mln call

A MEDICARE LEARNING NETWORK® (MLN) EVENT

IMPACT Act: Medicare Spending Per Beneficiary Measures Call

Wednesday, September 6, 2017

Presenters:

Tara McMullen, CMS
Charles Padgett, CMS
Melissa Morley, RTI International
Laurie Coots, RTI International
Betty Fout, Abt Associates

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

Acronyms in this Presentation

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

Agenda

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

Introduction and Background

Improving Medicare Post-Acute Care Transformation of 2014

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

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

Driving Forces of the IMPACT Act

Purposes Include:

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

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

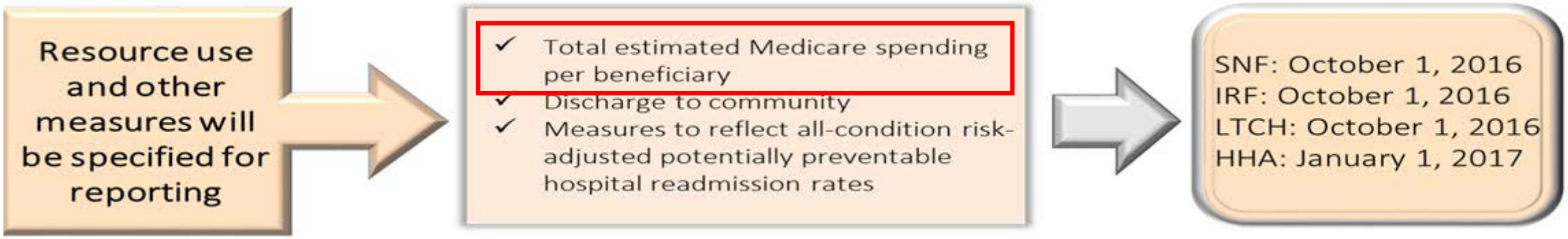
- Escalating costs associated with PAC
- Lack of data standards/interoperability across PAC settings
- Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting

Definitions

Applicable PAC settings and Prospective Payment Systems (PPS):

- Home health agencies (HHAs) under section 1895
- Skilled nursing facilities (SNFs) under section 1888(e)
- Inpatient rehabilitation facilities (IRFs) under section 1886(j)
- Long-term care hospitals (LTCHs) under section 1886(m)

IMPACT Act: Selected Measures and Timelines



Why Measure Resource Use in Post-Acute Care?

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

PAC Setting	Number of Beneficiaries	Cost to Medicare
HHA	3.5 million	$18.1 billion
SNF	1.7 million	$29.8 billion
IRF	344,000	$7.4 billion
LTCH	116,000	$5.3 billion

- From 2001 to 2015, Medicare PAC spending increased on average 5.4 percent per year and doubled to $60.3 billion[2]
- An Institute of Medicine study found variation in PAC spending explained 73 percent of variation in total Medicare spending[3]
- No existing endorsed resource use measures for PAC providers

[1]MedPAC, “Medicare Payment Policy, “ Report to Congress (2017). xvii-xx
[2]MedPAC, “A Data Book: Health Care Spending and the Medicare Program,” (2017). 112
[3]Institute of Medicine, “Variation in Health Care Spending: Target Decision Making Not Geography,” (Washington, DC: National Academies 2013). 2

Goals of the MSPB-PAC Measures

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

MSPB-PAC Measure Development Background

- IMPACT Act requires development of total estimated Medicare Spending Per Beneficiary (MSPB) resource use measures, referring to the Inpatient Prospective Payment System (IPPS) hospital MSPB measure
- CMS had contracted with Acumen to develop the IPPS hospital MSPB measure as mandated by the Affordable Care Act of 2010
  - Finalized in the FY 2012 IPPS/LTCH Prospective Payment System (PPS) Final Rule
  - Initial endorsement by National Quality Forum (NQF# 2158) in December 2013, and endorsement renewed in July 2017
  - Used in the Hospital Value-Based Purchasing Program's Efficiency and Cost Reduction domain since FY 2015
  - MSPB Hospital measure assesses Medicare Part A and Part B payments during an episode that spans from 3 days prior to admission through 30 days post-discharge

MSPB-PAC Measure Development Background, Continued

- The MSPB-PAC measures were developed to follow the general construction of the hospital MSPB measure
  - Hospital MSPB measure referenced in IMPACT Act
  - Create aligned incentives for providers across a patient's trajectory of care from hospital to post-acute care
  - Builds on existing familiarity with NQF-endorsed hospital MSPB measure

MSPB-PAC Measure Development Background, Continued

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

Program implementation and measure maintenance performed by RTI and Abt Associates

MSPB-PAC Measures Overview and Definitions

MSPB-PAC Measures Overview

- The MSPB-PAC measures evaluate a PAC provider's Medicare spending relative to that of the national median provider in the same PAC setting during an episode of care ("episode")
- The measure only covers Medicare Part A and B payments for fee-for-service (FFS) claims
- One MSPB-PAC resource use measure per PAC setting (four total measures)
- The four MSPB-PAC measures are closely aligned with each other (e.g., episode construction, measure calculation)
- Measures do account for setting-specific differences in payment policy, available data, and underlying health characteristics of beneficiaries (risk adjustment)

Key Definitions

- Providers
  - **Attributed provider:** provider for whom the measure is being calculated
  - **Other providers:** providers of other services during the episode
- Types of episode services:
  - **Treatment services:** services provided directly by or managed by the attributed provider during the treatment period
  - **Associated services:** services occurring within the episode window that are not part of the attributed provider treatment
  - **Clinically refined exclusions:** treatment or associated services that are clinically unrelated to treatment and are not counted toward episode costs

Episode Construction

Six Episode Construction Steps

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

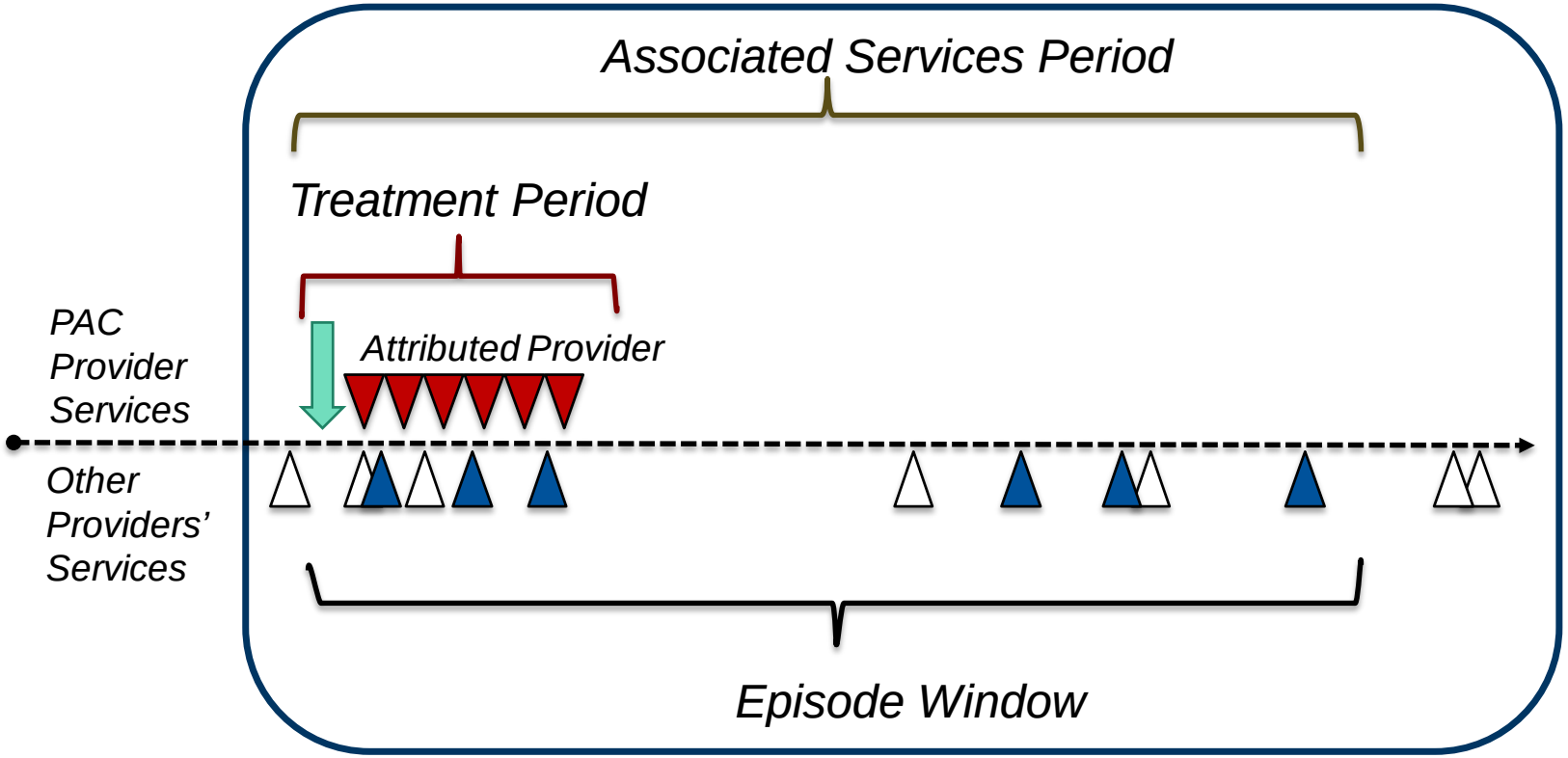
MSPB-PAC Episode Window

Trigger Service

Treatment Services

Associated Service

Clinically Unrelated Service (Excluded)



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

Step 1. Episode Trigger

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

- [1]Home health claims that are subject to both a LUPA and PEP adjustment are treated as PEP episodes to reflect their shorter duration

Step 2. Defining the Episode Window

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

MSPB-PAC Episode Type	Treatment Period	Associated Services Period
SNF & IRF	Trigger to discharge	Trigger to 30 days after end of treatment period
LTCH Standard & Site Neutral	Trigger to discharge	Trigger to 30 days after end of treatment period
HHA Standard & LUPA	Trigger to 60 days after	Trigger to 30 days after end of treatment period
HHA PEP	Trigger to discharge	Trigger to 30 days after end of treatment period

Step 3. Defining Treatment Services

- Treatment services are Medicare Part A and Part B services delivered to a beneficiary during the treatment period that are either provided directly or reasonably managed by the attributed PAC provider as part of the beneficiary's care plan
- Excludes certain services related to prior institutional care on the first day of MSPB-PAC episodes (e.g., ambulance transport related to a hospital discharge)
- Excludes services that are clinically unrelated to PAC treatment

Step 4. Defining Associated Services

- Associated services are non-treatment services that occur within the associated services period
- All spending for Part A and Part B services during this period are counted toward the MSPB-PAC episode, with certain exclusions for clinically unrelated services
- Example: an acute inpatient hospitalization for a complication arising during or after PAC treatment would generally be counted as associated services spending

Step 5. Excluding Clinically Unrelated Services

- Certain services are excluded from MSPB-PAC episodes because they are clinically unrelated to PAC care and/or because PAC providers may have limited influence over certain Medicare services delivered by other providers during the episode window
- Clinically unrelated services were determined with extensive consultation through the measure development process with CMS and independently-contracted clinicians and TEP members
- These services are not counted towards a PAC provider's Medicare spending to ensure providers do not have disincentives to treat patients with certain conditions or complex care needs
- Clinically unrelated services include:
  - Planned hospital admissions
  - Routine management of certain preexisting chronic conditions
  - Some routine screening and health care maintenance
  - Immune modulating medications

Step 6. Episode Closing

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

Measure Calculation

MSPB-PAC Measure Calculation Steps

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

Episode-Level Exclusions

MSPB-PAC episode exclusions include:

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

Payment Standardization

- MSPB-PAC measures use “allowed amounts,” which include Medicare payments and beneficiary deductible/coinsurance
- Payment standardization removes sources of payment variation not directly related to clinical decisions such as:
  - Wage index and geographic practice cost index (GPCI)
  - Incentive payment adjustments
  - Add-on payments that support broader Medicare program goals including graduate medical education (GME)
- Bonus or penalty amounts due to Medicare quality reporting or other special programs are not included
- This enables meaningful comparisons of resource use across geographic areas while preserving differences due to healthcare delivery decisions

Risk Adjustment

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

Risk Adjustment Factors

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

Clinical Case Mix Categories

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

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

Computing the MSPB-PAC Measures

- The MSPB-PAC measure for each PAC setting is a **price-standardized, risk-adjusted ratio** that compares a given provider's Medicare spending against the Medicare spending of other providers of the same type within a performance period
- **Numerator** is the MSPB PAC Amount:
  1. Compute the average risk-adjusted episode costs:
     - Risk-adjusted episode cost = episode's standardized spending divided by the expected standardized spending from applying risk adjustment
     - Average the risk-adjusted episode costs across all episodes for the attributed provider
  2. Multiply average risk-adjusted episode costs by the national average standardized spending for all PAC providers in the same setting
- **Denominator** is national median of the MSPB PAC Amounts for the same PAC setting of the attributed provider

Computing the MSPB-PAC Measures, Continued

- MSPB-PAC Measure for individual provider *j* equals:

$$\frac{MSPB\ PAC\ Amount_j}{National\ Median\ MSPB\ PAC\ Amount}$$

- A value greater than 1 indicates that a given provider's Medicare spending was higher than the national median Medicare spending for that PAC setting
- A value less than 1 indicates that a given provider's Medicare spending was lower than the national median Medicare spending for that PAC setting

Example

MSPB-PAC Resource Use Measure

	Episode 1	Episode 2	Episode 3	Episode 4	Episode 5	Episode 6	
Observed Spending /	$3,300 /	$4,890 /	$4,020 /	$5,270 /	$6,850 /	$5,460 /	
Expected Spending	$4,000 =	$4,100 =	$3,700 =	$6,200 =	$5,900 =	$5,000 =	
Ratio of Obs/Exp	0.825 +	1.193 +	1.086 +	0.850 +	1.161 +	1.092	**= 6.207**

Provider's Average Obs/Exp Ratio

6.207 / 6 episodes = 1.035

MSPB PAC Amount
*(Provider's Average Obs/Exp Ratio * National Avg Observed Spending)*

National Average Observed Episode Spending = $5,325

1.035 * $5,325 = $5,509

Provider Score
(MSPB PAC Amount/ National Median MSPB PAC Amount)

National Median MSPB PAC Amount = $5,700

$5,509 / $5,700 = 0.966

Reporting & Timelines

Reporting Timeline

- Confidential feedback reports
  - The purpose of these reports is to provide information ahead of public reporting on a provider's own average spending per episode, MSPB amount, and MSPB score compared to providers nationally. These reports will contain more detail than what will be posted publicly.
  - Timeline:
    - October 2017 for SNF, IRF, LTCH
    - January 2018 for HHA
- Public reporting
  - The purpose of public reporting is to provide patients, family members, and health care providers with a measure of Medicare spending relative to that of the national median provider in the same PAC setting during an episode of care while accounting for patient case mix through risk adjustment.
  - Timeline
    - October 2018 for SNF, IRF, LTCH
    - January 2019 for HHA
  - Preview reports available ahead of public reporting

Report Content

- Reports include calculations for individual providers and national calculations for comparison
- **Confidential feedback reports** will include the following elements:
  - *Provider-level:*
    - Number of Eligible Episodes
    - Average Spending During Treatment Period
    - Average Spending During Associated Services Period
    - Average Total Spending During Episode
    - Average Risk-Adjusted Spending (MSPB PAC Amount)
    - MSPB Score
  - *National-level:*
    - Number of Eligible Episodes
    - Average Spending During Treatment Period
    - Average Spending During Associated Services Period
    - Average Total Spending During Episode
    - Average Risk-Adjusted Spending (MSPB PAC Amount)
    - National Median MSPB PAC Amount
    - National Average MSPB Score
- **Public reporting** will include the following elements:
  - Your Provider's Number of Eligible Episodes
  - Your Provider's MSPB Score
  - National Average MSPB Score

Sample Confidential Feedback Report – LTCH, IRF, SNF, HHA

CASPER Report
LTCH QRP Facility-Level Quality Measure Report

		Report Period:	01/01/2015 – 12/31/2016
CCN:	999999	**Data was calculated on:**	04/15/2017
Provider Name:	SAMPLE LONG-TERM CARE HOSPITAL		
City/State:	WALTHAM, MA	**Report Run Date:**	06/20/2017
		Report Version Number:	1.00

Table Legend
[a]: The treatment period is the time during which the patient receives care services from the attributed LTCH, and includes Part A, Part B, and Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims.
[b]: The associated services period is the time during which any Medicare Part A and Part B services other than those in the treatment period are counted towards the episode spending.
Note: Dashes represent a value that could not be computed
N/A = Not Available
Note: Claims-based measures do not have CASPER Patient-Level Quality Measure reports

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

				Average Spending Per Episode			MSPB Amount		
Measure Name		**CMS Measure ID**	**Number of Eligible Episodes**	**Spending During Treatment Period[a]**	**Spending During Associated Services Period[b]**	**Total Spending During Episode**	**Average Risk-Adjusted Spending**	**National Median**	**MSPB Score**
Medicare Spending Per Beneficiary (MSPB) – Post-Acute Care Long-Term Care Hospital Quality Reporting Program	*Your Hospital*	L019.01	21	$11,206	$5,010	$16,216	$19,547	$20,473	0.95
	National	L019.01	6,000,000	$13,005	$5,165	$18,170	$20,268	$20,473	0.99

EXAMPLE DATA

Question & Answer Session

Resources

For More Information

- MSPB-PAC Measure Specifications (including risk adjustment factors and exclusion criteria): https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/2016_04_06_mspb_pac_measure_specifications_for_rulemaking.pdf
- IMPACT Act of 2014 Data Standardization & Cross Setting Measures webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-MeasuresMeasures.html
- If you have any questions not addressed in the materials available above, please submit them to: **PACQualityInitiative@cms.hhs.gov**

Quality Reporting Program Websites

- Home Health Quality Reporting Program: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html
- Long-Term Care Hospital Quality Reporting Program: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html
- Inpatient Rehabilitation Facilities Quality Reporting Program: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html
- Skilled Nursing Facility Quality Reporting Program: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-IMPACT-Act-2014.html

Thank You – Please Evaluate Your Experience

Share your thoughts to help us improve – Evaluate today's event

Visit:

- MLN Events webpage for more information on our conference call and webcast presentations
- Medicare Learning Network homepage for other free educational materials for health care professionals.

Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.