MSPB PAC MEASURE Q&A, NOVEMBER 2017

When will each MSPB PAC measure be publically reported?	The MSPB-PAC measures for the IRF, LTCH, and SNF Quality Reporting Programs (QRPs) will be publicly reported in October 2018, while the MSPB-PAC measure for the HH QRP will be publicly reported in January 2019. As noted on the MLN call, the purpose of public reporting is to provide patients, family members, and health care providers with a measure of Medicare spending relative to that of the national median provider in the same PAC setting during an episode of care while accounting for patient case mix through risk adjustment.
When will the confidential feedback reports for each measure be available?	Confidential feedback reports on their performance of the MSPB-PAC measure will be provided to IRF, LTCH, and SNF providers in October 2017, and for HHAs in January 2018. As noted on the MLN call, the purpose of these reports is to provide information to a PAC provider ahead of public reporting on their average spending per episode, MSPB amount, and MSPB score as compared to providers in the same PAC setting nationally. These reports will contain more detail than will be posted publicly.
When does the MSPB PAC penalty begin?	The MSPB-PAC measure was adopted for the PAC QRPs in the FY and CY 2016 final rules. Since the MSPB PAC measures are claims-based measures, there is no additional reporting requirement and therefore no reporting penalty.
When will CMS add patient level data for the MSPB measures?	We are currently exploring the feasibility of providing patient level information in accordance with the HIPAA regulations. We appreciate your patience on this topic.
Why not adopt the use of a uniform single MSPB-PAC measure for all PAC settings?	Currently, the four setting-specific MSPB-PAC measures account for differences across PAC providers in terms of the beneficiary risk pool, payment policy, and risk adjustment factors. The four measures are defined as consistently as possible across settings; however, there are differences in the payment systems and types of patients served in each setting. These differences needed to be considered when developing components of the measure such as episode definitions, service inclusions/exclusions, and risk adjustment methods for each setting. To the extent possible, the measures are aligned while ensuring the appropriateness of the measures to each PAC setting. However, as we modify, maintain and develop these measures, we will continue to assess whether one measure across PAC settings is feasible, particularly now that CMS is collecting standardized data.
The MSPB-PAC measures are resource use measures that are not standalone indicators of quality. How will you ensure they are used	The MSPB-PAC measures will be reported with quality measures from each of the corresponding PAC QRPs. We believe it is important that the cost of care be explicitly measured so that, in conjunction with quality measures, we can

in conjunction with other quality measures?	publicly report which providers providing high quality care at lower cost.
How will small facilities be impacted by the MSPB –PAC measures?	The MSPB score will be calculated for all providers in the PAC setting. Scores for providers with 20 or more episodes in the reporting time period will be reported.
Won't the measures give incentive to providers to avoid medically complex beneficiaries, such as those with chronic conditions like end-stage renal disease (ESRD), which would result in unintended consequences?	To mitigate the risk of creating incentives for providers to avoid medically complex beneficiaries, who may be at higher risk for poor outcomes and higher costs, we have included factors related to medical complexity in the risk adjustment methodology for the measures, including an indicator for ESRD. We also exclude certain services from the measures that are clinically unrelated or where the provider may have limited influence over those services delivered by other providers during the episode window, such as dialysis for ESRD.
Why don't the risk adjustment models include variables for social risk factors?	CMS and our measure contractors are considering social risk factors as we move through measure refinement activities.
May I ask that you segment the claims by type of setting to match those for the Acute Care MSPB? Not providing this type of data segmentation will miss-represent the total cost. The risk adjustment based on extraneous factors like long length of stay is very different than segmentation by hospital claim dollars. Lack of segmentation by claim type encourages fragmentation. It will make integration based on higher use of more cost effective care much more difficult.	The MSPB-PAC measures are aligned with the Hospital MSPB measure in their general measure construction, including using a very similar methodology to define services that are part of an episode and attribute the episode to a provider. You may be referring to the information available from Data.Medicare.gov that displays average Medicare spending per beneficiary by claim type and time period for each hospital. We certainly see the value in displaying the information in this manner and will take this in consideration in future development.
I have a question regarding the "Treatment Period" for home health. If I understand correctly, an episode for home health begins on the first day of the claim and ends at discharge. In home health, there can be multiple 6o day episodes of care associated with a single admission. If a particular patient is recertified for 3 subsequent episodes of care, then discharged at the end of the 4th episode, is the cost of that entire stay (240 days) "charged" to that single post-acute episode? I would think so, but just want to confirm.	For the MSPB-PAC Home Health (HH) measure, the treatment period starts with the beginning of a home health claim and ends 60 days afterwards, or at discharge if the episode qualifies for Partial Episode Payment (PEP). The associated services period begins at the trigger date and goes until 30 days following the end of the treatment period. Given this, excluding PEP episodes, the episode window for MSPB-PAC HH episodes is 90 days. Thus, even if there are multiple home health episodes due to re-certifications, each 90-day episode is treated separately. In the example provided, the 240 day stay would span four separate 60-day HH claims that trigger four separate MSPB-PAC HH episodes. The first MSPB-PAC HH episode would be triggered by the start of the first HH claim, and the treatment period would include the whole 60-day claim. In the associated services period after the end of the treatment period, 30 days of

	the second consecutive HH claim would be counted as associated services, along with any other services occurring during this time (the second HH claim would also trigger its own MSPB-PAC HH episode). The third and fourth HH claims from your example would not be included in the episode costs of this first MSPB-PAC HH episode as they would occur outside of the 90-day episode window. In the case that a patient involved is recertified for multiple successive episodes over a time period, these episodes would be overlapping, meaning that the treatment period for the second episode, for example, would overlap with the post-treatment associated services period of the first episode. Having this overlap between the first and second episodes assures that the provider has the same incentives to provide high quality and cost-efficient care in both episodes. In the case where a patient is recertified for multiple episodes, the costs of care for the entire time period would be allocated to multiple overlapping episodes, and not to the single, initial episode. As an additional note, the spending for all episodes over a given measurement period will be averaged for an attributed provider to obtain a cost measure. Because of this, double counting would not be a concern even if the same service is attributed to more than one episode.
Does the 30-day associated services period include the date of discharge from the trigger PAC stay?	The associated services period ends 30 days after the end of the treatment period for all MSPB-PAC episodes. This 30-day count begins on the first day immediately following the last day of the treatment period. For MSPB-PAC LTCH, IRF, and SNF episodes, the 30-day count begins on the first day immediately following discharge or the day when benefits exhaust (which is treated as a discharge date under each setting's respective payment policy). For MSPB-PAC HH Partial Episode Payment (PEP) episodes, the 30-day count begins on the first day immediately following discharge or transfer. For MSPB-PAC HH Standard and Low Utilization Payment Adjustment (LUPA) episodes, the 30-day count begins on the first day immediately following the end of the 60-day home health episode (i.e., 61 days after the episode trigger).
What are the services excluded because the service is not a PPS bill—CAH, SNF bills from CAHs, anything else?	The exclusion of non-PPS bills applies to claims constituting treatment; that is, where a non-PPS bill (such as CAH Swing beds) would constitute treatment, the episode itself is excluded. When building MSPB-PAC episodes from the claim-level data, any episode constructed with a non-PPS PAC claim will be excluded from the final episode list. These non-PPS PAC claims are identified in the related condition code field by a value of "65", indicating that it is a non-PPS claim, or "04", indicating an HMO beneficiary. The exclusion does not, however, exclude non-PPS bills from being grouped into an MSPB-PAC episode if it is observed during the associated services period. That is,

	non-PPS bills in the associated services period will count towards the observed episode spending.
How would the measures account for premature IP discharges to PAC settings or short PAC stays resulting from inappropriately early discharge?	The MSPB-PAC measures complement the hospital MSPB measure to ensure that there are consistent incentives for acute hospital and PAC providers to deliver quality care and improve care coordination throughout a patient's care trajectory. All the hospital MSPB and MSPB-PAC measures include a period during which post-treatment spending is attributed to the provider; this accountability incentivizes acute and PAC providers to engage in appropriate discharge planning and post-treatment care coordination to minimize the likelihood of costly adverse events, such as avoidable hospitalizations. In this way, acute care hospitals and PAC providers are discouraged from prematurely discharging a beneficiary. Under the design of the measures, short PAC stays resulting from inappropriately early discharge would trigger a new MSPB-PAC episode. Triggering an episode for potentially high-cost patients after admission helps to ensure complex beneficiaries receive the level of care that they need.
How do the MSPB–PAC HH and LTCH measures calculate scores with PEP and LUPA, and Standard and Site Neutral claims, respectively?	The MSPB-PAC LTCH measure calculation is performed separately for standard and site neutral episodes to ensure that they are compared only to other standard and site neutral episodes, respectively. The final MSPB-PAC LTCH measure for a provider combines the two ratios to construct one LTCH score. The MSPB–PAC HH measure calculation is performed separately for MSPB–PAC HH Standard, PEP, and LUPA episodes to ensure that they are compared only to other MSPB–PAC HH Standard, PEP, and LUPA episodes, respectively. The final MSPB–PAC HH measure for a provider is the episode-weighted average of the average scores for each type of episode.
How are LTCH interrupted stays treated by the MSPB–PAC LTCH measure?	A LTCH interrupted stay is reimbursed by Medicare as one claim under the LTCH PPS. Therefore, the treatment period begins at the episode trigger (that is, admission to the LTCH) and ends at the beneficiary's final discharge from the LTCH. The treatment period does not end when the patient leaves the LTCH for an acute care hospital, IRF, or SNF, nor does the patient's return to the same LTCH from those settings within the allowed number of days under the interrupted stays policy, trigger a new episode. The period during which the beneficiary is away from the LTCH and covered by the interrupted stays policy is included in the treatment period as it is treated as a single, albeit interrupted, LTCH stay under the LTCH PPS.