



IMPACT Act: Medicare Spending Per Beneficiary Measure Call

Moderated by: Charlie Eleftheriou
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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. 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 Charlie Eleftheriou. Thank you. You may begin.

Announcements & Introduction

Charlie Eleftheriou: This is Charlie Eleftheriou from the Provider Communications Group here at CMS, and I'm your moderator today. I'd like to welcome everyone to this Medicare Learning Network call on the IMPACT Act – Medicare Spending Per Beneficiary Measures.

During this call, CMS measure developers present information on the adopted Medicare spending per beneficiary post-acute care resources use measures focusing on the components of each measure as well as public reporting. A question-and-answer session will follow the presentation.

The Improving Medicare Post-Acute Care Transformation of 2014—or IMPACT—Act requires the development of resource use measures for post-acute care providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

Before we get started, I just want to remind everyone that you received a link to the presentation for today in your confirmation email.

The materials are available at the following website if you did not get that email. The website is [go.cms.gov/n – as in national – p as in provider – c as in call](http://go.cms.gov/n—as-in-national—p—as-in-provider—c—as-in-call). So that's go – GO – .cms.gov/npc.

At this time, I'd like to introduce our first presenter, Dr. Tara McMullen, Senior Health Analyst for the Division of Chronic and Post-Acute Care. I'll now turn the call over to Tara to begin today's presentation.

Presentation

Dr. Tara McMullen: Thank you, Charlie. And hi, everyone. It's Tara McMullen. And thank you so much for joining us today on this MLN call to discuss the Medicare spending per beneficiary measure set or what we like to call MSPB-PAC.

PAC stands for post-acute care. On behalf of our Medical Officer, Dr. Alan Levitt, and Charles Padgett and myself at CMS, RTI International, our colleagues at Abt and our colleagues also at Acumen, we thank you for calling in and we hope that you find today's presentation helpful in discussing what is the MSPB-PAC measure set.

So moving into slide 2, you'll see a full list of the acronyms that we use in our language – everyday language speech. We use these in our presentation as well. So if you have any questions about these acronyms, please let us know.



Slide 3 illuminates the agenda for today. You will see that we will begin with an introduction and some background.

We'll move into the MSPB measures themselves, kind of give an overview, definitions, talk about episode construction, measure calculation, including discussion pertaining to risk adjustment, reporting and timelines, and then we'll take your questions and answers.

And we also have received questions and answers from you all in the IMPACT Act mailbox, and we will be responding to some of those questions. Slide 4 tees us up for the introduction and background. And now on slide 5.

Introduction and Background

Many of you have seen this slide before. But it's a nice introduction to what is the Improving Medicare Post-Acute Care Transformation Act of 2014, otherwise known as the IMPACT Act.

It's a bipartisan bill that moved seamlessly through the House, the Senate, and it was then signed into law by Former President Obama on October 6th, 2014. The IMPACT Act has a lot of promise, has a lot behind it. It requires many things such as the standardization of quality measures, resource use measures, as well as standardized patient assessment data elements.

And all this work really is to help back end and improve the exchangeability of data, standardized data or data in general, for longitudinal reasons, coordinated care to improve coordination of care itself, to inform payment models, to be able to compare data across PAC settings and, really, beyond those PAC settings, to make uniform data elements – as you – we've discussed in many of these MLNs, data elements have many uses – and to improve beneficiary outcomes.

Moving into slide 6. This slide builds off our last slide, really building upon the reasons for why the IMPACT Act. But what I would like us to do is zero in onto the second area here for the attention on post-acute care. So there's a focus on costs associated with post-acute care and really a focus on cost and quality together.

And this is why Congress mandated the development of an MSPB measure set for post-acute care settings, for the reasons that we have illuminated here on the slide and for the reasons that Medicare payments to PAC have grown at a consistently higher rate than other Medicare sectors.

On average per year, PAC Medicare spending in the billions is, for LTCHs, roughly \$5.4 billion; for SNFs, \$28.6 billion; for IRFs, \$7 billion; and for home health agencies, it's \$17.7 billion. MedPAC has noted that in between the years 2001 and 2012, program payments to PAC providers have doubled to \$59 billion.

Thus, the development of a measure that assesses resource use within a PAC episode creates a continuum of accountability between Medicare providers and has the potential to improve post-treatment care planning and coordination.



Slide 7. You'll see on this slide definitions delineated under the IMPACT Act, which are really the settings of focus for the Medicare PAC measure set. And these settings here are listed on slide 7, and I'm going to give you some background.

The Home Health Quality Reporting Program was established in accordance with Section 1895(d)(3)(B)(v)(II) of the Social Security Act. The home health agencies under the Home Health Quality Reporting program are required to – required by the Social Security Act to submit quality data for use of evaluating quality. The Home Health Quality Reporting Program applies to all home health providers that receive the HH PPS.

The Quality Reporting Program for skilled nursing facilities was established in accordance with Section 1899(b) of the Social Security Act as amended by the Improving Medicare Post-Acute Care Transformation Act, the IMPACT Act. The SNF QRP applies to all SNF providers that are paid under the SNF PPS.

The Quality Reporting Program for the inpatient rehabilitation facility settings was established in accordance with Section 1886(j) of the Social Security Act as amended by Section 3004(b) of the Affordable Care Act.

The IRF QRP applies to all IRF facilities that receive the IRF PPS, that is – or hospitals or units that are collocated with affiliated acute care facilities and IRF units affiliated with critical access hospitals.

And then the Quality Reporting Program for long-term care hospitals was established in accordance with 1886(m)(5) of the Social Security Act as amended by the Affordable Care Act. The LTCH QRP applies to all LTCH providers that are paid under the LTCH PPS. So, moving into slide 8.

You now know the facets of the IMPACT Act, and you now know the facilities under the IMPACT Act and their stream back into the PPS system. And now the IMPACT Act has illuminated a lot of things, as we've established. But one of the main facets is the development of a resource use measure.

And as you see here on the slide in that red box, the resource use measure, as mandated or required by the IMPACT Act by CMS to be developed among three measures here, is the Total Estimated Medicare Spending Per Beneficiary measure. This measure has a specified application date or a start date for reporting – for SNFs, IRFs, and LTCHs October 1st, 2016, and home health agencies October 1st, 2017.

And in the fiscal year and calendar 2016 rules for home health agencies, IRFs, LTCHs, and SNFs, we proposed and eventually finalized the use of a Medicare – Estimated Medicare Total Spending Per Beneficiary PAC measure set.

Moving into slide 9. So beyond the mandate of the IMPACT Act itself, there are many reasons for why an MSPB measure for PAC settings is important for assessing – assessment in general and reporting.

As stated prior, evaluating Medicare payments during an episode ensures accountability between providers while improving or back-ending post-treatment care planning and coordination. Also, as stated prior, rising Medicare expenditures and variation in spending per PAC services underline the importance of measuring resource use in PAC settings.



Between 2001 and 2015, Medicare PAC spending grew at an annual rate of 5.4 percent and doubled to \$60.3 billion. A study commissioned by the Institute of Medicine found that variation in PAC spending explains 73 percent of variation in total Medicare spending.

And as you can see on this graph on slide 8, 1.7 million Medicare beneficiaries received SNF services, 3.5 million beneficiaries received home health agency services, 116,000 beneficiaries received LTCH services, and 344,000 beneficiaries received IRF services.

Therefore, it can be expected that the MSPB-PAC measures will affect a large number of Medicare beneficiaries receiving PAC services in general.

And given this variation in spending and services as well as the fact that there are currently no consensus organization-endorsed resource use measures that target Medicare PAC providers, MSPB-PAC measures have the potential to provide valuable information on their relative Medicare spending.

Moving into slide 10. And this will be the last slide before we tee it up on what are the measures, really moving into what the measures, how they're calculated, what are episodes.

So the purpose of the MSPB-PAC measures in general are to support reporting – public reporting of resource use in all four PAC provider settings as mandated by the IMPACT Act as well as to provide actionable, transparent information to support PAC providers' efforts to promote care coordination and improve the efficiency of care provided to patients.

Importantly, measures can facilitate – these measures can facilitate such comparisons while taking into account each provider's patient case mix through the use of risk adjustment.

Furthermore, the implementation of the MSPB-PAC measures will encourage improved coordination of care in PAC settings by holding providers accountable for Medicare resource use within an episode of care. And we will discuss episodes of care in the slides to follow.

While the MSPB-PAC measure – resource use measures in general do not take into account patient outcome or experience beyond those observable in the claims, providers involved in the delivery of high-quality PAC services as well as appropriate discharge planning and post-discharge care coordination would be expected to perform well on these measures since beneficiaries would likely experience fewer costly adverse post-treatment events. I will now hand this presentation over to Melissa Morley for RTI. Thank you.

Measure Development Process

Melissa Morley: Great. Thanks, Tara. This is Melissa Morley from RTI. First, I'd like to go into a little bit more of the measure development process for the MSPB-PAC measure.

The IMPACT Act requires the development of Total Estimated Medicare Spending Per Beneficiary, the MSPB, resource use measures. And it refers specifically to the Inpatient Prospective Payment System, the IPPS,



Hospital MSPB measure. CMS contracted with Acumen to help develop the IPPS Hospital MSPB measure as mandated by the Affordable Care Act of 2010.

The Hospital MSPB measure was finalized in the fiscal year 2012 IPPS and LTCH Prospective Payment Systems final rules. And the measure received initial endorsement by the National Quality Forum in December 2013. This endorsement was renewed in July of 2017.

The Hospital MSPB measure is used in the Hospital Value-Based Purchasing Program's Efficiency and Cost Reduction domain and has been used since fiscal year 2015. The MSPB Hospital measure assesses Medicare Part A and Part B payments during an episode where the episode is defined as spanning from three days prior to admission through 30 days post discharge.

Slide 12. We note that the MSPB-PAC measures were developed to follow the general construction of the Hospital MSPB measure. This was because the Hospital MSPB measure was specifically referenced in the IMPACT Act and it also aligns incentives for providers across a patient's trajectory of care between a hospital and post-acute care settings. It also builds on existing familiarity with the NQF-endorsed Hospital MSPB measure.

On slide 13, we provide an outline of the MSPB-PAC measure development process. The measure development began in July of 2015. In October of 2015, CMS held a technical expert panel in Baltimore to solicit feedback on the measure construction. In December of 2015, the measure was part of the NQF Measure Application Partnership, the MAP, Post-Acute Care and Long-Term Care Workgroup.

In early 2016, the measure went through the blueprint public comment period. And then in the spring of 2016, the measure was part of the Quality Reporting Program proposed rules for each of the post-acute care settings – LTCH, SNF, IRF and home health.

And later in 2016, the measure was included in the final rules for each of the post-acute care settings for the Quality Reporting Program. In October of 2016, the LTCH, SNF, and IRF Quality Reporting Program implementation began. And in January of 2017, the Home Health Quality Reporting Program implementation began.

The MSPB program – measure – the program implementation and measure maintenance for the MSPB measures are performed by RTI for the LTCH, IRF and SNF settings and by Abt Associates for the home health setting.

MSPB-PAC Measures Overview and Definitions

Moving on to slide 14 – and 15. I'd like to just provide a overview of the MSPB-PAC measure. The measure is evaluating a post-acute provider's Medicare spending relative to that of the national median provider in the same post-acute care setting during an episode of care.

This measure only covers Medicare Part A and B payments for fee-for-service claims, and there is one MSPB-PAC resource use measure per setting. So there's a total of four measures. The four MSPB-PAC



measures are closely aligned to one another with regard to episode construction and measure calculation. The measures do account for setting-specific differences and payment policies, available data, and underlying health characteristics of beneficiaries through the risk adjustment.

And turning to slide 16. I'd like to orient everyone to a bit of vocabulary that will be helpful as we walk through the measure construction process.

First is with respect to providers. There are two types of providers that are referenced through the measure construction. First, there's the attributed provider. This is the provider for whom the measure is being calculated. Second, there are other providers. These are providers of other services that occur during the episode.

Second, I'd like to distinguish between the types of episode services. First, there are treatment services. These are the services that are provided directly by or managed by the attributed provider during the treatment period.

Second, there are associated services. And these are the services that occur within the episode window that are not part of the attributed provider's treatments.

And lastly, there are clinically refined exclusions. These are treatment or associated services that are clinically unrelated to the treatment and are not counted toward episode costs.

Episode Construction

Next, I'd like to walk through the six main steps of the episode construction process. These are outlined on slide 18.

The first step is to determine when the episode starts or when it is triggered. Second is to define the episode window. This includes identifying the duration of the treatment period as well as the duration of the associated services period. The third step is to define treatment services. The fourth step is to define associated services. The fifth step is to exclude clinically unrelated services. And the last step is to determine when the episode closes.

Slide 19 contains a graphic to help display the different components of the episode. You can see the episode trigger in the bright blue downward-pointing arrow. Above the dotted line, you can see the treatment services provided by the attributed provider during the treatment period. These are in the red triangles. Below the line, you can see other services that are provided by other providers during the treatment period as well as during the associated services period. These are the blue triangles. You can also see below the line the white triangles, which identify clinically unrelated services. So these would be services that are excluded from the episode.

Next, we'll walk through each of these steps in more detail. Turning to slide 20, identifying the episode trigger. An episode is triggered when a beneficiary is admitted to a SNF, an IRF, or an LTCH. For home health, the



episode is triggered on the first day of a home health claim. For SNF, IRF, and LTCHs, adjacent readmissions for the same patient to the same provider within 7 days are collapsed into one treatment period.

In the case of LTCH and home health, we do allow for different types of episodes because of the different payment policies in place for these settings. For example, for LTCH, there are two types of episodes. There's standard episodes and site-neutral episodes. In the case of home health, there are three types of episodes. There is standard; there's partial episode payment, the PEP episodes; and there's low utilization payment adjustment episodes, LUPAs.

Episodes are only compared to other episodes of the same type for each measure. This is to ensure that meaningful and fair comparisons are made between providers. So, for example, home health LUPA episodes are only compared to home health LUPA episodes.

Turning to slide 21. Step 2 is to define 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. The episode window consists of a treatment period and an associated services period.

The treatment period begins at the episode trigger for all MSPB-PAC episodes and ends at discharge, except for two episode types. This is specifically for home health standard and home health LUPA. In this case – in the case of these episodes, the treatment period ends 60 days after the trigger. The associated services period begins at the episode trigger and ends 30 days after the end of the treatment period. This is summarized in a table you see at the bottom of slide 21.

Turning to slide 22, defining the 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 a beneficiary's care plan.

Treatment services exclude certain services related to prior institutional care on the first day of an MSPB-PAC episode. For example, transport related to a hospital discharge would be excluded. Treatment services also exclude services that are clinically unrelated to PAC treatments.

Slide 23 outlines step 4, which is defining the 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 towards the MSPB-PAC episode with certain exclusions for clinically unrelated services. As an example, an acute inpatient hospitalization for a complication arising during or after PAC treatment would generally be counted as associated services spending.

Turning to slide 24. Step 5 is excluding clinically unrelated services. There are certain services that are excluded from MSPB-PAC episodes because they are clinically unrelated to PAC care or because PAC providers may have limited influence over certain Medicare services delivered by other providers during an episode window.

The clinically unrelated services were determined with extensive consultation through the measure development process with CMS and independently contracted clinicians and technical expert panel members.



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

Examples of clinically unrelated services include planned hospital admissions, routine management of certain pre-existing chronic conditions, some routine screening and health care maintenance, and immune-modulating medications.

Turning to slide 25. Step six is identifying the episode closing. All MSPB-PAC episodes end 30 days after the end of the treatment period. Note that the full payment for all claims that begin within the episode window – all these payments are counted toward the episode regardless of the length.

Now, I'll turn it to Betty Fout from Abt Associates to walk through the measure calculation.

Measure Calculation

Betty Fout: Great. Thank you, Melissa. So, I'm on slide 27. My name is Betty Fout, and I will be describing the MSPB-PAC measure construction in the next few slides.

I will start with discussing the episode exclusions that are applied when constructing this measure. I will then describe the motivation for payment standardization and the methodology used. Then I will describe how the measures are risk adjusted and which factors are used in the risk adjustment models. And then, finally, I will walk through how the measure is constructed through an example.

So turning to slide 28. This slide describes the episode exclusions that are made prior to constructing the MSPB-PAC measures. These are distinct from the service-level exclusions discussed by Melissa in the previous section. The service-level exclusions involve spending for specific services – that is, clinically unrelated services that are excluded from the calculation of episode spending. On the other hand, episode exclusions relate to a provider's episodes that are excluded entirely from the provider's MSPB-PAC measure.

Episodes can be excluded for the following reasons: if they are triggered by a PAC claim outside of the 50 states, D.C., Puerto Rico, and the U.S. territories. This ensures that complete claims data are available for each provider.

The episode is excluded if the standard allowed amount on the claim cannot be calculated or is equal to zero. Since the measure is intended to reflect costs to Medicare, this exclusion ensures we do not misrepresent providers' resource use.

The episode is also excluded if the beneficiary for the episode is not enrolled in Fee-for-Service Medicare for the entire episode window and the 90 days prior to the start of the episode.

The episode is also excluded if the beneficiary for the episode is enrolled in Medicare Part C at any point during the episode window or during the 90 days prior to the start of the episode.



These two exclusions ensure that episodes included in the measure have the appropriate information needed for risk adjustment and measure calculation.

The episode is also excluded if the beneficiary for the episode has a primary payor at any time during the episode window or during the 90 days prior to the start of the episode. Again, this exclusion ensures that episodes included have complete claims that accurately represent the providers' resource use.

And finally, the episode is excluded if it includes claims attributed to the PAC provider's treatment that are not billed under a Prospective Payment System. Claims that are not Prospective Payment System-billed may not contain sufficient information to allow for payment standardization.

Moving on to slide 29. The MSPB-PAC measures use allowed amounts, which include Medicare payments and beneficiary deductibles and coinsurance amounts. These allowed amounts are standardized to remove sources of variation that are not directly related to clinical decision. These include wage index – sorry, these include the wage index, the geographic practice cost index, any incentive payment adjustments, and add-on payments that support broader Medicare program goals such as the graduate medical education payments.

Bonus or penalty amounts due to Medicare quality reporting or other special programs are also not included. The purpose of payment standardization is to enable meaningful comparisons of resource use related to health care delivery decisions across different geographic areas.

Moving on to slide 30. Risk adjustment compensates for patient health circumstances and demographic factors that affect resource use but are beyond the influence of the attributed provider. The MSPB-PAC risk adjustment models are adapted from the model used in the Hospital MSPB measure.

The MSPB-PAC measures risk adjust using a linear regression framework and is performed separately for each of the PAC types listed here. This ensures that comparisons are fair, meaningful, and reflective of payment policy differences within each particular PAC setting.

So turning to slide 31. This slide lists the risk factors used in the risk adjustment models for each setting. These include the hierarchical condition categories, or HCCs, using a 90-day period prior to the start of the episode. There are 70 HCCs included. Other risk factors include 11 age brackets; several bins for the length of stay of a prior inpatient visit; several bins for clinical case mix categories, including prior inpatient and post-acute care visits. And we'll talk more about these clinical case mix categories on the next slide. And finally, risk factors also include indicators for disability being the original reason for Medicare, end-stage renal disease indicator, long-term-care care status, and the use of hospice care during the episode window.

There are a few setting-specific risk factors to allow for further control of clinical characteristics. These include the payment category variables for providers that are inpatient rehabilitation facilities or long-term care hospitals.

Turning to slide 32. The clinical case mix categories included in the MSPB-PAC risk adjustment models were developed and refined through clinical and stakeholder input, analyses of public comments, and a technical expert panel. They are intended to account for differences in intensity in the type of care received by



beneficiaries prior to the start of the MSPB-PAC episode. Episodes are slotted into a clinical case mix category using information from the most-recent institutional claim in the 60 days prior to episode start.

These categories are prior orthopedic surgery in an acute inpatient hospital, prior non-orthopedic surgery in an acute inpatient hospital, prior non-surgical acute inpatient hospital stay with intensive care unit or ICU use, prior non-surgical acute inpatient hospital stay without ICU use, prior institutional post-acute care use – and this would include use of skilled nursing facilities, long-term care hospitals, or inpatient rehabilitation facilities – prior home health agency use, and then, finally, all others. And these are termed “community patients.” These seven categories are exhaustive and mutually exclusive.

These clinical case mix categories account for differences in beneficiaries coming from different settings which TEP panelists, clinicians and other stakeholders felt were important to account for in risk adjustment models. The clinical case mix categories were defined and refined based on TEP and stakeholder feedback.

Moving to slide 33 now. The MSPB-PAC measure is calculated for individual providers, allowing them to be compared relative to other providers in the same setting. The measure for each PAC setting is price-standardized – 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.

The numerator of the measure is called the MSPB-PAC amount. This is computed in several steps. The risk-adjusted episode cost ratio is first calculated by dividing the episode’s payment-standardized spending by the expected standardized spending resulting from applying the risk adjustment model.

This risk-adjusted episode cost ratio is then averaged across all episodes for a particular provider. The average risk-adjusted episode cost ratio for the provider is then multiplied by the national average standardized spending for all PAC providers in the same setting.

The resulting value is the MSPB-PAC amount, which is the numerator of the measure. The denominator of the measure is the national median of the MSPB-PAC amounts for all providers in the same PAC setting of the attributed provider.

Moving to slide 34. The MSPB-PAC measure for a provider is then calculated by dividing the numerator, which is the MSPB-PAC amount for a particular provider, by the denominator, which is the national median MSPB-PAC amount for all providers within the same setting.

A value of greater than 1 indicates the provider’s Medicare spending was higher than the national median Medicare spending amount for that PAC setting.

A value of less than 1 indicates that the provider’s Medicare spending was lower than the national median Medicare spending for that PAC setting.

Moving to slide 35. I’ll walk through an example to help in understanding the construction of this measure. In this example, there’s one provider with six episodes. The first row shows the provider’s observed spending amount. This example is a simplification, and the actual measure of this value is payment-standardized.



The second row shows the provider's expected spending amount after applying the risk adjustment model. So for episode 1, spending attributed to the provider totaled \$3,300.

Applying the risk adjustment model showed that, based on the beneficiary's demographic and clinical characteristics, spending for the episode was expected to be \$4,000.

Thus, the observed divided by the expected amount yielded a ratio of 0.825. This ratio is computed for each episode, and it's averaged across the six episodes to be 1.035.

The 1.035 average ratio of observed to expected spending is then multiplied by the national average observed spending, which is \$5,325 in this example. This results in the MSPB-PAC amount of \$5,509 for this provider. In this example, the national median MSPB-PAC amount is \$5,700.

The provider's MSPB-PAC amount is \$5,509. The provider's MSPB-PAC amount is divided by the national median MSPB-PAC amount for the setting. So \$5,509 divided by \$5,700 yields the MSPB-PAC measure value of 0.966.

This value is less than 1. So this provider's Medicare spending was lower than the national median Medicare spending for the PAC setting.

I will now turn the presentation over to Charles, who will present the reporting and timelines for the MSPB-PAC measures.

Reporting and Timelines

Charles Padgett: Thank you very much. This is Charles Padgett, and I am going to be presenting on reports and public reporting and the timeframes for each of these related to the MSPB measure.

Providers will – or CMS will make a number of reports available to providers that list all of your measures. And this includes the MSPB measure, the first of which are confidential feedback reports. And the IMPACT Act requires that CMS furnish providers with confidential feedback reports beginning 1 year after the – after providers begin collecting data on a particular quality measure that's required under the IMPACT Act.

And 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 will be publicly posted.

And the confidential feedback reports are also known as the Quality Measure reports for any particular setting, LTCH Quality Measure reports or IRF Quality Measure reports, for example. And there will be both a patient-level report and a facility-level report that are available to providers.

The timeline for the confidential feedback reports for SNFs, IRFs, and LTCHs – we're looking at October 2017 for the release of those reports. And for home health, we're looking at January of 2018 for the release of the confidential feedback reports.



For public reporting, the purpose of CMS publicly reporting this data is to provide patients, family members, and other health care providers with the 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, as has been described.

And the public reporting for each of the measures required under the IMPACT Act, including MSPB, will begin 2 years after the date that any particular setting began collecting data on a quality measure. So for the MSPB measure, we'll see public reporting for SNFs, IRFs, and LTCHs beginning October 2018, and then for home health agencies, beginning in January of 2019.

Beyond that, providers will receive what are called preview reports that we make available ahead of public reporting. And those reports will reflect the exact data that is expected to be publicly reported on a Compare website – on a CMS Compare website.

These reports are issued, you know, approximately 2 to 2 ½ months ahead of any publicly reported – any publicly reporting of the data. And providers will have a 30-day period during which they can review these preview reports and contact CMS should they have any questions or concerns about the data that they're seeing in those reports.

I'm moving on to slide 38 now. This talks about report content. The reports include calculations for individual providers as well as calculations – national calculations for comparison. The confidential feedback reports or the Quality Measure Reports I spoke about earlier will include the following elements.

The provider-level report will include the number of eligible episodes, average spending during treatment period, the average spending during associated services period, the average total spending during episode, the average risk-adjusted spending or MSPB amount, and then finally the MSPB score.

The national level will contain the number of eligible episodes, the average spending during treatment period, the average spending during associated services period, the average total spending during episode, the average risk-adjusted spending or the MSPB amount, the national median MSPB amount, and finally, the national average MSPB score.

Public reporting – when we publicly report this data, we'll – you'll only see three values there. And this also is true for the preview reports, which, as I said, will directly reflect what's going to be publicly reported. So, on the preview reports and on the associated Compare refreshes, you will see your provider's number of eligible episodes, your provider's MSPB score, and then the national average MSPB score.

Moving on to slide 39. Here we're looking at a sample of a confidential feedback report or the Quality Measure Report. And I just want to go over sort of the information that's included on these reports.

Beginning at the top of the report, you'll see that we include demographic data for the provider, including your CCN, the name of the provider and then the city and state in which the provider exists.



Beyond that, on your right, you'll see we include the reporting period, which states the target period for the data that was included in this report, the data was – the date that the data was calculated on, the date that this particular report was run on, and then the report version number.

Just below that, you'll see the table legend, which informs anybody viewing these reports about any of the footnotes that are located or that you come across on the report. And here, you'll see that the treatment period – or if you see an A it means the treatment period is the timing during which the patient receives care or services from the attributed LTCH. And that's just an example here. That could be for SNF, IRF, or any other setting as well. And it includes Part A, Part B, and durable medical equipment – prosthetics, orthotics and supplies.

If you see a B, it means 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. There's a note. Dashes represent a value that could not be computed. N/A means not available.

And a second note that says claims-based measures do not have CASPER patient-level quality measure reports. And CASPER is a CMS reporting system that is available to providers. And that's where these particular reports will be available to you as well.

Finally, you'll see – before you see the measure data, you'll see the source of the data that's included in the report. And here, you'll see it's Medicare Fee-for-Service claims and eligibility files.

Finally, I'll just review what's included on the report. This, as I stated, was just a sample report. This is not real data. But, first, you'll see the measure name listed on the left. And then you'll see in the first column your hospital scores. And then, just below that, you'll see the national score. So, while you look across, you can compare that your hospitals as compared to the national score.

So you'll see the CMS measure ID for the particular measure; the number of eligible episodes, both for your hospital and nationally; spending during treatment period, which is a dollar figure; the spending during the associated service period, which is a dollar figure, the total spending during episode; the average risk-adjusted spending; the national median; and then, finally, the MSPB score for your hospital and then nationally.

So that's all I have. I am going to actually turn it back over to our call moderator, Charlie Eleftheriou. Charlie?

Question & Answer Session

Charlie Eleftheriou: Yes. Thank you. At this time we'll begin to take and answer some questions. Before we take questions from the lines, though, we're going to read through a few questions we received in advance of today's call.

As a reminder, this event is being recorded and transcribed. I just wanted to remind everyone of that. We're now ready to start reading a couple of questions that were received in advance, and then we'll move on to calls from the phone lines.



Dr. Tara McMullen: Okay. Thanks, Charlie. Hi, everyone. It's Tara McMullen again. And I am going to read about five question-and-answer groups – a couple of questions that we received in the IMPACT Act mailbox. And that is the mailbox that is on slide 42 of your slide deck. You see that PACQualityInitiative. That's the IMPACT Act mailbox. And so, I'm going to read some questions and respond to those questions here.

So the first question is, "When does the MSPB-PAC penalty begin?"

So the answer is: The MSPB-PAC measure was adopted for all the PAC QRPs – that's home health, IRF, LTCH, and SNF in the fiscal year and calendar year 2016 final rules. Since the MSPB-PAC measures are claims-based measures, there is no additional reporting that's required. So there is no penalty for reporting. This is a claims-based measure.

Okay. The second question is: "When will CMS add patient-level data for the MSPB measures?"

And we are responding this way. We are currently exploring the feasibility of providing patient-level information in accordance with HIPAA regulations. And we appreciate your patience as we work through the details in how to be able to provide this level of information in the future.

The third question is: "Why not adopt the use of a uniform, single MSPB-PAC measure for all four PAC settings?"

The answer is: Currently the four PAC-specific MSPB-PAC measures account for distinctions between different types of PAC providers in terms of the beneficiary risk pool, payment policy, and risk adjustment factors for each PAC setting.

The four measures are defined as consistently as possible across settings. However, there are differences in the payment systems for each setting and the types of patients served in each setting. These differences were taken into consideration when aligning the specifications such as episode definition, service inclusions, exclusions, and risk adjustment methods for each setting. To the extent possible, while ensuring the accuracy of the measures, we included all these differences and we took them into account when we were developing the measures themselves.

However, we would like to note as we modify, maintain, and develop the MSPB-PAC measure set, we will continue to assess whether one measure across PAC settings is feasible, particularly under the lens that now CMS is collecting standardize patient assessment data.

The next question is: "The MSPB-PAC measures are resource use measures that are not standalone indicators of quality? How will you ensure they are used in conjunction with other quality measures?"

The answer is: The measures will be reported with quality measures from each corresponding PAC Quality Reporting program.

We believe it is important that the cost of care be explicitly measured so that, in conjunction with quality measures, we can be publicly reporting which providers are involved in the provision of high-quality care at the lowest cost.



The next question is: “How will small facilities be impacted by the MSPB-PAC measure set?”

And the answer to that question is: The MSPB score will be calculated for all providers based on data from all providers. However, only scores for providers with 20 or more episodes in the time period will be reported. And that’s really prototypical of our usual reporting process with all of our quality measures.

And I believe that’s it for the scripted or structured question-and-answer session. Charlie and Dorothy, we are now ready to take questions from the phone line. Thank you.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity. Once your line is open, state your name and organization.

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. If you have more than one question, press star, one to get back into the queue, and we will address additional questions as time permits.

Please hold while we compile the Q&A roster.

Please hold while we compile the Q&A roster.

Your first question comes from the line of Grace Wummer.

Grace Wummer: Hi. Grace Wummer from Philadelphia area. My question is, will the post-acute care provider – PAC provider get – I think you answered about the patient-level detail, but more of an aggregate detail of what the spending is in those confidential feedback reports?

For instance, for a SNF provider, will they get an aggregate on home health spending versus physician services versus inpatient level of care? And that question is in the essence of in order to create quality improvement plans for their organization.

Dr. Tara McMullen: Hi, Grace. It’s Tara McMullen from CMS. And I can answer this and if our Abt team wants to join in or Charles – but, I believe the question is in an aggregate sense, will the confidential feedback reports report all of the aggregate details of the spending for each PAC setting? And at this time, we’re working on those confidential feedback reports. But I believe they will just be reporting the aggregate spending for – so, if you’re in a SNF, you will be receiving information about a SNF. But, if I misunderstood your question, please let me know.

But I believe you – the reports will be focused on the setting that you’re currently in – not you, but, you know, if you’re in a SNF (inaudible)...

Grace Wummer: Yes. That was not my question. I’m sorry.

Dr. Tara McMullen: Okay.



Grace Wummer: I understand it will be reported for SNFs. But the average spending per episode, is that the spending during the associated services period particularly that – patients may get home health, they may get readmitted to the hospital.

Will that be designated somewhere on this report, what the spend is during the – when the patient leaves that skilled nursing facility setting, in each of those buckets – home health versus inpatient versus physician services?

Charles Padgett: No. This is Charles. So you're asking if it will sort of be broken out ...

Grace Wummer: Yes.

Charles Padgett: ...for everything that's included in that total.

Grace Wummer: Right.

Charles Padgett: And I believe the answer to that is no. You will see the total spending during the episode figure and the average risk-adjusted spending.

But I do not believe it is broken out for you as far as everything that's included in that total, although that – you know, the definitions and what actually is being included there is within our measure specifications.

Grace Wummer: Thank you.

Dr. Tara McMullen: Thank you, Grace.

Operator: Your next question comes from the line of Ellen Meehan.

Ellen Meehan: Hi. My name is Ellen Meehan, and I'm calling from a little company, Mary Home Care. And my question is related to what is attributed to us when the patient's under our care. I noted that one of the items that was excluded was planned hospitalizations. So I want to confirm my assumption that unplanned hospitalization spending would be attributed to my organization if the patient is active with my home health when he or she is admitted.

And then, how do we control that when, sometimes, the physicians are the ones who are directing when the patient should go to the hospital or not?

Betty Fout: So, this is Betty Fout, and I can answer some of your questions and, others, feel free to jump in.

Ellen Meehan: Thank you.

Betty Fout: Yes. You're right that the planned admissions are not – are considered unrelated and are excluded, but the unplanned admissions would be included as long as they occur during the treatment window or the associated services period or the entire episode window.



And, you know, the clinically unrelated services, I mean, are defined so that the ones that are – that were determined to be completely out of the agency’s or the provider’s purview would be excluded from the calculation for your measure. But there are certain unplanned hospitalizations that would still be included.

Ellen Meehan: And that would be included in our measure showing that...

Betty Fout: Right.

Ellen Meehan: ...it was our spending despite the fact that we can’t control if the physician sends the patient or not.

Betty Fout: That’s right. It would still be included as part of your measure.

Ellen Meehan: Okay.

Betty Fout: Yes.

Ellen Meehan: Okay. Thank you.

Operator: Your next question comes from the line of Ellen Strunk.

Ellen Strunk: Thank you. This is Ellen Strunk from Alabama. I was calling to find out – you mentioned that the MSPB results for individual providers will be compared to like providers. So I was wondering if that includes the MSPB for swing bed providers. Will they be compared to each other versus to a regular skilled nursing facility provider?

Melissa Morley: This is Melissa Morley from RTI. I can start. All providers receiving skilled nursing facility payments will be provided to each other. There will not be a breakdown for swing versus non-swing.

The distinction between like episodes was more related to the payment policies in the different settings. So, for instance, in the LTCH setting, because there is a standard payment and a site-neutral payment, there is a distinction made there between the types of episodes. But in the case of skilled nursing facilities, all episodes will be compared to each other.

Ellen Strunk: Okay. Thank you.

Operator: Your next question comes from the line of Munazza Malik.

Munazza Malik: Hi. This is Munazza Malik from Sienna Health Care. My question is that, if a SNF has an MSPB score of greater than 1 during the report period, then would there be any rate implication or penalty for that provider?

Dr. Tara McMullen: Hi. This is Tara McMullen. No, there will not be a penalty for that provider. We would, however, report that that SNF had a score of greater than 1 and then be able to detail, you know, what a score greater than 1 actually meant. But, as we stated prior, there – we have QRPs and they are – the penalty



programs for APU – the annual payment updates – but those penalties are for reporting data, assessment-based data. And since this is a claims-based measure, there is no reporting penalty associated with this measure.

Munazza Malik: Okay. Thank you.

Dr. Tara McMullen: Thank you.

Operator: Your next question comes from the line of Meredith Ladd.

Meredith Ladd: Yes. This is Meredith Ladd from Mercy Hospital in Oklahoma. And I was just wondering if dialysis for a patient with end-stage renal disease is considered a clinically unrelated service since it states that routine management of certain pre-existing condition is excluded.

Betty Fout: This is Betty Fout. Can I turn it over to Acumen? Do you know that question off the top of your head – the answer to that question?

Joyce Lam: Hi. This is Joyce Lam from Acumen. So, I believe that dialysis is in the list of clinically unrelated services. We do have a workbook which lists all of the services which have been determined through clinical and stakeholder input to be unrelated. So, I want to double check there to be sure of that.

Meredith Ladd: Okay. Thank you.

Dr. Tara McMullen: Thank you, Joyce and Meredith. If you can send that question to our inbox on slide – I think it's 42 – Joyce and team, we'll get back to you on that.

Meredith Ladd: Okay. Thank you.

Dr. Tara McMullen: Thank you, Meredith. And thank you, Joyce.

Operator: Your next question comes from the line of Mary Ellen Devard-Delavia.

Mary Ellen Devard-Delavia: Good afternoon. Thanks, Tara and Charles and the others for this MSPB presentation.

I saw the timeline for the provider reports – confidential provider reports coming out next month for MSPB. And

I was wondering if the other measures that had the application date of October 1, 2016, like falls, functional outcomes, and the other claims-based measures – would they also be – would the confidential provider report also be available next month for those measures as well?

Charles Padgett: Hi, Mary Ellen. This is Charles. Yes. I believe the answer to that question is yes.

Mary Ellen Devard-Delavia: Okay. Thank you.



Charles Padgett: Yes.

Operator: Your next question comes from the line of Deb Head.

Deb Head: Hi. Thank you. This is Deb Head. I'm from La Crosses, Wisconsin. My question is related to slide number 31 regarding the statement that says, "For IRFs, we include payment category variables for the rehab impairment categories, the RICs." I know there has been discussion about it or there was information in the proposed rules about CMG versus – the case mix group versus the RICs. And my question really kind of relates to, will there – how will you account for facilities that may choose to not want to take the most severe cases?

So within a RIC, there are 10 CMGs within that one RIC, and you can have a real low-level stroke patient and a real high-functioning stroke patient. But it doesn't look like that it will account for that. And then, the second part of that is it looks like DME is included in that. And so if you have patients that have specialized equipment needs and, again, are a very severe patient, will there be a disincentive for facilities to provide care for some of those really severe patients? And we would certainly hope not. But I'm just wondering how you'll look at that.

Melissa Morley: This is Melissa. I can maybe start and, others, please chime in. At this time, we will be using the RICs, the rehabilitation impairment categories, in the risk adjustment. And your point about the CMGs providing more specificity is definitely been something that we've heard previously.

So, I think that is something that we may consider – that we may continue to consider. But at this time the RICs will be part of the risk adjustment. And, also, we also have heard the comment regarding the DME and specialized equipment needs.

Deb Head: Yes.

Melissa Morley: So that's really helpful to hear more about. I think at this time, if something is not on the exclusions list, it is included. But I think it's good to hear, you know, the need to consider this going forward.

Deb Head: Yes. We just wouldn't want to not provide necessary treatment or equipment for patients. And if there's a financial disincentive to do that, just how do you juggle that? So, thank you for considering that.

Dr. Tara McMullen: All right. Thank you.

Operator: Your next question comes from the line of Holly Atrov – I'm sorry – Heidi Ochtrup.

Heidi Ochtrup: Hi. Yes. Thank you. And I would like to support Deb Head's comments. I would agree with those. My questions is, is there – and that may be on the resources page that Melissa had – is there a connection to the exclusion list so that we can know what is included and what is not included in terms of associated clinical services and those not associated?

Dr. Tara McMullen: Hi, Holly. It's Tara. I was waiting for someone else to jump in there. Sorry about that. Yes. We have this information posted about the measures that were finalized – the calculations, specifications. If



you go onto our IMPACT Act website – it's called PAC Quality Initiatives. In the Downloads and Video section, there's a lot there.

We're actually in the process of cleaning it up. But you will find all sorts of information about the MSPB measures, the exclusions, the risk adjustments, the coefficients, everything that's in there per as usual process of posting the specifications and information about the TEPs and the public comment.

And if you – because there's a lot posted on that page, a lot should be archived this week. But if you can't find what you're looking for, if you want to email me, that email on slide 42, I'll make sure I could send you the link.

Heidi Ochtrup: Okay.

Dr. Tara McMullen: But, everything is posted on the PAC Quality Initiatives page in Downloads and Video.

Heidi Ochtrup: And does that include, like, the information – somebody asked that question about dialysis. Is it – and somebody referred to a booklet. Is that – is it that level of information or...

Dr. Tara McMullen: Yes, I believe it is. Actually, I'm going to look right now. I believe it is. Right, Joyce? We included all the booklet work. We included – we have an Excel file there that includes a lot of this work. And I believe it does get down to that level. Yes.

Heidi Ochtrup: Okay. Thank you.

Alan Levitt: This is Alan, the Medical Officer. It's – there's a table, actually, on the measure specifications. And it includes in there the service exclusions. It's kind of a bulleted list.

Heidi Ochtrup: Perfect.

Alan Levitt: And the service exclusions actually do include dialysis for ESRD, enzyme treatments for genetic conditions, treatment for pre-existing cancers, treatment for organ transplants, etc. So it's on the table.

Heidi Ochtrup: Great. Okay. Thank you.

Operator: Your next question comes from the line of Leigh Ann Frick.

Leigh Ann Frick: Yes. Good afternoon. Thank you, Tara, Charles, and the team for all this information today. I just wanted to ask – there are clinical categories in the home health proposed rule as well as in the advanced notice of proposed rulemaking related to RCS. And I was just curious. The clinical categories or clinical case mix categories in this are very different from those. I was curious – the thought process and reasoning behind that.

Dr. Tara McMullen: This is ...

Betty Fout: Hi. It's ...



Dr. Tara McMullen: Go ahead.

Betty Fout: No. After you. I'll go after you.

Dr. Tara McMullen: We're all on different lines. It's tough. We don't see each other. No. After you.

Betty Fout: I was going to say that I do believe that they are different. But I would recommend sending an email to the email box so we can check on that. But...

Leigh Ann Frick: Okay.

Dr. Tara McMullen: Hi. I was going to say the same thing, Betty. It's Tara. And I was going to say a lot of work has also been developed at various times under – for various reasons. And so, while things may be very different, there are end goals eventually to standardize. That was the intent of the act. And the act wasn't limited to quality.

And so I think that as we move through the Quality team – because that's who we are – as we move through the development of the measures, we do – more now than ever, we're keeping an eye out on everything else that's going on. So we hope in the future things aren't so different. But like Betty suggested, send us that email. We'll be able to respond in more detail.

And I must preface, for everyone on the call, all the emails with the questions – we're going to develop a Q&A document and we're going to post it on the site. So, all the emails and the questions we get, you'll be able to see those responses as well and, hopefully, that will help you guys. Thank you.

Leigh Ann Frick: Great. Thank you very much.

Operator: Your next question comes from the line of Sharon Bargmann.

Sharon Bargmann: Hi. I am the Director of Nursing at a small health department in Illinois. And occasionally, we get discharges from a hospital to home health, and they are discharged a little too early. Are we then penalized when we have to resend the patient back to the hospital, and then, also, regarding chronic conditions that require frequent hospitalization like COPD and CHF's?

Betty Fout: This is Betty Fout. Could you say the second part of that question again?

Sharon Bargmann: Patients that have chronic conditions that require frequent hospitalizations like COPD and CHF.

Betty Fout: Yes. So, if the patient was discharged from the hospital and went to home health, and then went back to the hospital, that hospitalization would be part of that agency's – home health agency's measure.

But as we talked about in the risk adjustment slide, the location from where the patient came from is a part of the risk adjustment methodology, and so are some of those conditions. As long as they are captured in the



HCC indicators, it would also be part of the risk adjustment. So the hope is to be able to adjust for those kind of patients as much as possible, which I know will happen to, you know, many agencies.

Sharon Bargmann: We get quite a few. Unfortunately.

Betty Fout: Yes.

Charles Padgett: Hi. This is Charles. I also – I just want to clarify. I've sort of heard the word "penalize" a few times. And I just want to make it clear that for our Quality Reporting programs, what we – the requirement is that you report quality data to CMS.

And you're only penalized if you do not report Quality to CMS. And that is to say you are not penalized for your performance on these measures at this point in time. I just wanted to be sure that was clear.

Sharon Bargmann: Okay. Thank you.

Operator: Your next question comes from the line of Steve Tradagian.

Steve Tradagian: Hello. This is Steve Tradagian from California. We have a small home health care. My question is – maybe I did not understand the tone.

But – so, I understand that MSPB scores – the goal is to be low as possible. But as far as giving that information to the public, are they, you know, being pushed to – are they encouraged to pick one that has the lowest score?

Or do they – I don't know – for some reason, understand that maybe a higher score is better simply for the fact that we're giving more money devoted, you know, per patient? So I just want some clarification on that. Thank you.

Betty Fout: Thank you. That's an excellent question.

Dr. Tara McMullen: Hi.

Betty Fout: Go ahead.

Dr. Tara McMullen: Yes. That's very... No, you first. That's a very good question. I think we all have something to say about that. Go first.

Steve Tradagian: Yes.

Betty Fout: Yes. That's a good question. Definitely, you've been thinking about it a lot. And we – I just want to add that the MSPB measure will be one of multiple quality measures that are on the Compare sites that patients should use to judge the quality of a particular provider.



So I don't think that it's ever been meant to be used in isolation, that the patient should select either the highest or the lowest provider with...

Steve Tradagian: Okay.

Betty Fout: ...provider for that measure value. And Tara, go ahead.

Dr. Tara McMullen: Yes, thanks, Betty. I was just going to say it's just a good question. It is something we think about a lot. And I always like to drive home that, you know, okay, we know IMPACT Act has a lot going on.

But we also know that at some point – and this is why Charles is here – Padgett – that we have to report these measures. And what does – what do the outcomes of these measures mean to the public, to consumers? And how do people use this information?

And like I said, we're in the process – Betty said we're in the process. But this is not to dis-incentivize or say to someone, you know, "Don't go here. You're not allowed to go here."

We're just providing information. For us, it's surveillance. But for the consumer, it's information to help them with their choices in care when going somewhere. So at this time, like Charles said, there are no penalties to this measure.

We're reporting information that would hopefully help consumers in their decisionmaking. And we're hoping that in the way that we're reporting it, it's helpful to providers as well so that everyone's getting something out of the data that we're collecting. Thank you.

Steve Tradagian: All right.

Dr. Tara McMullen: It's a good question.

Steve Tradagian: Thank you.

Dr. Tara McMullen: Thank you.

Charles Padgett: Also, real quick – this is Charles. I just want to point out that, you know, the data that's being publicly reported for this quality measure is – you know, there are three values that I reviewed earlier. And that is your provider's number of eligible episodes, your provider's MSPB score, and then the national average MSPB score. So, in that, there's no dollar amount that consumers are going to go on and see and be able to just say, "Okay, well, this provider spent \$20,000 per patients and this provider spent \$5,000 per patients." And sort of the point of that was we didn't – you know, we took that into account when deciding what to publicly report.

That said, there will be, you know, explanations of the measure on the Compare sites that let the consumer know sort of how the measure works and so forth. But I don't believe there's going to be a dollar amount that's posted on the Compare website itself.



Operator: As a reminder, in order to ask a question, please press star, then the number one on your telephone keypad. To remove yourself from the queue, press the pound key.

Your next question comes from the line of Andrew Koski.

Andrew Koski: Yes. Thank you. This is Andrew Koski from the Home Care Association of New York State.

And my question was really related to the prior question. I was wondering with the data reported to the public, you know, how you would word it to know whether or not, you know, what the effect would be.

Would the data say – would it say from the effect of, “This provider’s costs are, you know, 5 percent higher than the national average. We suggest that you use this along with other data available on Medicare Compare.” I mean, have you thought through how you’re going to actually present and what the statement will say?

Charles Padgett: Hi. This is Charles. So, I mean, I think it’s something we’ve thought about. It’s not something – you know, we haven’t drafted the statement or decided exactly what it will say.

But I will tell you, you know, just as was said previously, all of our Compare websites and all of the quality metrics that we report, we do say that none of them should be used in isolation.

And, in fact, the Compare site itself should not be used in isolation in determining what provider to choose, that there are many other sources of information that can be helpful to providers and they should make that decision in conjunction with speaking to their doctor, speaking with family members, and so forth.

So, CMS does not encourage consumers to use a quality measure really in – you know, we don’t say you should choose this over this on our Compare websites but, rather, sort of present the information to them and let them know how they can use it in conjunction with other measures that are on the site.

Laurie Coots: And this ...

Andrew Koski: I’m... go ahead. I’m sorry.

Laurie Coots: This is Laurie Coots from RTI. I just wanted to add along with that. I think, as you saw in the presentation, we do list off the three elements that are intended for public reporting in next year – so, you know, October 2018.

And that includes the number of eligible episodes, your provider’s MSPB score, and then a benchmark of the national average.

I also wanted to point out that, as we heard earlier in the presentation, the MSPB measures sort of originated on the hospital side. And so, we – in thinking about what to publicly report, certainly, evaluated how hospitals present this information on Hospital Compare and tried to align as much as possible.



Andrew Koski: Thank you. Yes. I also wondered whether or not if you score higher than the national average, whether the public thinks that's good or bad. I don't know the answer to that, and I was curious if you have done any studies, you know, on that issue.

Laurie Coots: So, I think this is an interesting question. This is Laurie Coots from RTI again. We certainly have been evaluating, again, ways to sort of present the information.

Because the MSPB-PAC measures aren't yet publicly reported, there isn't any research specific to these measures on how consumers might view that information. And, so, I think, you know, we don't have any information at this time.

I think it's something, you know, CMS could consider in the future. But, you know, beyond the guidance that a score greater than the ratio of 1.0 is generally higher and lower is generally lower, really is just kind of the general guidance that's provided.

Andrew Koski: Thank you.

Operator: Your next question comes from the line of Justin Hunter.

Justin Hunter: Thanks, operator. Tara, Charles, everyone else, thanks for this presentation. If this was addressed earlier, my apologies. I dialed into the call a few minutes late.

So my question is this. As relates to the confidential feedback reports and for each patient, will health care providers receive specific information about the downstream health care providers and the expenditures that are associated with those services, i.e., the associated services comprising the overall episodic expenditures?

Laurie Coots: This is Laurie Coots from RTI. I'm happy to address this as well. But certainly, Charles and others, feel free to chime in. Yes, that information is provided in an aggregate way. So for the confidential feedback reports and the QM reports, the plan is to be reporting not only the total spending during the episode but also to break that out by the spending during the treatment period and then the spending during the associated services period.

So that information will be available. It's in aggregate. And at this time – I think there was a previous question about how the associated services spending would be broken out or whether it would be broken out. And at this time, it's the – it's an aggregate for the provider. Certainly...

Justin Hunter: So when you say an aggregate, you don't...

Laurie Coots: Yes.

Justin Hunter: ...that doesn't cover the individual patient. Am I understanding you correctly there?

Laurie Coots: I guess what I meant by an aggregate is that there might be different types of services that are rendered during the associated services period...



Justin Hunter: Yes.

Laurie Coots: ...in different claim types as a result. So, perhaps, there's Part A, perhaps there's Part B. Those all get summed up as the spending during the associated services period. So, at this time, there isn't a plan to break that out. But, certainly, hearing this feedback will be very useful for future refinements of the report.

Operator: Your next...

Justin Hunter: Thank you..

Laurie Coots: And I – yes. And I think – just to – sorry. Just to clarify, as Tara had shared earlier, at this time, the patient-level data are not available for the measure. So it is totaled up at the PAC provider level.

Justin Hunter: Okay. Thank you.

Laurie Coots: Sure.

Operator: Your next question comes from the line of Renee Tokarczyk.

Renee Tokarczyk: Hi. And thank you for the presentation. My question is just for clarification of when a treatment period starts and when the trigger starts. If we have a patient who's admitted, for example, to an IRF, been there for 10 days – that's her treatment period – the trigger is when it starts and the treatment period ends when they're discharged.

But the associated services period – if a patient's admitted to a skilled nursing facility directly afterwards. Those costs will be included in the associated services period up to 30 days after the discharge from the IRF. Does the SNF then start the trigger – is there – is the trigger for the SNF the day of admission to the SNF?

And so, then, the first maybe 30 days of the SNF will be a duplication of the charges that are accounted for on the IRF side in the associated services period as well as for the SNF because it will be their treatment period. So it will be accounted for in two different areas, is that – am I following? Is that correct?

Melissa Morley: This is Melissa Morley. I can maybe start. I guess – I think what your question is going to – like – are, you know, are there overlapping episodes?

Renee Tokarczyk: Yes.

Melissa Morley: And the answer is yes. But because we're not – you know, there's not a direct comparison. So this overlap is okay for the purposes of understanding a treatment period plus an associated services period for any given type of setting. There's not any, you know, total, like – we don't need – the overlap is okay for the purposes of the measure because we're not trying to attribute a given claim to a given provider in a mutually exclusive way. I guess the – but your point – your question is, is there overlap?



The answer is yes. But it's not – I guess maybe I'll turn it to Acumen or Abt. I'm sure you've faced this question before. You may have an answer at the ready. But there is overlap, and it is kind of okay because there's not this direct attribution across the providers.

Renee Tokarczyk: Okay. That helps. Thank you.

Operator: Your next question comes from the line of Darlene Brieno.

Darlene Brieno: Yes. I would just like a clarification regarding patients that are admitted to hospitals because they were discharged prematurely. Have you considered setting a window of timing which it is assigned to the hospital instead of to the home health agency?

For example, a 3-day window after DC from hospital. If you have a hospital that habitually discharges patients too soon, it seems wrong to assign that cost against the home health agency. Thank you.

Betty Fout: This is Betty Fout. And others chime in. But, I think this is somewhat related to the question prior that – I mean, that there's also a hospital MSPB measure.

And if a patient were discharged from a hospital and immediately re-enter the hospital, it would factor into that hospital's MSPB measure. It also factors into the post-acute care provider's MSPB measure. But because it's an average, that overlap is okay, as Melissa was saying.

But, yes, I think that, again, the – you know, we do our best to adjust for that with the risk adjustment models that note where the patient is coming from prior to entering the post-acute care setting.

But, I think, it's definitely a recurring theme. So please do email the email box listed on slide 42. And if anybody else wants to add anything, please do.

Dr. Tara McMullen: Betty, it's Tara. Alan and I are probably going to say the same thing. Alan, was that you?

Charlie Eleftheriou: That was me. This is Charlie. I think we have...

Dr. Tara McMullen: Oh, hi Charlie.

Charlie Eleftheriou: ...time for...

Dr. Tara McMullen: I'm sorry.

Charlie Eleftheriou: Yes. Thank you. I think we have time for one more last question.

Operator: And your last question comes from the line of Laura Liccione. And Laura, your line is open.

Laura Liccione: Hi. Thank you for taking my call. I believe my question was answered with the previous question having to do with the overlap between settings. Thank you.



Additional Information

Charlie Eleftheriou: Okay. Well, with that, that's all the time we have for today's call. If we did not – if you have a question that we weren't able to get to or you didn't get a chance to ask, please feel free to email it to the email address listed on slide 42.

For information on evaluating today's call, please see slide 44. Again, this is Charlie Eleftheriou. I'd like to thank our presenters and also thank everyone who participated in today's Medicare Learning Network event on the IMPACT Act. Have a great day, everyone. We appreciate your taking the time out of your day.

Operator: Thank you for participating in today's conference call. You may now disconnect.