



# Inpatient Quality Reporting (IQR) Program

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## Support Contractor

### Medicare Spending Per Beneficiary (MSPB) Measure

#### Question and Answers

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**Bethany Wheeler:** Hello and welcome to the Hospital Value-Based Purchasing Program Webinar on the Medicare Spending Per Beneficiary Measure and Hospital Specific Report. My name is Bethany Wheeler, and I will be your host for today's event. Before we begin I'd like to make a few announcements. This program is being recorded. A transcript of the presentation, along with the question and answers will be posted to our Inpatient website, [www.qualityreportingcenter.com](http://www.qualityreportingcenter.com), within 10 business days. If you registered for this event, a reminder email, as well as the slides, were sent out to your email about two hours ago. If you did not receive that email, you can download slides at our Inpatient website. Again, that's [www.qualityreportingcenter.com](http://www.qualityreportingcenter.com). And now I'd like to welcome our guest speaker, Rachel Yong, from Acumen. Rachel has a Master's of Science in Public Health and is a senior research analyst at Acumen. Rachel is currently the lead project coordinator for the Hospital Value-Based Purchasing Program, where she coordinates all project activities, including managing the calculation of the Medicare Spending Per Beneficiary Measure, application of the payment exchange function, the hospital Total



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Performance Scores using the Hospital Value-Based Purchasing Program and payment standardization of Medicare claims. Any questions that are not answered during our question and answer session at the end of the webinar will be posted to the [qualityreportingcenter.com](http://qualityreportingcenter.com) website within 10 business days, although we do hope to get to as many questions as we can in the last 10 to 15 minutes of the call. Thank you, again, to everyone for joining. Rachel, the floor is yours.

**Rachel Yong:**

Thank you, Bethany. On today's webinar we will be talking about the Medicare Spending Per Beneficiary Measure, also abbreviated as MSPB. The purpose of this presentation will be to give an overview of the MSPB measure and the Hospital Specific Reports that are sent to each eligible hospital. Today we will cover the goals of the MSPB measure, the measure methodology, how and how to perform and calculate the MSPB measure. We'll also go over the Hospital Specific Reports and where you can locate related supplemental files and where downloadable MSPB files can be found on [data.medicare.gov](http://data.medicare.gov).

By the end of the presentation, we hope that you'll be able to identify the goals of the MSPB measure, explain the MSPB measure methodology, and locate the following MSPB documents: the five downloadable MSPB files posted on [data.medicare.gov](http://data.medicare.gov); and, either – each hospital's HSR and supplemental files. The MSPB measure evaluates hospital efficiency relative to the national median hospital. Specifically, the MSPB measure evaluates the cost to Medicare for services provided by hospitals and other healthcare providers during an MSPB episode. An MSPB episode includes all Medicare part A and B claims during the period immediately before, during, and after a patient's hospital stay.

The MSPB measure is an Efficiency Measure in the Hospital Value-Based Purchasing Program, also known as [the] Hospital VBP program. The measure was included starting in fiscal year 2015, and the measure was required for inclusion by the Social Security Act and is endorsed by the



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National Quality Forum. More measure details are included in the fiscal year 2012 and 2013 IPPS Final Rules. The links are included on the slide.

Over today's call I will go over the goals of the measure, then the methodology, specific calculation steps, and an example calculation. I will then go over the Hospital Specific Report and supplemental files to provide and make sure that everyone is able to understand the reports are received by – are received during the summer.

In conjunction with the Hospital VBP Program quality measures, the MSPB measure aims to promote more efficient care for beneficiaries by financially incentivizing hospitals to coordinate care and improve efficiency. So, for example, hospitals can improve efficiency through actions, such as improving coordination with pre-admission and post-acute providers to reduce a likelihood of readmission or reducing the unnecessary post-acute services, or shifting post-acute care from more expensive services to, like, SNF stays, to less expensive services, like home health in cases that would not affect patient outcomes.

Next, I will provide a description of the measure methodology and define a few key terms.

The MSPB measure is a claims based measure, so that means that includes price standardized payments for all part A and part B services provided from three days prior to a hospital admission through 30 days after the hospital discharge. The hospital admission is indicated by the red triangle on this slide, is also known as the index admission. To help further explain how the MSPB measure is calculated, it is important to understand some key terms. The next two slides will define when MSPB measure – what an MSPB episode and an MSPB amount is, and what the MSPB measure is in terms of those two contexts.

The MSPB measure is based on all MSPB episodes an IPPS hospital has during a period of performance. As depicted on the previous slide, an



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MSPB episode is the period before, during, and after an admission to an IPPS episode hospital. Some may ask why an episode includes three days prior to a hospital admission. The reason why is to promote consistency between services provided, regardless of the diagnosis code, and where the services are provided. This is because there are services that can be captured in the inpatient diagnosis related group, or DRG payment, for the hospital and their services are billed and paid separately from the hospital payment. So, on one hand, when the index hospital performed diagnostic and non-diagnostic services that are related to the reason for admission, the services are captured in the inpatient DRG payment. On the other hand, however, when other providers perform diagnostic services, or when the index admission performs non-diagnostic services that appear to be unrelated to their reason for admission, those services are paid separately under Medicare. To capture all of those services, the MSPB episode includes include services – includes all services three days before the hospital admission. Similarly, some may ask why an episode includes 30 days after a hospital discharge. The episode includes 30 days after to emphasize the importance of care transitions and care coordination in improving patient care. Before we move on to the definition of MSPB amount, I'd like to clarify what type of hospital admissions qualify to start an MSPB episode. Hospital admissions that are not considered an index admission to start an episode include: admissions that occur within 30 days of discharge from another index admission; or transfers between acute hospitals that are also not included (in other words, neither the hospital which transfers a patient or the hospital which receives the patient will qualify to start an episode); admissions that have zero-dollar payment will also not be allowed to start an episode; and last, admissions having a discharge date fewer than 30 days before the end of the measurement period will not count as an index admission. Now that we've gone over the definition of an MSPB episode, I will next define what an MSPB amount is.



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An MSPB amount is the sum of all standardized payment risk adjusted spending across all of the hospitals MSPB episodes divided by the number of episodes. Building on the terms we just discussed, so MSPB episode and MSPB amount, the MSPB measure is defined as the hospital's MSPB amount divided by the national episode-weighted median MSPB amount. In other words, the denominator is a median MSPB amount across all hospitals weighted by an episode challenge. Next I will go over how to interpret the measure and provide more detailed measure specifications.

So, how should hospitals interpret their MSPB measure? An MSPB measure that has less than one indicates that a hospital spends less than the national median MSPB amount across all hospitals during a given performance period. So, improvement on this measure for a hospital would be observed as a lower MSPB measure value across performance period. For example, a hospital would have improved in their MSPB measure if they had a measure value of 1.05 in the 2012 baseline period, and then that decreased to 1.01 in the 2014 performance period. Note that the MSPB measure alone does not necessarily reflect the quality of care provided by hospitals. A decrease in MSPB measure across performance period, as in the hospital has a lower Medicare spending per beneficiary, across years, should not necessarily be interpreted as better care. The MSPB measure is most meaningful when presented in the context of other quality measures, which is why the MSPB measure is combined with other measures in the Hospital VBP Programs to provide a more comprehensive assessment of hospital performance.

Now that I have gone over the definition of key terms and how to interpret the MSPB measure, this slide will discuss what populations are included and excluded when calculating a hospital's measure. Beneficiaries are included and those are enrolled in Medicare parts A and B from 90 days prior to the episode through the end of the episode and are admitted to sub-section D hospitals. Starting with 2014 data the beneficiaries covered by the railroad retirement board will also be included in the hospital's



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MSPB measure. Beneficiaries that are excluded are those enrolled in Medicare Advantage, have Medicare as a secondary payer, or died during the episode.

Many of you may be asking how we account for the transition to ICD-10 codes in this year's performance periods. As mentioned before, the MSPB measure includes costs to Medicare from all services occurring in the episode window, regardless of the ICD code billed on the claim. As a result, the transition to ICD-10 codes being billed on claims from October 1, 2015 onward has a low impact on the MSPB measure calculation. On a related note, MSPB will be using the hierarchical condition categories, or HCC model, from the HCC version 22 model. The benefit of using this is that this model already accounts for the inclusion of ICD-10 codes by mapping ICD-9 codes to condition categories, or CCs, and ICD-10 codes to CCs.

The next part of this presentation will focus on the step to calculate in hospitals' MSPB measure. There are nine steps we will walk through over the next set of slides. The first step is to standardize claim payment so that the cost of an MSPB episode, and that's an MSPB amount and measure, can be compared across the country. This is because standardization removes geographic differences in claim payments. The second step is to calculate the standardized spending for all episodes the hospital has. The third step is to estimate the expected episode spending using linear regression. Next, all extreme values produced by their regression in step three are truncated. The fifth step is to calculate the residuals for each episode from the regression, so that we can identify outlier payments. Then, in step six, the outlier payments are excluded, and step seven is to calculate the MSPB amount for each hospital. Then you calculate the MSPB measure based on the MSPB amount, and then you report and use the MSPB measure for the Hospital VBP program for eligible hospitals.



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So, in the first step, claims payments are standardized to adjust for geographic differences, and payments from special Medicare programs that are not related to resource use, so, for example, Medicare pays hospitals' graduate Medical education fund for training residents; this is not directly related to a hospital's choice in resource use, so it is removed when calculating standardized payment amounts. Payment standardization maintains differences that result from healthcare delivery choices, such as the setting where the service is provided, specialty of the provider, the number of services provided in the same visit, and outlier cases. For more information and the full methodology that's used in calculating standardized payments, you can visit the *QualityNet* web page that's linked on this page and look at the detailed methods, as well as the Basic Methods document that is listed on that site.

In the second step, all standardized Medicare part A and part B claim payments made during an MSPB episode is summed together. So, this includes patient deductibles and co-insurance, and claims based on the from date variable. This inclusion criteria is defined by the summed variable on claims, which is the first day on the billing statement covering services rendered to the beneficiary. For inpatient claims, the inclusion criteria is based on admission date on the claim. We often get questions about post-acute care services that extend beyond 30 days after hospital discharge. All post-acute care hospitals – post-acute care services that have a claim from date within the 30 day post hospital discharge will be included. For example, if a hospital is admitted to the – if a patient is admitted to the hospital, triggers an MSPB episode, and then receives home healthcare that begins with within the 30 days after discharge, the index hospital is responsible for the full cost of their home health claims. The measure calculation does not pro rate the cost of home health care or any post-acute care.

The third step is to calculate the expected episode spending amount. In this step, the episode spending amount is adjusted for age and severity of



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illness. Specifically, to account for case mix variation and other factors across hospitals, a linear regression is used to estimate the relationship between a number of risk adjustment variables and the standardized episode cost calculated in step two. The regression model (inaudible) follows the CMS HCC risk adjustment methodology, which is arrived from the Medicare part A and B claims and is used in Medicare Advantage program. The expected spending for each episode is calculated by using a separate model for episodes within a major diagnostic category or MDC. The MDC of an episode is determined by the (MSDRG) of the index hospital stay.

In the fourth step, the extremely low expressed in values of episodes calculated in step three are truncated. In the regression model, using step three, a large number of variables are included to more accurately capture beneficiary case mix. A risk of using a large number of variables is that the regression can produce some extreme predicted values due to having only a few outlier episodes in a given cell. So this step truncates expected value at the points of percentile. The process of truncating extremely low cost expected value (inaudible). So, for each MDC, which is defined by the MSDRG of the hospital admission, episodes that fall below the 0.5 percentile of the MDC expected cost distribution are identified. Next, the expected cost of those extremely low cost episodes are set to the .5 percentile. Last, the expected costs are renormalized to ensure that the average expected episodes spending level for any MDC is the same before and after truncating.

Next, the fifth step calculates the residual for each episode's identified outliers. The residual is calculated as the difference between the standardized episode spending, which is calculated in step two, and the truncated expected episode spending, which is calculated in step four. In the sixth step, the outlier episodes are identified, as we stated in step five, and then are excluded to mitigate the effect of high cost and low cost outliers for each hospital's MSPB measure. High cost outliers are





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identified when the residuals fall above the 99 percent term of the residual cost distribution. Low cost outliers are identified when the residual falls below the first percentile. This step also renormalizes the expected cost to ensure that the average expected costs are the same as the average standardized cost after outlier exclusions.

In the seventh step, the MSPB amount is calculated as a ratio of the average standardized episode spending by the average expected episode spending. That is then multiplied by the average spending level across all hospitals. The equation included in the slide hopefully presents this definition in the text form as well as simplified math form.

In the eighth step, the MSPB measure is then calculated as a ratio of the MSPB amount for a given hospital, as calculated in step seven that we just discussed, and the national episode weighted median MSPB amount.

In the last step, the MSPB measure of hospitals that are eligible for the hospital VBP program and have at least 25 episodes are reported and used for payment purposes.

Now on slide 30, now that we've gone over each of the steps to calculate the MSPB measure, the next set of slide will walk through the calculation of an example hospital.

Over the next three slides, we'll go over how the MSPB amounts and the MSPB measure is calculated. In this example, our hospital has 30 MSPB episodes ranging from \$1,000 to \$33,000 in standardized episode spending. That spending amount is calculated in steps one and two, which is calculating standardized payments, as well as summing it across an MSP episode (inaudible) period. Now that we – Next we apply steps three and four where we calculate the expected episode spending and truncate extremely low cost episodes. After doing those steps, we see that the hospital has one episode with the residual higher than the 99 percentile. As a refresher, the residual is calculated as a difference between



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standardized episode spending and the truncated expected episode spending. This episode, which has a residual higher than the 99th percentile, is then excluded in step six. The MSPB amount and the MSPB measure will then be calculated based on the remaining 29 episodes that this hospital – that this example hospital has. Please note that we have an example calculation that is fully explained with sample data on the MSPB *QualityNet* webpage that's linked on this slide.

The MSPB amount for our example hospital is then calculated as the ratio of the average standardized episode spending over the average expected episode spending, which is then multiplied by the average episode spending across all hospitals. So, as shown in this slide, we see that example hospital A – MSPB amount can – what equal \$8,462.

Next, the MSPB Measure for our example hospital is calculated as the ratio of the MSPB amount, which we calculated in the previous slide, divided by the national episode-weighted median MSPB amount. Let's pretend that the national episode-weighted median amount is \$9,100. As a result, our example hospital would then have an MSPB measure of 0.93. Last, in step nine, we need to determine if the MSPB Measure of our example hospital will be reported for payment purposes. As we stated before, to be eligible for payment purposes, the hospital must have at least 25 MSPB episodes during the performance period. Since our example hospital here has 29 episodes, it's MSPB measure will be reported and used in the hospital VBP program.

In the next two sections of this call, I will provide an overview of the MSPB Hospital-Specific Report and supplemental files that each hospital will receive during the summer. I will also review the files that are released publically in the fall, around October.

So once MSPB Hospital-Specific Reports, abbreviated as HSRs, are sent to hospitals, there is a 30-day preview period where hospitals can review and submit questions or comments before their MSPB measure is released



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publically on the *Hospital Compare* website. Hospitals receive an HSR, which includes six tables and three supplemental hospital-specific data files. The tables in the MSPB HSRs include results for the individual hospital, as well as presents results for hospitals in the state and the nation. The supplemental hospital-specific data files contain information on the hospital admissions considered, as well as other data on Medicare payments that were included in the calculation of the hospital's MSPB measure.

Here in this slide we see Table 1 which is included in each hospital's HSR, and this displays the hospital's MSPB measure.

In Table 2, we see that we show the number of eligible admissions and the MSPB amount for a given hospital. This table also provides the average for the hospital, state, as well as the national average.

Here in slide 38, we see an example of what Table 3 would look like. Table 3 displays detailed statistics related to a hospital's MSPB measure. It includes data such as the number of eligible admissions, average spending per episode, and MSPB amount. As we saw in previous slides, the MSPB measure is calculated using the MSPB amount as a numerator and the national median MSPB amount as a denominator. Thus, hospitals can calculate their MSPB measure by using the row for MSPB amount for their hospital and divide that amount by the U.S. national median MSPB amount.

Table 4 displays the national distribution of the MSPB measure across all hospitals in the nation, and Figure 1 shows that in graphical form.

Table 5 provides a detailed breakdown of a given hospital's spending, for the three time periods of an MSPB episode: the three days prior to index admission, during index admission, and 30 days after hospital discharge. Spending levels are then broken down by claim type within each of these time periods. Hospitals can compare the percent of total average of



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spending by claim type and time period to the total average spending in hospitals in their state and in nation. The costs included in Table 5 are the average actual standardized episode spending amount. The spending amounts included are not risk adjusted for hospital case mix because risk adjustment is performed at the MDC level.

Here on slide 41 you can see an excerpt of table five. In this example the hospital has an average actual spending of about \$5,200 on Inpatient services during the index hospital stay. This is about 32 percent of episode spending for the hospital.

Looking at the same excerpt of Table 5, we can also compare as a percent of total average spending in the hospital to the average in the state and in the nation. The red box highlights the comparison we can make for the percent of spending on Inpatient services during the index hospital admission. We see that the hospital spends about 32 percent of episode spending, which is lower than the percent of spending in the state, which is 47 percent, as well as the percent of the spending in the nation, which is about 46 percent. A lower percent of spending in a given hospital than the percent of spending in the state or in the nation means that for a given category and claim type, the episode spends less than the other hospitals in the state and in the nation.

Table 6 of your MSPB HSR shows similar information as in Table 5, but instead it provides a breakdown of average actual and expected spending for an MSPB episode by MDC. So here hospitals can compare their average actual and expected spending to the state and national average actual and expected spending.

Here on slide 44, you'll see an excerpt of Table 6. In this example the hospital can look at a specific MDC and identify the average actual and expected spending per episode. So here in this example, we can look at the MDC for circulatory system and see that we have an actual and expected spending per episode in columns A and B. As you see, there is



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an actual spend – this hospital has an actual spending of about \$19,000 per episode and expected spending of about \$17,000 per episode.

Now, looking at the same Table as the last slide, here in slide 45 we can look at column C through F to compare the spending level of the hospital to the spending level in the state and in the nation. For episodes in the MDC for circulatory system we can look at columns E and F and identify the national average actual and expected spending, and we see that that is about \$20,000 per episode. Hospitals can compare the national average expected spending per episode, which is column F, to their hospital average expected spending per episode, which is column B. Here we see at – the hospital we are looking at has a lower than average expected spending per episode in column B than the nation, as you see in column F. In addition to receiving an MSPB HSR, each hospital receives three supplemental hospital-specific data files. There is the index admission file, a beneficiary risk score file, and an MSPB episode file. In the index admission file, you'll see all the inpatient admissions for the hospital – for your hospital, in which a beneficiary was discharged during the performance – the period of performance, which for this year's report, would be 2015 data. The beneficiary risk score file identifies beneficiaries and their health status based on the beneficiary's claims history in the 90 days prior to the start of an episode. In this file you'll see the data that was used in the risk adjustment regression model. In the third file, MSPB episode file, you'll see the type of care and the spending amount in the top five billing providers in each care setting for each specific MSPB episode that is given to your hospital.

As mentioned before, hospitals may preview their MSPB measure for 30 days after the release. During the period – the preview period, hospitals may submit questions or requests for corrections to the email address linked up here on the slide: [cmsMSPBmeasure@acumenllc.com](mailto:cmsMSPBmeasure@acumenllc.com). Please be sure to include your hospital's CMS certification number, or CCN, so that we can easily analyze your hospital's questions against the data we



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sent. In addition, if you have a question that we do not get to today during the call, please feel free to email that address as well. As with any other claims-based measures, hospitals may not submit additional corrections to underlying claims data, and they may not submit new claims to be added to the calculations.

Here on slide 49 we list a few of the data files are published and available on the *Hospital Compare* and *Data.Medicare.gov* website. The MSPB measure for all eligible hospital VBP that have at least 25 episodes will be published online. The state and national average is also published and downloadable online. Another set of files is the Medicare Hospital Spending by Claim Type, and this file is very similar to Table 5 in the HSRs that we reviewed earlier. It provides a breakdown of each hospital's average MSPB episode spending level by claim type and by time period. A description of this file is found on the hospital VBP website, which is linked here. CMS also makes available the Hospital MSPB Measure for each hospital up to six decimal places on the *Data.Medicare.gov* site for informational and research purposes.

Over this call we went through quite a bit: the goals of the MSPB measure to the steps involved to calculate the MSPB Measure to the reports hospital receive each year, as well as to the files that are available online. I hope you found this presentation helpful to better understand the MSPB Measure. And I will now pass the presentation back to Bethany to discuss continuing education approval process and to go over any questions that you may have.

**Deb Price:**

Well, thank you very much. Today's webinar has been approved for one continuing education credit by the boards listed on this slide. We are now a nationally accredited nursing provider, and as such, all nurses report their own credits to their boards using the national provider number 16578. It is your responsibility to submit this number to your own accrediting body for your credit.



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We now have an online CE certificate process. You can receive your CE certificate two ways. [The] first way is if you register for the webinar through ReadyTalk®, a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate. We will also be sending out the survey link, in an email, to all participants within the next 48 hours. If there are others listening to the event that are not registered in ReadyTalk® please pass the survey to them. After completion of the survey, you'll notice at the bottom right-hand corner, a little grey box that says [Done], you will click the [Done] box and then another page opens up. That separate page will allow you to register on our Learning Management Center. This is a completely separate registration from the one that you did in ReadyTalk®. Please use your personal email for this separate registration so you can receive your certificate. Healthcare facilities have firewalls that seem to be blocking our certificates from entering your computer.

If you do not immediately receive a response to the email that you signed up with the learning management center, that means you have a firewall up that's blocking the link into your computer. Please go back to the [New User] link and register a personal email account. Personal emails do not have firewalls up. If you can't get back to your new user link, just wait 48 hours because, remember, you are going to be getting another link and another survey sent to you within 48 hours.

Okay, this is what the survey will look like. It will pop-up at the end of the event and will be sent to all attendees within 48 hours. Click [Done] at the bottom of the page when you are finished.

This is what pops up after you click [Done] on the survey. If you have already attended our webinars and received CEs, click [Existing User]. However, if this is your first webinar for credit, click [New User].

This is what the [New User] screen looks like. Please register a personal email like Yahoo or Gmail or ATT since these accounts are typically not



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blocked by hospital firewalls. Remember your password however since you will be using it for all of our events. If you notice, you have a first name, a last name, and the personal email, and we are asking for a phone number in case we have some kind of backside issues that we need to get in contact with you.

This is what the [Existing User] slide looks like. Use your complete email address as your user ID and, of course, the password you registered with. Again, the user ID is the complete email address including what is after the [at] sign.

Okay, now I am going to pass the ball back to your team lead to end the webinar and to over any questions that came in. Thank you for taking the time spent with me.

**Bethany Wheeler:** Thanks, Deb. This is Bethany Wheeler again. We received some questions during the webinar, and we do have some time to answer them. It looks like we have about 14 to 15 minutes currently. So we'll go ahead and get started with the questions. The first one, "Can you tell me the estimated date when the HSR tool be available for download on *QualityNet*?"

**Rachel Yong:** Sure, this is Rachel. We expect to be done downloading and having the files available by the end of this week. So you can log into your *QualityNet* account and download your Hospital Specific Reports.

**Bethany Wheeler:** Great, thank you Rachel. And can you clarify, is that both IQR and VBP HSRs together?

**Rachel Yong:** This would just be the IQR specific for MSPB. So everything related to MSPB will be combined into one zip file. So you'll have the PDF, as well as the three supplemental CSV files that we went over in today's call.





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**Bethany Wheeler:** Okay, thank you Rachel. The next question, “For an episode, how long prior to and for how long after the hospitalization are covered? Are we talking days or weeks or just something that is immediately prior to the hospitalization?”

**Rachel Yong:** So, the MSP episode includes all claims which have a start date that falls between three days prior to inpatient admission, which is at an IPPS hospital, through all the way [un]til 30 days after the patient is discharged from that hospital.

**Bethany Wheeler:** Okay, thank you. The next question, “Why doesn’t the episode of care and after all services are completed which started in the last 30 days. For example, home health that started in the 30 days after discharge but continues for a longer than 30 days.”

**Rachel Yong:** Great, this is a good question. So, the MSPB measure associates the index hospitals, so that starting – triggering IP stay with the cost of all claims are billed within 30 days after discharge from that index submission. So, the patient admitted to the hospital and triggers and MSPB episode and then goes to receive home health care that is billed within the 30 day window after discharge, then that index hospital is responsible for the full cost of the home health claim. So the measure calculation does not pro-rate the cost of home healthcare or any post-acute care. So, specifically, the episode end date is 30 days after discharge, so that end date doesn’t change, but the episode can include costs from claims that continue after the episode end date.

**Bethany Wheeler:** Okay, thank you, Rachel. The next question, “How would you recommend we address this measure with the Outpatient SNF pending. In our case they are surcharging more for spending than the acute side.”

**Rachel Yong:** So, a hospital can improve their MSP Measure by reducing spending or improving delivery systems within institutions. One of the other ways that



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we were suggesting during the call was that you can improve coordination with post-acute care providers to reduce their likelihood of hospital readmissions or reduce unnecessary Inpatient services, for example multiple CT scans. You can also reduce unnecessary post-acute services or shift post-acute care for more expensive services to a less expensive services, like home health, when appropriate. There are multiple other ways that you can improve on your measure, but those are just some to start.

**Bethany Wheeler:** Thank you. The next question is, “Is the MSPB measure geographically adjusted?”

**Rachel Yong:** Yes, it is. So in the first step that we talked about today, your payment standardized claims – so payment standardization is the process of adjusting the allowed charge for a Medicare service to facility comparisons that we’ve received across geographic areas. So, as a result, standardization is not calculated by geographic location, so the methodology eliminates differences that result from regional variations and hospital weight index or a geographic practice cost indexes. For more information, I definitely encourage everyone to look at the *QualityNet* MSPB web pages, and there you will find both in detailed methods, as well as the basic description payment standardization.

**Bethany Wheeler:** Thank you, Rachel. The next question is, “Slide 33 refers to 25 episodes of care needed or received in MSPB score, and the example hospital having 29 episodes of care. What timeframe do these 25 episodes of care need to fall in?”

**Rachel Yong:** So, the timeframe that we are talking about, in both the example, as well as the Hospital Specific Reports that you’ll receive this week, is based on the performance period of 2015. So, for the example that we went over in slide 33, the 25 episodes occur between January and December 2015.



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**Bethany Wheeler:** Thank you. The next question is, “Is the MSPB measure only for IPPS hospitals? Are critical care hospitals excluded?”

**Rachel Yong:** So, the index admission is what is allowed to trigger an MSPB can only be from short term acute hospitals, so specifically sub-section D hospitals during the period of performance. So these are hospitals in the 50 states and D.C., that do not, other than psych hospitals, rehab hospitals, children hospitals, or CAH hospitals, critical access hospitals.

**Bethany Wheeler:** Thank you. Our next question is in reference to slide 44. “How is the expected spending on slide 44 calculated?”

**Rachel Yong:** So, the expected spending that was discussed in slide 44 is calculated based on what – after risk adjustment is applied. So risk adjustment, the measure and the expected spending of risk adjusted for age and severity of illness, in that way we account for the case mix variation among hospitals. So, specifically, the severity of illness is measured across using the hierarchical condition categories in the HCC version 22 model. And that’s based on what we find in the beneficiary’s claim information during the 90-day period before the start of an MSPB episode. We also take a look at the HCC interaction variables and the MSDRG of the index hospitalization. So these variables are regressed against the price-standardized episode cost and then the predicted values, or expected values, in other words, from this regression are used to calculate what we used to see as expected spending in slide 44.

**Bethany Wheeler:** Thank you. The next question is, “What are the risk factors in the linear regression to risk adjust the payments. How does the MSPB measure – how does the MSPB measure differ from the other payment measures in the IQR program, such as AMI, heart failure, or pneumonia payment?” I believe that’s two questions. The first question is, What are the risk factors in the linear regression to risk adjust the payments?”



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- Rachel Yong:** Right, so the risk factors on the linear regression is what I just mentioned in the previous answer. The measure information document that's posted on the *QualityNet* MSPB webpage, as well as some of the other supporting documents, has each of those risk factors listed out. So I highly recommend, as people are looking at their Hospital Specific Report, that they also look at the supporting documentation, and they can examine what each risk factor is used for our linear regression.
- Bethany Wheeler:** Thank you. The next question of that two-part question is, "How does MSPB measure differ from the other payment measures in the IQR programs, such as AMI, heart failure, or pneumonia payment?"
- Rachel Yong:** So, for that question we'd would probably recommend – we would recommend that the viewers look at the *QualityNet* webpages specific to those payment measures. In those web pages you'll find supporting documentation, as well, listing all the risk factors that are using their model.
- Bethany Wheeler:** Thank you. The next question is in regard to slide 19. "Slide 19 refers to the HCC version 22, but then goes on to indicate that ICD-10 codes are mapped to CCs. Where can I find the full list of CCs with ICD-10 codes?"
- Rachel Yong:** So, that's a good question. So, for that – for the mapping, I would recommend going to – if you look at the Risk Adjustment web page on cms.gov, specifically we're modeling after the HCC model used in Medicare Advantage, so one of the risk adjuster items is this entire download section where you can download the exact mapping of ICD-10 codes to HCC models. So if you want to fullest, I would recommend that you (inaudible) download page.



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**Bethany Wheeler:** Thank you. Our next question is, “Are all the costs, related and unrelated to the index submission during the 30 day period, included in the total cost or only those costs related to the index submission?”

**Rachel Yong:** So just like mentioned in, I think one of the first few questions – so all cost, since this is an all cost measure, we look at all the costs that are billed during the 30-day period after discharge. So, to answer that question, all costs related or unrelated, are all included in the episode.

**Bethany Wheeler:** Thank you. I think we have time for few more questions here. “Since hospitals generally get the same payment amount for patients within a particular DRG, what drives the differences in Inpatient Medicare spending across hospitals? The only factors we could think off are outlier payments, length of stay for patients, and transfer DRGs with a post-acute stay and risk adjustment. Is there something else that might impact spending or this portion of the episode?”

**Rachel Yong:** That’s a good question, so, like that person asked. The IP-based payment often – are described as being determined by the DRG of that stay. But there are actually other factors that go into the calculation of the IPSS payment. So, for example, a number of factors could include fiscal year as a DRG related payment, an outlier payment, the length of stay, new technology payments, hemophilia clotting factor payment, device credits, short stage transfer adjustment, and the sequester adjustments. So there are a handful of other factors that are used to calculate the IPSS payment that could make a difference in between hospitals.

**Bethany Wheeler:** Thank you. Another question we received is, “Is the risk calculated for the patient each time they are admitted or is the risk only calculated once?”

**Rachel Yong:** That’s a good question. The risk adjustment is done at the episode level. If there are more specific questions related to that, we are happy to answer



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that, and they can email the MSPB email address that we had mentioned at the end of the slide.

**Bethany Wheeler:** Thank you, Rachel. And that's all the time that we have for questions today. I did see one coming towards the end, and that is, "Where can I get a copy of this presentation?" Copies of these slides are available currently on [qualityreportingcenter.com](http://qualityreportingcenter.com), again, that's [www.qualityreportingcenter.com](http://www.qualityreportingcenter.com). In addition, a full transcript, including the questions and answers, those that were answered on the phone and those that we have not answered yet, will also be available within 10 business days on that same website, [www.qualityreportingcenter.com](http://www.qualityreportingcenter.com).

Thank you for everyone, for joining us today. Hope you have a great rest of your day. Thank you.

**END**