IMPACT Act: Medicare Spending Per Beneficiary Measures Call

Wednesday, September 6, 2017

Presenters:

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Acronyms in this Presentation

- ESRD: End Stage Renal Disease
- FFS: Fee-For-Service
- FY: Fiscal Year
- HCC: Hierarchical Condition Category
- HHA: Home Health Agency
- IMPACT Act: Improving Medicare Post-Acute Care Transformation Act
- IPPS: Inpatient Prospective Payment System
- IRF: Inpatient Rehabilitation Facility
- LTCH: Long-term Care Hospital
- LUPA: Low Utilization Payment Adjustment
- MAP: Measure Applications Partnership
- MDC: Major Diagnostic Category
- MS-LTC-DRG: Medicare Severity – Long-Term Care- Diagnosis-Related Group
- MSPB: Medicare Spending Per Beneficiary
- MSPB-PAC: Medicare Spending Per Beneficiary – Post-Acute Care
- NQF: National Quality Forum
- PAC: Post-acute Care
- PEP: Partial Episode Payment
- PPS: Prospective Payment System
- QRP: Quality Reporting Program
- RIC: Rehabilitation Impairment Category
- SNF: Skilled Nursing Facility
- SSA: Social Security Act
Agenda

• Introduction and Background
• Medicare Spending Per Beneficiary – Post Acute Care (MSPB-PAC) Measures Overview and Definitions
• Episode Construction
• Measure Calculation, Including Risk Adjustment
• Reporting & Timelines
• Questions & Answers
• Resources
Introduction and Background
Improving Medicare Post-Acute Care Transformation of 2014

Bipartisan bill passed on September 18, 2014 and signed into law by President Obama on October 6, 2014

• Requires Standardized Patient Assessment Data that will enable:
  – Quality care and improved outcomes
  – Data Element uniformity
  – Comparison of quality and data across post-acute care (PAC) settings
  – Improved discharge planning
  – Exchangeability of data
  – Coordinated care
  – Inform payment models
Driving Forces of the IMPACT Act

Purposes Include:

• Improvement of Medicare beneficiary outcomes
• Provider access to longitudinal information to facilitate coordinated care
• Enable comparable data and quality across PAC settings
• Improve hospital discharge planning
• Research

Why the attention on Post-Acute Care (PAC):

• Escalating costs associated with PAC
• Lack of data standards/interoperability across PAC settings
• Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting
Applicable PAC settings and Prospective Payment Systems (PPS):

- Home health agencies (HHAs) under section 1895
- Skilled nursing facilities (SNFs) under section 1888(e)
- Inpatient rehabilitation facilities (IRFs) under section 1886(j)
- Long-term care hospitals (LTCHs) under section 1886(m)
IMPACT Act: Selected Measures and Timelines

- Total estimated Medicare spending per beneficiary
- Discharge to community
- Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates

- SNF: October 1, 2016
- IRF: October 1, 2016
- LTCH: October 1, 2016
- HHA: January 1, 2017

Resource use and other measures will be specified for reporting.
Why Measure Resource Use in Post-Acute Care?

- Significant number of Medicare beneficiaries and total PAC spending (2015)¹

<table>
<thead>
<tr>
<th>PAC Setting</th>
<th>Number of Beneficiaries</th>
<th>Cost to Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHA</td>
<td>3.5 million</td>
<td>$18.1 billion</td>
</tr>
<tr>
<td>SNF</td>
<td>1.7 million</td>
<td>$29.8 billion</td>
</tr>
<tr>
<td>IRF</td>
<td>344,000</td>
<td>$7.4 billion</td>
</tr>
<tr>
<td>LTCH</td>
<td>116,000</td>
<td>$5.3 billion</td>
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</table>

- From 2001 to 2015, Medicare PAC spending increased on average 5.4 percent per year and doubled to $60.3 billion²
- An Institute of Medicine study found variation in PAC spending explained 73 percent of variation in total Medicare spending³
- No existing endorsed resource use measures for PAC providers

Goals of the MSPB-PAC Measures

- Provide actionable, transparent information to support PAC providers’ efforts to promote care coordination and improve efficiency of care provided to patients
- Facilitate comparisons while accounting for patient case mix through risk adjustment
- Encourage improved coordination of care in PAC settings by holding providers accountable for the Medicare resource use within an “episode of care.” An episode of care includes:
  - The period of time the patient is directly under the case of the PAC provider, and
  - A defined period after the end of the PAC provider’s treatment
- Create a continuum of accountability between Medicare providers by measuring resource use through episodes of care
MSPB-PAC Measure Development Background

• IMPACT Act requires development of total estimated Medicare Spending Per Beneficiary (MSPB) resource use measures, referring to the Inpatient Prospective Payment System (IPPS) hospital MSPB measure

• CMS had contracted with Acumen to develop the IPPS hospital MSPB measure as mandated by the Affordable Care Act of 2010
  – Finalized in the FY 2012 IPPS/LTCH Prospective Payment System (PPS) Final Rule
  – Initial endorsement by National Quality Forum (NQF# 2158) in December 2013, and endorsement renewed in July 2017
  – Used in the Hospital Value-Based Purchasing Program’s Efficiency and Cost Reduction domain since FY 2015
  – MSPB Hospital measure assesses Medicare Part A and Part B payments during an episode that spans from 3 days prior to admission through 30 days post-discharge
The MSPB-PAC measures were developed to follow the general construction of the hospital MSPB measure

- Hospital MSPB measure referenced in IMPACT Act
- Create aligned incentives for providers across a patient’s trajectory of care from hospital to post-acute care
- Builds on existing familiarity with NQF-endorsed hospital MSPB measure
## MSPB-PAC Measure Development Background, Continued

<table>
<thead>
<tr>
<th>Date(s)</th>
<th>Work Groups</th>
<th>Public Comment Periods/Proposed Rules</th>
<th>Final Rules</th>
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</thead>
<tbody>
<tr>
<td>7/6/2015</td>
<td>MSPB–PAC Measure Development Starts</td>
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<tr>
<td>10/29/15-10/30/15</td>
<td>Technical Expert Panel (TEP) in Baltimore, MD</td>
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<tr>
<td>12/15/15</td>
<td>NQF Measure Applications Partnership (MAP) Post-Acute Care/Long-Term Care Workgroup</td>
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<td></td>
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<tr>
<td>1/13/16-2/5/16</td>
<td>Blueprint Public Comment Period</td>
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<td></td>
</tr>
<tr>
<td>4/8/2016</td>
<td>FY 2017 LTCH QRP Proposed Rule</td>
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<td></td>
</tr>
<tr>
<td>4/22/2016</td>
<td>FY 2017 SNF and IRF QRP Proposed Rules</td>
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<td></td>
</tr>
<tr>
<td>6/24/2016</td>
<td>CY 2017 HH QRP Proposed Rule</td>
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<td>8/5/2016</td>
<td>FY 2017 SNF and IRF QRP Final Rules</td>
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<td>8/22/2016</td>
<td>FY 2017 LTCH QRP Final Rule</td>
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<tr>
<td>11/3/2016</td>
<td>CY 2017 HH QRP Final Rule</td>
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<tr>
<td>10/1/2016</td>
<td>LTCH, SNF, IRF Quality Reporting Program (QRP) Implementation</td>
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<tr>
<td>1/1/2017</td>
<td>HH QRP Implementation</td>
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</tbody>
</table>

Program implementation and measure maintenance performed by RTI and Abt Associates
MSPB-PAC Measures Overview and Definitions
MSPB-PAC Measures Overview

• The MSPB-PAC measures evaluate a PAC provider’s Medicare spending relative to that of the national median provider in the same PAC setting during an episode of care (“episode”)

• The measure only covers Medicare Part A and B payments for fee-for-service (FFS) claims

• One MSPB-PAC resource use measure per PAC setting (four total measures)

• The four MSPB-PAC measures are closely aligned with each other (e.g., episode construction, measure calculation)

• Measures do account for setting-specific differences in payment policy, available data, and underlying health characteristics of beneficiaries (risk adjustment)
Key Definitions

• Providers
  – **Attributed provider**: provider for whom the measure is being calculated
  – **Other providers**: providers of other services during the episode

• Types of episode services:
  – **Treatment services**: services provided directly by or managed by the attributed provider during the treatment period
  – **Associated services**: services occurring within the episode window that are not part of the attributed provider treatment
  – **Clinically refined exclusions**: treatment or associated services that are clinically unrelated to treatment and are not counted toward episode costs
Episode Construction
Six Episode Construction Steps

• **Step 1**: Determine when the episode starts ("triggered")

• **Step 2**: Define the episode window
  – Duration of the treatment period
  – Duration of the associated services period

• **Step 3**: Define treatment services

• **Step 4**: Define associated services

• **Step 5**: Exclude clinically unrelated services

• **Step 6**: Determine when the episode closes
MSPB-PAC Episode Window

- **Step 1:** Determine when the episode starts (“triggered”)
- **Step 2:** Define the episode window
  - Duration of the treatment period
  - Duration of the associated services period
- **Step 3:** Define treatment services
- **Step 4:** Define associated services
- **Step 5:** Exclude clinically unrelated services
- **Step 6:** Determine when the episode closes

**Diagram Description:***
- **Trigger Service**
- **Treatment Services**
- **Associated Service**
- **Clinically Unrelated Service (Excluded)**

**Legend:**
- **PAC Provider Services**
- **Other Providers’ Services**
- **Attributed Provider**

**Timeline:**
- **Treatment Period**
- **Associated Services Period**
- **Episode Window**
Step 1. Episode Trigger

- An episode is triggered when a beneficiary is admitted to a SNF, IRF, or LTCH. For HHAs, the episode is triggered on the first day of a home health claim.
- SNF, IRF and LTCH: adjacent readmissions for the same patient to the same provider (within 7 days) are collapsed into one treatment period.
- LTCH and HHA: allow for different types of episodes (resulting from differences in payment policies):
  - LTCH – 2 types
    - Standard
    - Site Neutral
  - HHA – 3 types
    - Standard
    - Partial episode payment (PEP)
    - Low utilization payment adjustment (LUPA)\(^1\)
- Episodes are only compared to other episodes of the same type (for each measure) to ensure meaningful and fair comparisons between providers (e.g., HHA LUPA episodes are only compared to HHA LUPA episodes).

\(^1\)Home health claims that are subject to both a LUPA and PEP adjustment are treated as PEP episodes to reflect their shorter duration.
Step 2. Defining the Episode Window

• The episode window is the time period during which the MSPB-PAC measures assess the Medicare spending for Part A and Part B services delivered to a beneficiary
• Consists of a treatment period and an associated services period:
  – **Treatment period:** Begins at the episode trigger for all MSPB-PAC episodes and ends at discharge for all MSPB-PAC episodes except HHA Standard and HHA LUPA episodes where the treatment period ends 60 days after the trigger
  – **Associated services period:** Begins at the episode trigger and ends 30 days after the end of the treatment period

<table>
<thead>
<tr>
<th>MSPB-PAC Episode Type</th>
<th>Treatment Period</th>
<th>Associated Services Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF &amp; IRF</td>
<td>Trigger to discharge</td>
<td>Trigger to 30 days after end of treatment period</td>
</tr>
<tr>
<td>LTCH Standard &amp; Site Neutral</td>
<td>Trigger to discharge</td>
<td>Trigger to 30 days after end of treatment period</td>
</tr>
<tr>
<td>HHA Standard &amp; LUPA</td>
<td>Trigger to 60 days after</td>
<td>Trigger to 30 days after end of treatment period</td>
</tr>
<tr>
<td>HHA PEP</td>
<td>Trigger to discharge</td>
<td>Trigger to 30 days after end of treatment period</td>
</tr>
</tbody>
</table>
Step 3. Defining Treatment Services

• Treatment services are Medicare Part A and Part B services delivered to a beneficiary during the treatment period that are either provided directly or reasonably managed by the attributed PAC provider as part of the beneficiary’s care plan.

• Excludes certain services related to prior institutional care on the first day of MSPB-PAC episodes (e.g., ambulance transport related to a hospital discharge).

• Excludes services that are clinically unrelated to PAC treatment.
Step 4. Defining Associated Services

• Associated services are non-treatment services that occur within the associated services period

• All spending for Part A and Part B services during this period are counted toward the MSPB-PAC episode, with certain exclusions for clinically unrelated services

• Example: an acute inpatient hospitalization for a complication arising during or after PAC treatment would generally be counted as associated services spending
Step 5. Excluding Clinically Unrelated Services

• Certain services are excluded from MSPB-PAC episodes because they are clinically unrelated to PAC care and/or because PAC providers may have limited influence over certain Medicare services delivered by other providers during the episode window.

• Clinically unrelated services were determined with extensive consultation through the measure development process with CMS and independently-contracted clinicians and TEP members.

• These services are not counted towards a PAC provider’s Medicare spending to ensure providers do not have disincentives to treat patients with certain conditions or complex care needs.

• Clinically unrelated services include:
  – Planned hospital admissions
  – Routine management of certain preexisting chronic conditions
  – Some routine screening and health care maintenance
  – Immune modulating medications
Step 6. Episode Closing

- All MSPB-PAC episodes end 30 days after the end of the treatment period
- The full payment for all claims that begin within the episode window is counted toward the episode, regardless of length
Measure Calculation
MSPB-PAC Measure Calculation Steps

- Determining episode-level exclusions
- Standardizing payment
- Risk adjustment
- Computing the measure numerator and denominator
Episode-Level Exclusions

MSPB-PAC episode exclusions include:

• Any episode triggered by a PAC claim outside of the 50 states, D.C., Puerto Rico, and U.S. territories
• Any episode where the standard allowed amount cannot be calculated or is equal to 0
• Any episode in which the beneficiary is not enrolled in Medicare FFS for the entirety of the 90-day lookback period (i.e., 90-day period prior to episode trigger) plus episode window, or is enrolled in Part C for any part of the lookback period plus episode window
• Any episode in which a beneficiary has a primary payer other than Medicare for any part of the 90-day lookback period plus episode window
• Any episode where the claims constituting treatment include one or more with a related condition code indicating that it is not a prospective payment system bill
Payment Standardization

• MSPB-PAC measures use “allowed amounts,” which include Medicare payments and beneficiary deductible/coinsurance

• Payment standardization removes sources of payment variation not directly related to clinical decisions such as:
  – Wage index and geographic practice cost index (GPCI)
  – Incentive payment adjustments
  – Add-on payments that support broader Medicare program goals including graduate medical education (GME)

• Bonus or penalty amounts due to Medicare quality reporting or other special programs are not included

• This enables meaningful comparisons of resource use across geographic areas while preserving differences due to healthcare delivery decisions
Risk Adjustment

- Risk adjustment uses patient claims history to account for case-mix variation and other factors that affect resource use but are beyond the influence of the attributed provider.
- The MSPB-PAC risk adjustment models are adapted from the hospital MSPB model to each PAC setting.
- Uses linear regression framework and performed separately for each PAC type:
  - SNF
  - IRF
  - LTCH Standard
  - LTCH Site Neutral
  - HHA Standard
  - HHA LUPA
  - HHA PEP
Risk Adjustment Factors

• Hierarchical Condition Categories (HCCs) with a 90-day lookback
• Age brackets
• Prior inpatient stay length bins
• Intensive care unit stay length bins
• Clinical case mix categories, including prior inpatient and PAC use
• Indicators for:
  – Originally disabled
  – ESRD enrollment
  – Long-term care status
  – Hospice claim in episode window
• For IRFs, we include payment category variable Rehabilitation Impairment Categories (RICs)
• For LTCHs, we include payment category variable MS-LTC-DRGs and MDCs to account for cases where there are too few beneficiaries per MS-LTC-DRG to justify a separate MS-LTC-DRG dummy variable
Clinical Case Mix Categories

- Categories are used in risk adjustment models to account for differences in intensity and type of care received by beneficiaries prior to start of MSPB-PAC episode
- Episodes are defined into clinical case mix categories using information from the most recent institutional claim in 60 days prior to episode start

<table>
<thead>
<tr>
<th>Clinical Case Mix Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Prior Acute Surgical IP - Orthopedic</td>
<td>Beneficiaries who have most recently undergone an orthopedic surgery in an acute inpatient hospital</td>
</tr>
<tr>
<td>(2) Prior Acute Surgical IP - Non-Orthopedic</td>
<td>Beneficiaries who have most recently undergone a non-orthopedic surgery in an acute inpatient hospital</td>
</tr>
<tr>
<td>(3) Prior Acute Medical IP with ICU</td>
<td>Beneficiaries who have most recently stayed in an acute inpatient hospital for non-surgical reasons and had a stay in the ICU</td>
</tr>
<tr>
<td>(4) Prior Acute Medical IP without ICU</td>
<td>Beneficiaries who have most recently stayed in an acute inpatient hospital for non-surgical reasons but did not have a stay in the ICU</td>
</tr>
<tr>
<td>(5) Prior PAC - Institutional</td>
<td>Beneficiaries who are continuing PAC from an institutional PAC setting (i.e., coming from an LTCH, IRF, or SNF)</td>
</tr>
<tr>
<td>(6) Prior PAC - HHA</td>
<td>Beneficiaries who are continuing PAC from a HHA</td>
</tr>
<tr>
<td>(7) Community</td>
<td>All other beneficiaries</td>
</tr>
</tbody>
</table>
Computing the MSPB-PAC Measures

• The MSPB-PAC measure for each PAC setting is a **price-standardized, risk-adjusted ratio** that compares a given provider’s Medicare spending against the Medicare spending of other providers of the same type within a performance period

• **Numerator** is the MSPB PAC Amount:
  1. Compute the average risk-adjusted episode costs:
     • Risk-adjusted episode cost = episode’s standardized spending divided by the expected standardized spending from applying risk adjustment
     • Average the risk-adjusted episode costs across all episodes for the attributed provider
  2. Multiply average risk-adjusted episode costs by the national average standardized spending for all PAC providers in the same setting

• **Denominator** is national median of the MSPB PAC Amounts for the same PAC setting of the attributed provider
Computing the MSPB-PAC Measures, Continued

• MSPB-PAC Measure for individual provider $j$ equals:

\[
\frac{MSPB\ PAC\ Amount_j}{\text{National Median MSPB PAC Amount}}
\]

• A value greater than 1 indicates that a given provider’s Medicare spending was higher than the national median Medicare spending for that PAC setting

• A value less than 1 indicates that a given provider’s Medicare spending was lower than the national median Medicare spending for that PAC setting
### Example MSPB-PAC Resource Use Measure

<table>
<thead>
<tr>
<th>Episode 1</th>
<th>Episode 2</th>
<th>Episode 3</th>
<th>Episode 4</th>
<th>Episode 5</th>
<th>Episode 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed Spending</td>
<td>$3,300 /</td>
<td>$4,890 /</td>
<td>$4,020 /</td>
<td>$5,270 /</td>
<td>$6,850 /</td>
</tr>
<tr>
<td>Expected Spending</td>
<td>$4,000 =</td>
<td>$4,100 =</td>
<td>$3,700 =</td>
<td>$6,200 =</td>
<td>$5,900 =</td>
</tr>
<tr>
<td>Ratio of Obs/Exp</td>
<td>0.825 +</td>
<td>1.193 +</td>
<td>1.086 +</td>
<td>0.850 +</td>
<td>1.161 +</td>
</tr>
</tbody>
</table>

\[ 0.825 + 1.193 + 1.086 + 0.850 + 1.161 + 1.092 = 6.207 \]

\[ \frac{6.207}{6 \text{ episodes}} = 1.035 \]

National Average Observed Episode Spending = $5,325

\[ 1.035 \times \$5,325 = \$5,509 \]

National Median MSPB PAC Amount = $5,700

\[ \frac{\$5,509}{\$5,700} = 0.966 \]
Reporting & Timelines
Reporting Timeline

• Confidential feedback reports
  – The purpose of these reports is to provide information ahead of public reporting on a provider’s own average spending per episode, MSPB amount, and MSPB score compared to providers nationally. These reports will contain more detail than what will be posted publicly.
  – Timeline:
    • October 2017 for SNF, IRF, LTCH
    • January 2018 for HHA

• Public reporting
  – The purpose of public reporting is to provide patients, family members, and health care providers with a measure of Medicare spending relative to that of the national median provider in the same PAC setting during an episode of care while accounting for patient case mix through risk adjustment.
  – Timeline
    • October 2018 for SNF, IRF, LTCH
    • January 2019 for HHA
  – Preview reports available ahead of public reporting
Report Content

• Reports include calculations for individual providers and national calculations for comparison

• **Confidential feedback reports** will include the following elements:
  – **Provider-level:**
    • Number of Eligible Episodes
    • Average Spending During Treatment Period
    • Average Spending During Associated Services Period
    • Average Total Spending During Episode
    • Average Risk-Adjusted Spending (MSPB PAC Amount)
    • MSPB Score
  – **National-level:**
    • Number of Eligible Episodes
    • Average Spending During Treatment Period
    • Average Spending During Associated Services Period
    • Average Total Spending During Episode
    • Average Risk-Adjusted Spending (MSPB PAC Amount)
    • National Median MSPB PAC Amount
    • National Average MSPB Score

• **Public reporting** will include the following elements:
  – Your Provider’s Number of Eligible Episodes
  – Your Provider’s MSPB Score
  – National Average MSPB Score
## Sample Confidential Feedback Report – LTCH, IRF, SNF, HHA

### CASPER Report

**LTCH QRP Facility-Level Quality Measure Report**

<table>
<thead>
<tr>
<th>CCN:</th>
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<tbody>
<tr>
<td>Provider Name:</td>
<td>SAMPLE LONG-TERM CARE HOSPITAL</td>
</tr>
<tr>
<td>City/State:</td>
<td>WALTHAM, MA</td>
</tr>
<tr>
<td>Report Period:</td>
<td>01/01/2016 – 12/31/2016</td>
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<tr>
<td>Data was calculated on:</td>
<td>04/15/2017</td>
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<tr>
<td>Report Run Date:</td>
<td>06/20/2017</td>
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<tr>
<td>Report Version Number:</td>
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</tbody>
</table>

### Table Legend

[a]: The treatment period is the time during which the patient receives care services from the attributed LTCH, and includes Part A, Part B, and Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims.

[b]: The associated services period is the time during which any Medicare Part A and Part B services other than those in the treatment period are counted towards the episode spending.

Note: Dashes represent a value that could not be computed.

Note: NA is Not Available.

Note: Claims-based measures do not have CASPER Patient-Level Quality Measure reports.

### Source: Medicare Fee-For-Service Claims and Eligibility Files

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>CMS Measure ID</th>
<th>Number of Eligible Episodes</th>
<th>Average Spending Per Episode</th>
<th>MSPB Amount</th>
<th>Average Risk-Adjusted Spending</th>
<th>National Median</th>
<th>MSPB Score</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Spending During Treatment Period[a]</td>
<td>Spending During Associated Services Period[b]</td>
<td>Total Spending During Episode</td>
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<td>Medicare Spending Per Beneficiary (MSPB) – Post-Acute Care Long-Term Care Hospital Quality Reporting Program</td>
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<td>$11,206</td>
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<td>$10,005</td>
<td>$5,105</td>
<td>$15,170</td>
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**EXAMPLE DATA**
Question & Answer Session
Resources
For More Information

• MSPB-PAC Measure Specifications (including risk adjustment factors and exclusion criteria):
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-
  Reporting/Downloads/2016_04_06_mspb_pac_measure_specifications_for_rulemaking.pdf

• IMPACT Act of 2014 Data Standardization & Cross Setting Measures webpage:
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-
  Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-
  Setting-MeasuresMeasures.html

• If you have any questions not addressed in the materials available above, please submit them to:
  PACQualityInitiative@cms.hhs.gov
Quality Reporting Program Websites

• Home Health Quality Reporting Program: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html

• Long-Term Care Hospital Quality Reporting Program: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html


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