MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
Home Health Quality of Patient Care Star Rating Call
MLN Connects National Provider Call
Moderator: Leah Nguyen
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call.

All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Leah, you may begin.

Announcements and Introduction

Leah Nguyen: I'm Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on the Home Health Quality of Patient Care Star Rating. MLN Connects Calls are part of the Medicare Learning Network®.

During this call, learn about proposed changes to the Home Health Quality of Patient Care Star Rating on Home Health Compare based on stakeholder and technical expert panel feedback, overview of the current calculation algorithm, proposed changes, and potential rollout plans. A question-and-answer session follows the presentation.

Before we begin, I have a few announcements.

You should have received a link to the presentation for today's call in previous registration emails. If you've not already done so, please download the presentation from the following URL: go.cms.gov/npc. Again, that URL is go.cms.gov/npc. Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website.

At this time, I would like to turn the call over to Sara Galantowicz from Abt Associates.

Presentation

Sara Galantowicz: Thanks, Leah. Hello, everyone. And thank you for joining for the Provider Call. My name is Sara Galantowicz, and I'm with Abt Associates, the contractor that supports the Quality of Patient Care Star Rating.

Today, as noted on slide 4 and in the comments that Leah just made, we'd like to provide an overview of the methodology and development of the Quality of Patient

Care Star Rating and describe some changes that are under consideration. We'll share the analyses that support these changes, describe next steps and timelines, and leave time for your questions and comments.

First, however, I'd like to turn the presentation over to Joan Proctor, the CMS program lead for the Home Health Quality Reporting Program, to share a few words. Joan?

Introduction and Purpose

Joan Proctor: Thanks, Sara.

In terms of background, the Center for Medicare & Medicaid Services has long played a leading role in the use of public reporting as an important tactic for driving health care quality improvements. Launched starting in 1998, the Compare Health Plan websites support key CMS priorities: transparency of health care information, improved quality of care, and informed decisionmaking by consumer and their families.

More recently, CMS has adopted an initiative to expand the use of Star Ratings across all Compare and Health Plan sites. Star ratings are a good tool to provide easily understood information on provider quality, thereby empowering consumers and their loved ones to make informed decisions about where they receive care. Visual display of stars is an efficient, familiar, and consumer-centric way to communicate relative performance.

The format of Star Ratings addresses the potential barrier of numeracy because it is not necessary to understand or interpret the numbers and data behind the stars in order to understand and use them. Greater transparency encourages providers to deliver higher levels of quality, which, in turn, can drive overall health systems improvement. The objectives of Star Ratings are in line with the Affordable Care Act, which calls for transparent information on provider quality to be publicly reported and made widely available and with a national quality strategy goal of better care.

The Quality of Patient Care Star Ratings have been publicly reported on Home Health Compare for nearly 2 years. As discussed further in this presentation, during this time, we have conducted monitoring, held several expert panels, and reviewed stakeholder comments and questions. Based on the input collected and analyses conducted by our team, we are considering two changes that we believe will enhance the ability of the

Quality of Patient Care Star Ratings to do its job: reflect quality and enable meaningful comparison across agencies.

As you know, quality improvement is an ongoing activity, and we encourage your feedback and input through the Qs and As at the end of the session and via comment email address that will be provided at the end of this presentation. We look forward to hearing your thoughts on both of these particular changes as well as future considerations.

And, now, I'm going to turn it over to Sara.

Overview of Current QoPC Star Rating Methodology

Sara Galantowicz: Thanks, Joan.

And for those of you who are following on, we're now on slide 5.

As Joan noted, we'd like to present to you today two changes to the Quality of Patient Care calculation that are under consideration specifically for your feedback. These are listed on slide 5. The changes that are being considered are the removal of the Influenza Immunization measure from the Star Rating calculation to be replaced by the claims-based Emergency Department Use without Hospitalization measure.

Turning now to slide 6. There are currently over 12,000 home health agencies which range considerably in size, location, and patient population. And effective January 1st of this year, there are over 20 quality measures on Home Health Compare to facilitate comparison of these agencies. These include 18 measures based on OASIS assessment data, 7 process measures, and 7 outcome measures. And I would like to note that these counts that I'm giving today will be reflected on the next Home Health Compare refresh, which is scheduled for January 26th. So, the website currently still shows six process measures whose removal from Home Health Compare was finalized in the calendar year '17 Home Health Payment Rule.

In addition, there are four claims-based outcome or utilization measures and five measures calculated using survey data from the Home Health Consumer Assessment of Health Care Providers and Systems—or HHCAHPS—survey. Outcome measures can illustrate how effective care is in providing desired outcomes such as improved function, while process measures show how often agencies are providing evidence-based care.

Utilization measures, such as the claims-based measures, can show the prevalence of undesirable or costly outcomes such as return to the hospital or use of the emergency room. All of these can be valuable quality indicators. As we will soon describe, all three types of measures are also included in the Quality of Patient Care Star Rating algorithm.

Currently on Home Health Compare, there are separate Star Ratings for the quality of patient care and patient experience. The Quality of Patient Care Star Ratings are based on the process and outcome and utilization measures, and the Patient Experience Star Rating is based on data from Home Health CAHPS. In addition, I would like to note that the methodologies for calculating existing Star Ratings differ across not only the survey-based rating and the quality measure–based rating but across other Compare sites, including Nursing Home Compare, Home Health Compare, Dialysis Facility Compare, Hospital Compare, and Medicare Plan Finder.

As noted on slide 7, when selecting the measures to be included in the Star Rating, we evaluated all of the measures that were currently reported on Home Health Compare for their potential use using the criteria that are shown on this slide. The criteria that we used for selecting measures included that the measure applies to a substantial portion of home health patients and has sufficient data to be reported for a majority of agencies. The criteria also included that these measures show a variation among agencies and it is possible for agencies to show improvement. In other words, we didn't want to use measures that were topped out.

Additionally, we will –looked for measures that had high face validity and clinical relevance and that the measure be stable and did not show wide random variation over time. The appendices in the Quality of Patient Care Star Ratings Methodology Report, which is posted on the Home Health Star Ratings webpage, shows the data from our original evaluation of potential measures to include in the Star Rating calculations algorithm.

Slide 8 shows the measures that are currently included in the Quality of Patient Care Star Rating. As noted on the slide, initially 10 measures were selected. However, based on stakeholder feedback, the Pneumococcal Vaccination measure was dropped, leaving nine measures total, and they are listed here.

These include three process measures, which are not risk adjusted: Timely Initiation of Care, Drug Education on all Medications Provided to Patient and Caregiver, and Influenza Immunization Received for Current Flu Season. And, then, there are six outcome measures, which are risk adjusted. The first five are based on OASIS data: Improvement in Ambulation, Improvement in Bed Transferring, Improvement in Bathing, Improvement in Pain Interfering with Activity, and Improvement in Dyspnea.

And, then, the ninth measure is a claims-based measure of Acute Care Hospitalization. Home health agencies must be able to report five of the nine measures on this list in order to have a Star Rating computed, and the threshold for a public reporting or being able to report the measure is at least 20 episodes in a measurement period.

So, slide 9 provides a general overview of the calculation methodology. And, again, this overview will be very general. There's more detail available in the methodology report that's on the Home Health Star Ratings page of the CMS website and also in the preview reports that home health agencies receive each quarter.

Briefly, for each of the nine measures that are in the calculation algorithm, home health agencies are ranked based on the measure results and assigned into 10 equally sized groups. Their assigned ranking might then be adjusted if their result is not statistically significantly different from the national median value for that measure. If an agency's result is found to be statistically significantly different from that national median, no change is made to the initial rating for that measure. Similarly, no change is made if the agency's initial rating is already in the middle of the distribution, namely, two and a half or three stars.

However, in some cases, the agency results might look different than the national median. But, a statistical test finds that this difference is not significant. In this case, the initial Star Rating is moved a half star closer to the middle. So, for example, an initial rating of four for a particular measure would become three a half and an initial rating of 1.5 would become two. These adjusted ratings are then averaged, and the final step in the calculation process is to assign a final Star Rating value on a scale of from 1 to 5 stars. There are nine Star Rating categories with the middle value being 3 stars. And most agencies have a Quality of Patient Care Star Rating value that falls right in that middle of 3 or 3.5 stars.

As noted on slide 10, CMS first provided preview reports to home health agencies in April of 2015 that showed the quality of patient care values that would published that following July, as well as how those ratings were derived. To accommodate the preview process, the individual quality measures and the quality of patient care results shown on Home Health Compare are based on data that are 6 months lagged for OASIS-based measures and 9 months lagged for claims-based measures.

These preview reports are placed in the CASPER mailbox for each agency approximately 3 months before the results will be displayed. A schedule for the preview reports and Home Health Compare updates is available on the CMS Spotlight page.

And just for reference, the next refresh of Home Health Compare is scheduled to occur on January 26th and will include data for the dates that are listed on the slide here. To date, CMS has actually calculated eight quarter of quality of patient care ratings, including the April 2017 values that are in the preview reports that were placed into CASPER the first week of January.

So, I'll talk a little bit now about how stakeholders have been involved in the development and ongoing monitoring of Star Ratings. Slide 11 lists the stakeholder engagement opportunities during both the Quality of Patient Care development process as well as our ongoing monitoring activities. CMS held a conference call for stakeholders prior to its general – apologies – held a conference call for stakeholders prior to a general announcement of the planned Star Ratings and then two special Open Door Forums to share the draft methodology and solicit stakeholder input. And the final ratings methodology definitely reflects the feedback that we received during this process.

In addition, rating results are analyzed each quarter to monitor trends in the areas that are noted here. In addition, we held a 2-day technical expert panel, or TEP, in May of 2016 to share monitoring data for review and feedback. This feedback prompted several additional analyses that were then shared again with the TEP in September of 2016. The summary of both these meetings, the May and September TEP, are publicly available at the URL that's shown on this slide.

And I will note that TEP feedback was instrumental in identifying the changes we are presenting today. In addition, CMS operates a mailbox specifically for questions related

to home health quality measures, including the Quality of Patient Care Star Ratings. And that mailbox is also listed on the slide.

I will now turn the presentation briefly back to Leah for an announcement before Dr. Gene Nuccio describes the changes under consideration and the supporting analytics.

Leah?

Keypad Polling

Leah Nguyen: Thank you, Sara.

At this, we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note, there will be a few moments of silence while we tabulate the results.

Holley, we are ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine. Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling. Again, please hold while we complete the polling. Please continue to hold while we complete the polling.

Thank you for your participation. I would now like to turn the call back over to Leah Nguyen.

Leah Nguyen: Thank you, Holley. I will now turn the presentation over to Gene Nuccio to describe the changes under consideration and supporting analytics.

Presentation (Continued)

Dr. Eugene Nuccio: Good morning. Thank you, Sara and Leah.

I'm Dr. Gene Nuccio from the University of Colorado Anschutz Medical Campus. We are a member of the contractor team that supports the Home Health Quality Reporting Program for CMS.

Changes under Consideration and Supporting Analyses

You should be on slide number 12 at this time. The TEP reviewed the performance characteristics of all the measures currently used to compute the Quality of Patient Care Star Rating, as Sara pointed out previously. Additionally, the TEP members commented on the home health agencies' ability to improve or change their scores on individual members – to the individual measures.

One process measure that concerned the TEP members and that has been commented on by several others in the home health community was the Influenza Immunization Received for the Current Flu Season measure. Among the concerns raised were the perception that the performance on this measure could be influenced by factors outside the control of the home health agency. For example, there are differences among the States in allowing nurses to administer the flu vaccine in a patient's home.

The TEP was very supportive of increasing the number of claims-based measures on the Quality of Patient Care Star Rating metric. The new Emergency Room Use without Hospitalization measure was seen as an opportunity to reward home health agencies that were implementing strategies to reduce emergency department use among their patients. Claims-based measures, in general, were regarded – excuse me – regarded as less prone to manipulation when compared to process measures.

If you turn to slide 13, slide 13 displays the definition of the numerator and denominator for Emergency Department Use without Hospitalization, as well as the national risk-adjusted averages compared with the claims-based acute care hospitalization risk-adjusted rates for the past few quarters. The results indicate that the Emergency Department Use without Hospitalization measure performs quite consistently across these several quarters. A key question that we addressed in our analyses was what was the effect of the National Quality – excuse me – what was the effect on the National Quality of Patient Care Star Rating distribution if we removed the

Influenza Immunization Received for the Current Flu Season measure and substituted the Emergency Department Use without Hospitalization measure.

Slide 14 shows these results. On slide 14, the red bars represent the Quality of Patient Care Star Rating distribution for Star Rating data covering the OASIS period April 2015 through the end of March 2016 and claims-based data from January 2015 through the end of December 2015. The red bars include the current data using the Influenza Vaccine Received measure while the gray bars represent the data for the same period but substitute the Emergency Department Use without Hospitalization claims-based measure for the Influenza Received measure.

As you can see, the distributions are virtually identical and even have the same average quality of patient – national average Quality of Patient Care Rating of 3.24. The number of home health agencies with available data decreases by 25 home health agencies because the Emergency Department Use measure is a claims-based measure and so is available only for the agency's Fee-for-Service patients, whereas the Flu measure is available for all quality of episodes – quality of care episodes.

The next question that we needed to address was how much change does an individual agency see when its Quality of Patient Care Star Rating is switched from using the Influenza Vaccine Received measure to the Emergency Department Use measure. The next slide, slide 15, provides us with these results.

Okay. So, we agree that there's a lot going on with slide 15. And we'd like to work on this slide and describe it to you from the bottom up.

The two bottom lines, labeled "Star Rating Current" and "Star Rating ED, No Flu," show the percentage of agencies that changed their Quality of Patient Care Star Rating by 1 or more stars when we compared the scores during the past four quarters. This represents approximately 2 percent or fewer than 2 percent of the agencies changed their Star Rating—either increased or decreased—by one star.

The lines in the middle are all of the OASIS-based quality measures. Typically, between 10 to 14 percent of agencies have a 1-decile change in performance from one quarter to the next with the exception of the Flu Vaccine line, that's that one that zigzags from a low of about 3 percent to a high of about 18 percent.

The top two lines are both of the claims-based measures. These measures show that about – show the highest quarter-to-quarter decile change from agencies. In part, this is because only the agency's Medicare Fee-for-Service patients are included in these measures. The Star Rating is very stable over time using the current and the one that is under consideration that uses the ED measure even when that cannot be said for the decile rankings for the component measures. We also calculated the CAPA statistic each quarter comparing the previous quarter – comparing the performance to the previous quarter, and we found that the Star Ratings to be consistent and have a weighted CAPA of about 0.8, which is considered excellent, meaning the scores are very stable over time.

We analyzed how swapping the Emergency Department Use measure for the Flu Vaccine measure affects the Quality of Patient Care Star Ratings for smaller agencies, that is, a smaller agency has 250 or fewer quality episodes of care annually. If you turn to slide 16, you will see that, as in the previous graphs, the red bars reflect the current method that includes the Flu Vaccine, while the gray bars show the switch to using the Emergency Department Use for these small agencies. So, this distribution is for small agencies only or about 4,388 home health agencies with 250 or fewer episodes per year. So, it's about a quarter of all home health agencies.

What we see is that there's a slight improvement in the average Quality of Patient Care Star Rating. When we switched to the Emergency Department, No Flu, the Quality of Care Star Rating was 3.06, whereas the current measure showed a Star Rating of 3.03. Because we have such a large number of agencies involved, even this small change in Star Rating was statistically significant at the 0.05 level.

Another question that we wanted to address was how does this change affect agencies with longer quality of care episodes on average? We will see the answer to that on slide 17. So, please click on that slide now.

Again, on slide 17, the red bars reflect the current method while the gray bars show the switch to using the Emergency Department Use measure for agencies with large percentages of long-stay patients. We defined long-stay home health agencies as those agencies that have a disproportionate percentage of episodes that lasted longer than 90 days. By disproportionate, we define that as having more than 40 percent of the

agency's episodes lasting more than 90 days. Forty percent is approximately the 75th percentile of all agencies. So, we're talking about the top quarter of all agencies.

There are 2,071 long-stay agencies with a Quality of Patient Care Rating who we evaluated. Using the current method, their score was 2.90 whereas in the – when we substituted the Emergency Department Use without Hospitalization, the average Quality of Patient Care Star Rating was 2.97. Again, this seemingly small difference is statistically significant at the 0.05 level.

I thank you so much for staying with me on these slides with a large amount of rather technical information.

And, now, back to Sara.

Next Steps and Timelines

Sara Galantowicz: Thank you, Gene, for walking us through all of that.

I'd like to now turn to slide 18 and review the next steps in the process.

Specifically, CMS will be accepting public comment on these changes, that is, the change to replace the Influenza measure with the Emergency Department measure. Public comment will be accepted until February 20th, and the address for public comment is shown on the slide. I would like to underscore that the address shown on the slide is only for public comment. It's not the same address that was shown earlier for submitting general questions about the Home Health Quality measures or the Quality of Patient Care Star Rating.

Once we receive and review public comment, an update will be provided to stakeholders at the next Home Health Open Door Forum, which is currently scheduled for March 17th. Should CMS choose to move forward with these changes, the methodology report that describes the Quality of Patient Care Star Rating algorithm will be updated and reposted on the CMS website, and the new rating's calculation would likely be reflected in the preview reports that will be distributed in April 2017 for the July 2017 refresh.

As with the current Quality of Patient Care Star Ratings, the impact of any changes will be closely monitored through the ongoing analytics described earlier. So, as noted

earlier when talking about the overview process, each quarter we repeat a set of prescribed analytics that the – for the Quality of Patient Care Star Ratings to monitor stability and so forth.

That's just a brief overview of next steps.

If you turn to slide 19, this slide lists links for further reading as well as for Home Health Compare as well as the addresses for the two mailboxes. So, if you want more information about the Star Ratings and the frequently asked questions document, those are both available at the first URL. And any questions that you have about the Star Ratings, you can go to the Home Health Quality Measures mailbox listed there. And, again, the comments on proposed changes specific to today's presentation, you can go to hhqmcomment@abtassociates. And then, finally, at the bottom of that slide is the link to Home Health Compare.

So that concludes the formal portion of our presentation. And we would like to now open the line for any questions or comments you may have.

Question and Answer Session

Leah Nguyen: Thank you, Sara.

We will now take your question. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your question to just one. If you would like to ask a followup question or have more than one question, you may press star, one to get back into the queue, and we'll address additional questions as time permits.

All right, Holley, we are ready to take our first question.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Please hold while we compile the Q&A roster. Again, to come into the queue, press star, then one.

And we do have a question from the line of Carol Elrod.

Carol Elrod: Yes. I've been looking for this answer for quite a while. But, we have about 500 episodes a month. We deal with the new ACAs, and we have groups of physicians that are limiting the episodes of care, no matter what the patient's condition is, to 3 weeks. They will not allow us to call them and report and get more visits or time.

What I want to know is, you get the claim-based admissions to the hospital and the ED – you get them from the hospitals or CMS. How do you know whether our agency has those patients still on service? If they've been off-service for 4, 5, or 6 weeks, does that ER admission still count against us?

Alan Levitt: Yes, hi. This is Alan Levitt. I'm the Medical Officer in the Division of Chronic and Post-Acute Care here at CMS. Again, these are claims-based episodes – measures that are accumulated by claims. And they're based on the episodes of care that an agency would have, which is paid by a 60-day episode of care. And, so, if it's within that episode of care that the – either this hospitalization or ER use, that those patients would be included in the numerator of the measure.

Carol Elrod: Okay. So, it would be for the whole 60 days, whether we have discharged them or not? That's my question.

Alan Levitt: That is correct. As long as your episode of care that's a part of that 60-day episode that CMS has been paying, that's happened…

Carol Elrod: Okay.

Alan Levitt: … you would be responsible for…

Carol Elrod: Okay. So, it's really not compared to the OASIS discharge at all. It's just the 60 days from start of care?

Alan Levitt: Right. This is a claims-based measure, right. It's not an OASIS-based measure.

Carol Elrod: Okay. Okay, I think that clears it up.

Alan Levitt: Okay.

Carol Elrod: Thank you.

Operator: Our next question comes from the line of Cheryl Jasin.

Cheryl Jasin: Yes. I was wondering if there is an analysis available for the impact on agencies greater than 250 episodes or that do not have long lengths of stay, or is the assumption that there is no impact on those agencies?

Alan Levitt: Again, this is Alan Levitt. And, again, the – we're comparing different types of agencies. As you know, home health care is very heterogeneous in terms of its makeup. Different types of patients are admitted in percentages to one agency vs. another and there are different sizes of agencies as well.

And, so, we're always looking at these factors and trying to make sure that whatever we are doing within our Quality programs, that we're not adversely affecting or having any unintended consequences on different types of agencies. And, so, we compare different sizes. We compare different types of patients just like you saw in the comparison graphs that Gene presented – Dr. Nuccio presented.

Leah Nguyen: Thank you.

(Female voice on participant line): Did that answer your question?

Cheryl Jasin: No.

Leah Nguyen: Hello? Operator, can we take the next question, please.

Operator: Yes. Your next question will come from the line of Audrey Ozols. Audrey, your line is open.

Audrey Ozols: No. I didn't have a question. Sorry.

Leah Nguyen: Thank you.

Operator: Thank you. Our next question will come from the line of Kathy Cook.

Kathy Cook: My question was similar to the last one. I wondered if there is some place where we can go to see the comparison for larger agencies for -- related to slide 16.

Alan Levitt: Dr. Nuccio, do you know, do we have those slides available at all?

Dr. Eugene Nuccio: Hi. This is Gene. We don't obviously have the slides in this slide deck. The distribution actually looks very much like the distribution that you would see in slide 14. But, we can – we could perhaps generate a slide for those above 250 and make it available as part of the documentation for this call.

Kathy Cook: Thank you. That would be helpful.

Leah Nguyen: Thank you.

Operator: Again, if you would like to ask a question, press star, then one on your telephone keypad. If you'd like to withdraw a question or if your question has been answered, you may withdraw your question by pressing the pound key. Again, that's star one to ask a question. And our next question will come from the line of Heather Jones.

Heather Jones: Thank you.

Operator: Heather, your line is open.

Heather Jones: Thank you. Looking at the preview reports for Home Health Compare for what will be posted in July, there's a report for the measures to be posted and, then, there is also one specific for the Quality of Patient Care Star Rating. And those dates are different. So, is it correct that the Star Rating that's posted is for a different time period than the data that's actually available on Home Health Compare at that same time?

Alan Levitt: This is Alan Levitt. For the last refresh that was done, there was an error in the data that was going to be posted on Home Health Compare. Actually, the Star Ratings data, the time interval for that is correct. And we are either in the midst of or have already corrected the data that's going to be posted on Home Health Compare.

Joan Proctor: Yes. This is Joan Proctor. It has been corrected. So, if you were to go back into your – and pull another through CASPER, you would get the correct dates range.

Alan Levitt: And that was noted by you, the stakeholder. So, we really appreciate it. It makes us feel good that you're looking at the data.

Operator: And our next question will come from the line of Cynthia Lewis.

Cynthia Lewis: Yes. This is Cynthia. I'm wondering, is there a corresponding Quality measure for physicians related to ER utilization?

Alan Levitt: I am not sure. I mean, again, this is the Home Health Quality Reporting Program. I can tell you that as part of the different program, the ACO programs, there are hospitalization measures that I know of that are parts of that. But, in terms of the ER use, we wouldn't know. You may want to check with the Physician Compare websites or those other types of program website for an answer to that question.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Patricia Sciortino.

Patricia Sciortino: Hi. Our question is, will this data apply for the hospitalization to the Medicare managed care patients as well?

Alan Levitt: The claims-based measures that we use—so, the Hospitalization measure and the ER Use measure—are only for Medicare Fee-for-Service patients.

Patricia Sciortino: Okay. Very good. Thanks.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Jessica Kosmatka.

Jessica Kosmatka: I just wanted to ask about the date range. If the methodology is approved for the April posting, that would be public in July. Can you confirm, will that be for patients on service January 1st, 2016, through December 2016?

Alan Levitt: I always get my dates wrong in terms of what's – what the interval is going to be. It's always going to be – that interval would be for a year. And for the claims-based measure, it's always a quarter behind the measures for OASIS dates.

I don't know – Sara or Dr. Nuccio, do you know the exact interval that's going to be used for that refresh?

Sara Galantowicz: Sure. This is Sara. So, as noted at the beginning, the data that are displayed in July of 2017 will be 6 months delayed – so, as you – for OASIS. So, if you go back 6 months, it would be calendar year of 2016 for the OASIS data. And the claims-based measures will be 9 months delayed. So, go back an additional quarter -- October 1st through September 30th.

Gene, you can confirm if my math is correct.

Dr. Eugene Nuccio: Those numbers sound right to me.

Jessica Kosmatka: Okay. Thank you.

Alan Levitt: Thank you, Sara.

Operator: And our next question will come from the line of Cynthia Wessel.

Cynthia Wessel: Yes. Could you please clarify what you said earlier to – I believe it was the first question as to that 60-day count for the emergency department visit? If that home care episode has ended at day 45 and an ED event occurs on day 55, then does that count against the home care agency?

Alan Levitt: Again, it is throughout the entire 60-day episode. So, it would be any ER use or hospitalization that occurs during that 60-day period would be counted in the measure.

Cynthia Wessel: Okay. Thank you very much.

Operator: Thank you. And our next question will come from the line of Carol Elrod.

Carol Elrod: Hi, this is Carol again. And the last caller really clarified it for me, but she put it better than I did.

But, now, let me ask you this – if one agency admits and discharges on day 40, the patient goes in the hospital on day 50 and gets admitted to another home health agency.

And then 5 days after that – this would be your CHFers – goes back into the hospital, are both agencies counted as having ED and hospital admissions? Or does the first agency's 60-day period still hold?

Alan Levitt: Yes. Hi. This Alan Levitt. And this is where I – once again, I call either Dr. Nuccio or Dr. Kito. Do you remember the exclusion/inclusion criteria for cases like this?

Dr. Eugene Nuccio: Hi. This is Gene. I certainly will defer to David. The -- I don't know the algorithm that well or that much detail. But we can certainly provide a -- do some other investigation and provide a written answer to that.

David Kito: This is David…

Carol Elrod: I would appreciate that. Because, to me, that would really – if it was being counted against both agencies -- would really screw -- skew this for a Quality measure.

Leah Nguyen: Thank you. If you want to send that in…

Carol Elrod: That's my opinion.

Leah Nguyen: … I was going to say, if you want to send that in a

Leah Nguyen: -- you can send it to the address on slide 19.

Carol Elrod: Okay. The numbers?

Leah Nguyen: Yes. On slide 19, we have an email address; you can send your question there.

Carol Elrod: Okay. And they'll answer it from there?

Leah Nguyen: Yes, we'll take a look at it.

Carol Elrod: Okay. All right. Thank you.

Joan Proctor: This is Joan Proctor. I do want to point out to everyone here that you are dealing with a claims-based measure. So, what you've done on your OASIS side is not necessarily indicating for our claims processing people that your episode has ended unless you have taken action within the claim. So, if you are looking at your data based upon what you have in OASIS but have not updated the status of that patient to indicate for claims processing that the patient is no longer in an episode, that claims-based measure is going to apply.

So one of the things, I think, is important to note here is that in looking at claims-based measures, it is important for you as a provider to know what you had done with the claim on the claim side to indicate, to provide for our claims processing staff to be able to process this, to be able to update your status there. So, if you are – when you speak of discharging -- if you've ended the episode but you've ended it on the OASIS and the assessment side but your claims processing people haven't done anything, you are going to have information that conflicts.

Alan Levitt: And this is Alan Levitt. Thank you for forcing me to go back and look at the measure specifications that I should always know. And we actually exclude both patients whose home health stays are from multiple agencies during the time period. So, they are excluded from the measure.

Leah Nguyen: Thank you.

Operator: Again, if you would like to ask a question, press star, then one on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

Our next question will come from the line of Marilyn Kirby.

Marilyn Kirby: Hi. I'm Marilyn Kirby. I'm in California with Eskaton Home Healthcare. And with the 60-day stay, which everyone is addressing right now, if a patient were to go back on the 40th day and we discharged them on the 30th and it's completely unrelated – we originally were treating them for a fractured hip with physical therapy and now they decide to have a massive coronary attack and go back into that hospital. How is that something we can control when there was nothing that would have demonstrated that

to us? So, my question is why aren't diagnoses part of that key indicator to determine whether or not we would be faulted for that?

Alan Levitt: Again, the measures that we are talking about are all-cause measures. And the question you really need to ask yourself is, is there attribution that can be assigned to agencies for certain types of admission? And, again, when we look at this statistically and – the answer is yes. Does that mean you're 100-percent attribution? No. But, is there something that the agency in generally may be able to do to decrease these all-cause rates, either in terms of hospitalization or into the emergency room? The answer to that is yes.

I would note that we also have now as part of the IMPACT Act, and you may have noticed in that past year's rule, that we actually have a Potentially Preventable measure that also has been finalized for patients after they've been discharged from home health. And, so, we are always looking, much like we're looking at the Star Ratings and looking at ways that we may want to redefine things or relook at things – we're always looking at different ways to make these measures better and more representative of the performance of our providers.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Ernest Roy.

Ernest Roy: Hello. I was curious if in the formulation of these measures that CMS has taken into account how to verify the accuracy of some of this data. It just strikes me that whenever you ask any sort of an entity to self-report large amounts of data, there's, well, frankly, some incentive in – although it's not appropriate, to, well, for a lack of better word, massage the numbers. And I'd appreciate the presenters' comments. Thank you.

Alan Levitt: Thank you for a very good question. And what we try to do – again, there's two different types of measure that you're, I guess, seeing for Star Ratings, for example. So, you see the claims-based measures and the assessment-based measures, which, as you mentioned, are self-reported measures.

For the assessment-based measures, agencies are responsible for providing and submitting complete and accurate OASIS assessments and part of the surveying process

that then is looking at the accuracy of the assessment. And, so, we rely on our surveyors for part of that validation.

In addition, we really – we look at the data and we try to look at whether there are certain trends that may be going on that maybe indicate that validation may be an issue. And we take that into account in terms of our measure development and measure maintenance.

Leah Nguyen: Thank you.

Operator: Thank you. Our next question will come from the line of Michelle Fernandez. Michelle, your line is open.

And that question has been withdrawn.

Our next question will come from the line of Amy Wiegle.

Amy Wiegle: Yes. I am new in Quality Assurance and trying to understand the Home Health Compare website and so on. And I apologize, I know that this was already discussed. But in reference to slide 10 and the refresh that's going to be taking place, I understand – I believe on the 26th of January, from what it states, it says that the OASIS data goes back 6 months and then I understand for 9 months for claims. So, for the OASIS data, are we going back 6 months from July 1st? I just wanted to clarify that, please.

Alan Levitt: Okay. Well, Amy, first of all, welcome to Quality.

Amy Wiegle: Thank you.

Alan Levitt: For the refresh that is done, again, these are done – the data that we are collecting is actually yearly data. So, it's rolling types of data. So, you'll see OASIS being an entire year of data. And, again, there's this delay that we have because of the submission requirements, you know, of the agencies to get it in and then our ability to get the data calculated and to give the agencies an opportunity to review the data and, if they feel like there's an error, to submit any necessary corrections to CMS.

And, so, there's this timeline, a lag between when the data initially is done and when it's finally put up on Home Health Compare. We are sensitive to that because, obviously, we want to keep things as timely – in real time as possible so that, not only for the consumers who we are doing these websites for – to help them in their own selection process, but also for you and your own Quality activities.

Taking that into account, again, the refresh – and Sara, I'll rely on you again. So, the refresh for July 2017 will be data from – in OASIS and claims, if you can just repeat that again, Sara.

Sara Galantowicz: Sure. And, I think, to answer the specific question about slide 10, the dates that are shown there are the actual dates of the data that will be reported. So, the OASIS-based measures that you'll see next week are based on OASIS submitted between July 1st, 2015 or June 30th, 2016. So, that the 6-month delay. There's no additional delay upon the dates that are already shown on that slide.

And then, again, for the refresh in this coming summer, July 17, those OASIS will be from calendar year 2016 and the claims-based measures will be from October 1st, 2015, to September 30th, 2016.

So, I hope that answered your question.

Amy Wiegle: Okay. So, when I look up, I know we can look at the real-time and look at that daily. That's an update daily based on our specific site, correct?

Sara Galantowicz: Right. So, you're talking about the on-demand reports that you can run?

Amy Wiegle: Yes.

Sara Galantowicz: Yes. So, those would be a different data range, and they would be more recent data than what's shown on Home Health Compare...

Amy Wiegle: Right. Correct.

Sara Galantowicz: ... again, as noted, because there's a 6-month delay.

Amy Wiegle: Right. Okay. That's what I had understood. But, okay. Thank you.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Bonnie Albright.

Bonnie Albright: Hi. Earlier in the call, the speaker said that, based on the 2017 final rule, some Home Health Compare measures would be removed. Can you please elaborate on that? Did I hear that correctly? Are there going to be public data changes to Home Health Compare beyond the two changes that were discussed in this call?

Alan Levitt: Well, first of all, the change that we're talking about on the call, which will be reflected on Home Health Compare, are going to be reflected in the Star Ratings that are published on Home Health Compare. In addition, in Home Health Compare, as you know, there are measures that are individually reported with percentages that are listed there for agencies – for consumers to be able to look at. We always continue to look at all the measures in our program.

Home Health Quality Initiative is an older program. It's a program that goes back really to 1999–2000, and there are many measures that have existed really since then. And as they go through a certain life cycle and – we continue to monitor that because we don't want to overwhelm you or the public with information that, you know, may no longer be timely or necessary. And we did this review over a year ago, and we had an expert panel that came and looked at all the measures in the program. And in the end, we – at first, we moved 28 measures that were older legacy measures that were part of the Home Health Quality Initiative but were never finalized within the Quality Reporting Program and weren't reported on Home Health Compare.

In addition to that – and that's what was mentioned in this part year's rule – there were six measures that were still being publicly reported on Home Health Compare that after reviewing with our expert panel and doing our own analytics, we also proposed for removal. And, so, with their proposed and finalized removal, they would no longer be seen on data on Home Health Compare. None of those six measures are measures that are part of the Star Rating calculation. But, what you will notice is that if you go to Home Health Compare and you're looking for those particular measure results, you will no longer see them.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Amy O'Brien.

Amy O'Brien: Hi. Thank you. If memory serves, the Pneumococcal Vaccine measure was initially removed from that Star measure list, particularly because it posed such a large emphasis on vaccine measures. So, now, with the flu vaccine being removed in the proposal and the addition of the EDUs about hospitalization, there's going to be an extreme emphasis on these hospital utilization measures. I was wondering if that was discussed in the technical expert panel and, if so, what was the conversation around that to kind of elaborate on that emphasis and what that means for home health agencies, particularly considering some of those complexities, such as what has come up in this call, which is if that patient has already been discharged and the home health agency is still then held accountable for that entire 60-day period.

Alan Levitt: Okay. I'm sorry. I had difficulty hearing the question. If I could answer part of it, I think you were asking a question about the vaccination measures and what happened to them.

Amy O'Brien: No. Hi. Can you hear me now …

Leah Nguyen: It's really echo-ey. Are you on a cell phone?

Amy O'Brien: Hello?

Leah Nguyen: Yes. That's much better.

Amy O'Brien: Okay. I was on a headset. I apologize. So, my question wasn't about the vaccines. It was about how the Pneumococcal Vaccine measure was initially removed because it placed such a heavy emphasis on that vaccine category within the Star measures. And so, now with the flu vaccine being removed entirely, you've got two out of nine measures that will be hospital- and claims-based measures.

And so I was wondering, was that kind of discussed in the technical expert panel when this was – this proposal was drafted and, if so, kind of what was that conversation to justify considering some of these additional complexities such as what was discussed earlier with that 60-day period and early discharge?

Alan Levitt: I mean, the technical expert panel agreed and recommended the changes that we are talking about. The measures that we are adding – the measure that we're adding is a claims-based measure. And, so, it adds a different type of measure vs. the OASIS measure that was the Flu measure.

I want to mention – I mean, first of all, the Pneumococcal measure was removed from Star Ratings merely based on stakeholder feedback. We have initially in a call just like this came with 10 measures in our methodology. And based on the feedback from stakeholders, you said that the Pneumococcal measure did not add value in terms of measuring performance for agencies in the Star Rating.

And we took another look and agreed with you. In addition, the use of half stars vs. whole stars was, again, a stakeholder suggestion that we looked at and we thought was very good idea. And, so, we took the Pneumococcal Vaccination measure out because of recommendation of the stakeholders.

The Flu Vaccination measure – there's no question that we don't – we agree that vaccination is very important. But, there was – there really is an issue in terms of whether or not that measure fairly measured the performance of agencies, that agencies were not doing as well on that measure due to things that were really out of their control. And, so, that's why we went ahead and reviewed that measure with the expert panel and agreed with the recommendation to remove it.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Billi St.Clair.

Billi St.Clair: Yes. I had a question regarding when this would be implemented or if it's been approved yet for the Star Rating changes. I may have missed that question – or that discussion.

Alan Levitt: Right. Today is just the announcement. As was noted on one of the slides, now it is your turn both to, I guess, give comments now but then also to submit public comments on what we are planning to do. On the slides, you'll see the address to submit those public comments. Much like we did initially when we started Star Ratings, as I just mentioned, we look at all these public comments and we do our own analytics.

And we received helpful recommendations from you that – perhaps we will once again. And, so, we have this comment period. And, then, we'll be able to have better ideas as to how to go forward from there. But, no, this is not set in stone. This is an announcement today as to what we 've proposed to do. And we are asking for your comments back on that.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Michelle Fernandez.

Michelle Fernandez: Hi. We're wondering whether visits to an urgent care clinic vs. an emergency room are excluded from the ED measure.

Michelle Fernandez: Hello.

Alan Levitt: Yes, hi. Again, it's a claims-based measure.

Michelle Fernandez: Right.

Alan Levitt: If there is a – I would guess, if there is a Part B claim and – Dr. Nuccio, you can correct me otherwise. But, if a Part B claim is generated, then that would be counted. Is that correct?

Michelle Fernandez: Even it was in an urgent care clinic rather than an emergency department?

Alan Levitt: Why don't you submit – can you submit that question to the mailbox?

Michelle Fernandez: Sure.

Alan Levitt: And we'll look into that. I'm sorry I don't have the answer off the top of my head.

Michelle Fernandez: That's okay.

Leah Nguyen: That's on slide 19.

Michelle Fernandez: Yes.

Joan Proctor: This is Joan Proctor. I don't want you to walk away with – typically, we consider the -- those Minute Clinics, those types of places, to be physician providers. So, they're not going to fall into the algorithm to be able to note a service is being provided on that day. So, I just want to make sure that no one walks away concerned that we are expanding beyond the definition of emergency department to just apply those types of providers as emergency departments.

Dr. Eugene Nuccio: Alan, this is Gene. I mean, there are four exclusions in the denominator. If a patient is not continuously enrolled in the Fee-for-Service for the 60 days following the start of home health care or until death, that's one. If the stay begins with a LUPA, that's excluded. As Alan, I think, mentioned previously and I think it was a previous question, if a patient receives services from multiple agencies during that 60-day period, they're excluded. And, finally, again, the – is the Fee-for-Service issue. And it says for 6 months prior to the home health stay. So, it's both a post and a prior. But, if the claim is captured for that type of unit that you describe, then I think it would be included in the calculation.

Leah Nguyen: Thank you.

Operator: Thank you. Our next question comes from the line of Anju Agarwal.

Anju Agarwal: Hi. I'm the Infusion Coordinator for Dignity Home Health in California. And I have a question regarding cath flow or alteplase for home health patients who are having trouble with their lines, central lines and keep lines from being clogged. Medicare does not pay for the medication to be done in the home. Those patients are required to go into the hospital for that procedure, and not all hospitals have an outpatient infusion center that can do that. So, I'm wondering is that still going to be counted against the home health agencies that have to send those patients to the ED to have that done?

Leah Nguyen: Hold on a moment.

Alan Levitt: Again, there are planned readmissions that are excluded from the numerator. But, if a patient goes to the emergency room or goes to the hospital for certain diagnoses, they will be included in the numerator.

Anju Agarwal: Okay.

Leah Nguyen: Thank you.

Anju Agarwal: All right. Thank you.

Operator: Thank you. Our next question will come from the line of Carla Williams.

Carla Williams: Yes. I had a question about slide 15. When you're looking at those claims, you're looking at only – again, I just want to validate that, that that is only the Medicare claims. It doesn't include the Medicaid or the Advantage plans for Medicare?

Alan Levitt: For the claims-based measures, for the hospitalization measure and the ER Use measure, those would only be Medicare Fee-for-Service patients.

The OASIS-based measures would include Medicare, Medicaid, and the Advantage program.

Leah Nguyen: Thank you.

Carla Williams: Thank you.

Operator: Our next question will come from Billi St.Clair.

Billi St.Clair: Yes. You have stated that there were – the process measures were being removed, and I had – was on that call with CMS and they were saying that those weren't being removed until October of 2017. But, you're stating that for January they're going to be removed.

Alan Levitt: Are you referring to the measures that were proposed in the past year's rule?

Billi St.Clair: I'm not -- the process –was it seven process measures that were being removed stated in the call that – it was probably 2 months ago – that they were going to be removed in October of 2017.

Sara Galantowicz: This is ...

Alan Levitt: Yes, Sara, you can answer it …

Sara Galantowicz: I think the confusion may be they will be removed from Home Health Compare next week. So, they will not display on Home Health Compare effective January 2017. If you are referring to one of the training calls that had to do with the preview reports, there may be a delay in which – in when those measures are removed from the preview reports.

So there will be a discrepancy for some period of time between what is shown on your Home Health Compare preview report, which will list the measures that are removed, and what's actually shown on Home Health Compare. And it may be as late as October 2017 when they come off the preview report, but the public-facing version of the measures is scheduled to end this month.

Does that address your question?

Billi St.Clair: Yes. Thank you for clarifying.

Operator: Our next question has been withdrawn. At this time, we have no further questions.

Additional Information

Leah Nguyen: Thank you.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 21 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's MLN Connects Call on the Home Health Quality of Patient Care Star Rating. Have a great day, everyone.

Operator: That concludes today's conference call. Presenters, please hold.

-END-


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