in measure calculation. The next round of confidential reporting is scheduled for spring 2020 using a performance period of July 1, 2018 through June 30, 2019.

CMS conducts measure re-evaluation on an annual basis in order to refine the measure based on stakeholder feedback and recommendations from the measures expert workgroup, a panel of clinicians with expertise in oncology care. The measure results reported to facilities in April were calculated using updated measure specifications that include several refinements made during the 2018 re-evaluation of the measure. The following refinements were made. Refinement one, CMS added a cohort exclusion for patients receiving chemotherapy for non-cancer treatment. Stakeholder feedback suggested patients were included in the measure

cohort due to receipt of chemotherapy for non-cancer conditions, typically autoimmune conditions. CMS identified 20 existing chemotherapy administration codes in the measure's denominator that had been approved for billing for non-cancer chemotherapy administration. The new exclusion seeks to ensure that non-cancer patients are not included in the measures cohort. The exclusion assesses if a patient's claim has one of these 20 codes, a qualifying autoimmune condition known to be treated with chemotherapy agents, and does not have a cancer diagnosis. If all of these conditions are met, then the case is excluded from the denominator. Refinement 2, exclusions of patients with leukemia and remission. The original measure specification included patients receiving chemotherapy with a diagnosis of leukemia and remission in the cohort. Stakeholder feedback suggested all leukemia patients, even those in remission, should be excluded. The updated measure specification now excludes all patients with a diagnosis of leukemia. Refinement 3, removal of admissions for procedures and diagnoses considered always planned from the measure outcome. Facilities indicated that some inpatient admissions attributed to their hospital were planned admissions. These planned admissions were for procedures such as stem cell transplantation and CAR-T cell therapy. The measure now excludes planned inpatient hospital admissions from the measure outcome using the "always planned" diagnoses or procedure groups defined in the existing planned admission algorithm, which is outlined in detail in the 2018 annual updates and specifications report. Refinement 4, addition of risk model variable that assesses whether or not a patient has concurrent radiotherapy and chemotherapy. Stakeholders, including the National Quality Forum, noted that patients receiving concurrent radiotherapy and chemotherapy are at a higher risk for an outcome due to higher toxicity of combined treatment. Stakeholders were concerned about the impact on facilities with high number of patients receiving some mild treatment. Updates to the risk adjustment models to add a patient-level risk factor that assesses whether patients index outpatient chemotherapy case, which is the case included in the measure denominator, was accompanied by concurrent radiotherapy, which is defined as receipt of radiotherapy on the date of the chemotherapy, or up to 14 days before the administration, was added to both measures risk

models. Refinement 5, minor refinements to the measure numerator and denominator code set. This includes annual updates based on changes to ICD-10, HCPCS and CPT code sets, as well as a thorough review of the existing numerator code sets, with the goal of removing diagnoses codes not associated with chemotherapy in cancer care. Overall, 17 codes were removed from the numerator code sets in this review. For more detailed explanations of each measure refinement and an overview of the impacts on measure results, please review the 2018 annual updates and specifications reports available on the chemotherapy measure *QualityNet* page, filed under measure methodology.

The measure cohort for [the] denominator includes Medicare fee for service patients aged 18 years or older with a diagnosis of cancer receiving outpatient chemotherapy treatment. The measure includes all adult patients, rather than only those aged 65 or older, to assess a broader population and more comprehensively evaluate the quality of care provided.

The measure has four inclusion criteria. Criteria one, 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 that this measure intends to capture. Exclusion 2, patients who are not enrolled in 12-month continuous Medicare fee for service Part A and B prior to their first chemotherapy treatment during the performance period. 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 their first chemotherapy treatment during the period to identify co-morbidities. Exclusion 3, patients who are not continuously enrolled in Medicare fee for service Part 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. Exclusion 4, as discussed in the measure refinement section, the measure now excludes cases in which

patients received chemotherapy for non-cancer treatment. The measure excludes these patients as inclusion of chemotherapy administration for non-cancer conditions is not aligned with the measures intent.

The measure assesses two separate-but-related outcomes for this population. The measure has two rates. The first rate measures whether one or more inpatient hospital admission occurred within 30 days of outpatient chemotherapy treatment, with at least one of 10 potentially preventable qualifying diagnoses. These diagnoses qualified for the outcome if they are either the primary diagnosis, signaling that was the reason for admission, or are present as the 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 10 qualifying guidelines. Some important details are that, if someone experiences both an inpatient hospital admission and an ED visit, we count the inpatient hospital admission but not the ED visit, and, if someone had multiple inpatient hospital admissions, only the first one counts. In this respect, if the patient-level measure is testing whether at least one of these outcomes occurred, not an event or case-level measure. Finally, both of these two rates are risk adjusted using age, exposure, and the number of co-morbidities that I won't go through here, that are listed in Appendix B of the measure's technical report, which can be found on the measure's *QualityNet* page.

On this slide, you'll see the equation used to calculate both risk-standardized rates we use in the measure. We divide a facility's predicted outcomes by expected outcomes and then multiply by the national observed rate. Estimates of expected number of outcomes for each hospital is calculated using the hospital's patient mix and an 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 adjustment model, please review Appendix B of the measure's technical report, which can be found on the measure's *QualityNet* page.

As noted previously, CMS distributed Facility-Specific Reports, FSRs, for each facility included in measure calculation in April 2019. 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 1, chemotherapy measure workbook, which is a cover page with a link to the measure's page on the *QualityNet* website and the measure inbox for directing questions. Worksheet 2, Table 1, performance results. This includes each facility's risk-standardized rates and associated performance category. It displays each facility's results for the chemotherapy measure and also displays the observed rate at a facility, and for the 11 PCH facilities in the nation. There are two separate columns which show the information for the inpatient admissions outcome and the ED visit outcome. Worksheet 3, Table 2, distribution of facility performance. This table presents the distribution of PCH facilities by performance category across the nation for the chemotherapy measure during the performance period. Again, separate columns show information for the inpatient admission outcomes and the ED visit outcomes. Worksheet 4, Table 3, patient information. This table provides patient-level data for all eligible patients at a given PCH that met inclusion criteria for the chemotherapy measure. Please note that excluded patients are also included in this table, and they're denoted as such in [the] column part of the table. Worksheet 5, Table 4, case mix comparison. This table provides case mix information for patients at your facility and across all PCHs in the nation. With the data in this worksheet, you can assess your facility's case mix compared to other facility case mix in the nation. The case mix information presented in these tables may help you understand differences between the observed rate and risk-standardized rate in Table 1 of this workbook. Please note that there is also an FSR user guide available on the measure's *QualityNet* page, which provides a more in-depth explanation for each section of the FSR.

As noted earlier, for each facility, CMS calculates two rates, a Risk-Standardized Admissions Rate and a Risk-Standardized Emergency Department rate that adjusts for differences in case mix across facilities in

a facility-specific effect. To categorize facility performance, CMS also calculates the corresponding 95 percent interval estimates for each facility's risk-standardized rate. The interval estimate represents the range of probable values for the rate. A 95 percent interval estimate indicates that there's a 95 percent probability that the true value of the risk-standardized rate lies between the lower limit and the upper limit of the interval.

CMS assigns facility performance categories by comparing each facility's interval estimate to the national observed hospital admission rate and national observed ED visit, 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 the national rate" if the entire 95 percent 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 percent interval estimate of the 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 percent interval estimate of the facility's rate is lower than the national observed outcome rates. If a facility has fewer than 25 patients, CMS assigns the facility a separate category, number of facilities in the nation that had too few cases. Results will still be provided for these facilities in an FSR. Finally, although CMS provides information to facilities on performance categories, the measure results will not be publicly reported for this measurement period.

There are several resources available on the chemotherapy measures PCHQR [Program] *QualityNet* page, including an FAQ document, measure factsheet, methodology document such as the measure's annual update and specification report, and measure data dictionary, and the FSR user guide. The link for the page can be found on this slide. Additionally, if you have specific questions in the future, please feel free to use the *QualityNet* Questions and Answers tool. This will direct your questions to the measure's Help Desk, which will provide you with a detailed response.

The link for the Help Desk is also found on this slide. And with that, I'm going to turn things back over to Lisa to wrap up this webinar.

Lisa Vinson: Thank you, Mario. At this time, I would like to review a few important PCHQR Program dates and reminders.

Our next Outreach and Education event is tentatively scheduled for Thursday, July 25. We will provide the topic, purpose, and objective, starting at least one to two weeks in advance of the scheduled date. I would like to encourage our program participants to continue to provide feedback, as we receive for today's event, on topics you would like presented. We are always brainstorming and developing ideas for future events, and your feedback is valuable. You can always provide your suggestions via the post-event survey and/or the *QualityNet* Questions and Answers tool, which I will review shortly. Second, our upcoming data submission deadline dates and data contained within that period are provided here as well. Wednesday, July 3, Quarter 1 2019 HCAHPS survey data are due. Thursday, August 15, Quarter 1 HAI measure data for CAUTI, CLABSI, SSI, MRSA, and CDI are due. The calendar year 2018 measure data for the OCMs and EBRT are due as well. On Tuesday, September 3, the fiscal year 2020 Data Accuracy and Completeness Acknowledgement, also known as the DACA, is due. This attestation will be submitted electronically via the *QualityNet Secure Portal*.

For the July and October 2019 *Hospital Compare* refreshes, the data listed on this slide will be publicly reported. You will note that the HAI measures listed under the October 2019 refresh are currently proposed for public display in the Fiscal Year 2020 IPPS/LTCH PPS Proposed Rule. Also, the last display of the CST hormone data will occur in October 2019 as well. 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 notify you of these exact dates via Listserv communication.

As mentioned earlier, the *QualityNet* Questions and Answers tool should be utilized to address any questions you may have pertaining to the Admissions and ED Visits for Patients Receiving Outpatient

Chemotherapy measure. On the next series of slides, we will review how this process will look when you access the tool. Ultimately, the VIQR support contractor team is available to answer questions you may have, and this tool can certainly 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 Hospital, which is found on the *QualityNet* home page. If you are a first-time user, you will need to complete the registration process to establish your login credentials. Once you have completed the registration process and logged in, you will be directed to the page on the next slide.

So again, once you click the PPS-Exempt Cancer Hospitals link on the *QualityNet* home page as shown on the previous slide, you will be taken to this screen, where you are 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 for the PCHQR Program.

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 box on this slide. This link was added to the PCHQR Program Select An Answer category section last year. Please remember that this tool is not limited to questions pertaining only to the OP chemotherapy measure. You can also provide suggestions regarding future webinar topics [and] inquire about program requirements and measures via this tool as well.

Now, we would like to address a few questions we have received. As I mentioned at the start of our event, we will address as many questions as time allows. If we're not able to address your question during this period, the questions-and-answers summary documents will be posted at a later date on both *QualityNet* and *Quality Reporting Center* websites. So, let's begin with our first question. Did CMS consider excluding patients receiving concurrent radiotherapy and chemotherapy given the higher toxicity of combined treatment? Mario?

Mario Marchesi: Hi, Lisa. Thanks. So, yes, CMS did consider this approach initially, but ultimately, we opted for a risk-adjustment approach, and this was after we conferred with our expert workgroup. So, the expert workgroup recommended a risk-adjustment approach because, in their clinical opinion, this approach would more likely incentivize better coordination and management of care for these beneficiaries, rather than just excluding these cases.

Lisa Vinson: Thank you. Our next question: Did CMS consider using "present on admission" information to refine the measure outcome?

Mario Marchesi: Thanks, Lisa. Yes. CMS did consider this approach and, while we explored using "present on admission" information to refine the measure outcome, we observed in the data that not all hospitals included in the Hospital Outpatient Quality Reporting Program were consistently reporting.

Lisa Vinson: Thank you. What were the overall impacts of the five measure refinements on the measure results?

Okay. We can move to the next question. When will the PCH-30 and PCH-31 measure be publicly reported on *Hospital Compare*? As you may recall, the PCH-30 and 31 measure was proposed in the Fiscal Year 2020 IPPS/LTCH PPS Proposed Rule, which was published in May. The proposal did indicate that this measure is being proposed for public display beginning with calendar year 2020. So, CMS's final decision on this proposal, along with the other PCHQR Program proposals, will be addressed in the Fiscal Year 2020 IPPS/LTCH PPS Final Rule, which is customarily published in August. So, the VIQR support contractor will communicate via Listserv when the final rule is available.

Mario Marchesi: Hi Lisa. This is Mario. I think I got cut off during my last response, although I'm not sure at what point I got cut off.

Lisa Vinson: Okay. So, would you like to readdress where you finished? Did CMS consider using the "present on admission" information?

Mario Marchesi: Sure, if that's okay with you, and apologies …

Lisa Vinson: Sure.

Mario Marchesi: … for the technical difficulties and apologies if I'm repeating myself at all. So, we did consider that approach, and we looked at "present on admission" information, and we looked at the data to see if it would be useful in refining the measure outcome. But, when we dug into the data, we observed that not all hospitals in the OQR Program were consistently reporting "present on admission" information and data, and so, when we presented this to our expert workgroup, we ultimately decided that, for the time being, we wouldn't pursue using it because of issues with consistency of reporting, but it's certainly something that we're going to revisit periodically in future measure re-evaluation cycles.

Lisa Vinson: Okay. Thank you, Mario. There was one other question. What were the overall impacts of the five measure refinements on the measure results?

Mario Marchesi: Sure. So, I can give a high-level overview, but again I would recommend looking at the annual updates and specifications report from 2018, which is now posted on the PCHQR [Program] *QualityNet* page. So, applying the refinements to the measure resulted in the measure cohort for PCHs decreasing by 109 cases, which was about 0.5 percent of the total cohort. And, we also saw the national observed inpatient admissions rate drop from 14.6 to 14.0 and the national observed ED visit rate drop from 6.5 to 6.2. But, like I said, there's much more detailed results in the annual updates and specifications report now on the PCHQR [Program] *QualityNet* web page.

Lisa Vinson: Okay. Thank you for that. And lastly, Mario, we are going to wrap up our session here but, before we do that, I would like to ask you if you could provide some additional information or details on the appendices, which are the risk adjustment model tables that are displayed on slides 32 and 33.

Mario Marchesi: Sure. So, slides 32 and 33 provide a listing of the variables that we use in our risk models. So, the first page is for the inpatient admissions risk model. It currently has 21 variables and, as I mentioned earlier in the talk,

we risk adjust for multiple things, so of course age, gender, the exposure, and we do that by looking at both the number of chemotherapy treatments received in the outpatient setting during the performance period and also the new risk variable that we had a concurrent radiotherapy and chemotherapy. We look at that. So that's another exposure risk variable.

In addition to that, we look at several co-morbidities, and we also look at several specific cancer groupings and adjust for that as well. The ED model, which is on Slide 33, is similar, but there are a couple of variables that we don't adjust for in the ED model that we do adjust for in the inpatient model because they're not associated as strongly with ED visit outcomes as they are with inpatient outcomes. Similarly to the last question, you know, not only are these detailed and listed in the annual updates and specifications report, but we go into some length about how we decided on our risk variables and the process we used initially developing the measure.

Lisa Vinson: Great. Thank you so much, Mario, and that will conclude our questions-and-answers session for this event. Please remember that, if we were not able to address your question, again the questions-and-answers summary document will be posted at a later date to *QualityNet* and *Quality Reporting Center*. So, as always, we would like to thank everyone for their time and attention during today's presentation. I would especially like to thank our guest speaker, Mario Marchesi, for joining us and providing valuable information about the refinements to the outpatient chemotherapy measure. We hope that our program participants found this information useful, particularly in their analyses of their measure results. So, thank you again, everyone, and have a great day.