Hospital Value-Based Purchasing (VBP) Program

Support Contractor

Hospital-Specific Report Fast-Track: The Quickest and Easiest Way to Examine Your January 2020 *Hospital Compare* and FY 2020 Hospital VBP Program Medicare Spending Per Beneficiary Measure and Hospital-Specific Reports

Presentation Transcript

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July 11, 2019
2 p.m. ET

Maria Gugliuzza: Hello, and welcome to the *Hospital-Specific Report Fast-Track: The Quickest and Easiest Way to Examine Your January 2020 Hospital Compare and FY 2020 Hospital VBP Program Medicare Spending per Beneficiary Measure and Hospital-Specific Reports* webinar. My name is Maria Gugliuzza, and I am with the Inpatient VIQR Support Contractor. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation and the questions and answers will be posted to the inpatient web site, *www.QualityReportingCenter.com*. If you registered for this event, a reminder e-mail and the slides were sent out to your e-mail about two hours ago. If you did not receive the e-mail file, you can download the slides at the inpatient web site, *www.QualityReportingCenter.com*.

As a reminder, we do not recognize the raised hand feature in the chat tool during webinars. Instead, you can submit any questions pertinent to the webinar topic to us via the chat tool. All questions received via the chat tool during this webinar that pertain to this webinar topic will be reviewed, and a QA summary will be made available at a later date. To maximize the usefulness of the QA summary, we will consolidate the questions received during this event and focus on the most important and frequently asked questions. These questions will be addressed in a questions-and-answers summary to be published at a later date. Any questions received that are not related to the topic of the webinar will not be answered in the chat tool nor in the questions-and-answers summary for the webinar. To obtain answers to questions that are not specific to the content of this webinar, we recommend that you go to the *QualityNet* Q&A tool. You can access the Q&A tool using a link on this slide. There, you can search for questions unrelated to the current webinar topic. If you do not find your question there, then you can submit your question to us via the Q&A tool which again you can access at the link on this slide.

I would now like to introduce the speakers for today's presentation. Our first speaker is from the Medicare Spending per Beneficiary, MSPB, Measure Maintenance Contractor. I would like to note that this section of the webinar was previously recorded. Our next presenter is Melissa Muth.

She is the Claims-Based Measure Project Manager at the Healthcare Quality Analytics and Reports Contractor. Our next presenter is Bethany Bunch. She is the Hospital Value-Based Purchasing Program Lead at the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor.

This presentation will provide an overview of the Medicare Spending per Beneficiary measure and Hospital-Specific Reports, including the goals of the MSPB measure, the measure methodology, and the steps to perform MSPB measure calculation. Additionally, participants will learn how to download the MSPB HSRs from the *QualityNet Secure Portal*. By the end of the presentation, participants will be able to identify the goals of the MSPB measure, explain the MSPB measure methodology, and download the MSPB HSRs.

I would now like to hand the presentation over to our first presenter, Bethany. Bethany, the presentation is now yours.

Bethany Bunch: Thank you, Maria. I'll just be covering a few quick slides on receiving and downloading your MSPB HSRs.

The MSPB HSRs were delivered last Wednesday, July 3. You should only receive one report which serves as the HSR for the Hospital Value-Based Purchasing Program and also the results on *Hospital Compare*. This HSR includes claims from January 1 through December 31 of 2018 which will be used in the fiscal year 2020 Hospital Value-Based Purchasing Program results. We anticipate the fiscal year 2020 Hospital VBP Program Percentage Payment Summary Reports will be enabled on *QualityNet* and available to hospitals by August 1. In comparison to the HSRs that you received last year, you will notice that the six Clinical Episode-Based Payment, or CEBP, measures are no longer included. These six measures were removed from the Hospital Inpatient Quality Reporting Program beginning with the calendar year 2018 data. We anticipate that these measures will be removed from the *Hospital Compare* web site in January of 2020.

Now, we will move onto receiving your HSR. Active hospital *QualityNet* users that have been assigned to Hospital Reporting Feedback - Inpatient and File Exchange and Search roles for your hospitals will receive the report in their *QualityNet* Secure File Transfer inbox.

If you received a report last Wednesday, you should've received an Auto Route File Delivery Notification e-mail similar to the one displayed at the bottom of the screen. In addition, a Listserve communication announcing the availability of the report and also specifics on how to submit a review or correction requests was sent on July 3, as well.

To download your report, log into the *QualityNet Secure Portal* and select Secure File Transfer from the home page.

On the left-hand side, you will select Auto Route Inbox. You will then see the file containing the report. You can select the desired file and then click Download. Please note that the files will be deleted after a specified period of time after transmission, normally 30 to 60 days. So, please download the report timely after receiving the notification. If you are not able to download the report in time, you can contact the *QualityNet* Help Desk via the contact information on the next slide for another copy of the report to be sent.

Hospitals may review and request correction to their MSPB measure for 30 days after the release of their HSR. The Hospital Value-Based Purchasing Program review and correction period ends on August 5 at 11:59 Pacific Time. MSPB measure scores will be used to calculate the Efficiency and Cost Reduction domain. Hospitals will be notified of their fiscal year 2020 Hospital Value-Based Purchasing Program results by August 1, 2019 in the Percentage Payment Summary Reports. During this preview period, hospitals may submit questions or requests for corrections to the *QualityNet* Help Desk at qnetsupport@hcqis.org. Please be sure to include your hospital CMS Certification Number, or CCN, so we can easily analyze your hospital's questions against the data we sent. 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. If you have any questions regarding the receipt of your HSR, please contact the *QualityNet* Help Desk. Thank you for your time. I will now turn the presentation over to discuss the MSPB measure methodology.

MSBP Contractor: The MSPB measure evaluates hospitals' efficiency relative to the national median hospital. Specifically, the MSPB measure evaluates the cost to Medicare for services performed by hospitals and other healthcare providers during an MSPB episode. An MSPB episode includes all Medicare Part A and B claims during the periods immediately prior to, 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 National Quality Forum. More measure details are included in the fiscal year 2012 and 2013 inpatient prospective payment system final rules. The links are included on this slide.

Over today's call, I will go over the goals of the measure, the measure methodology, calculation steps, and example calculations.

I'm going to start with the goals of the measure.

In conjunction with the Hospital Value-Based Purchasing Program quality measures, the MSPB measure aims to promote more efficient care for beneficiaries by financially incentivizing hospitals to coordinate care, reduce system fragmentation, and improve efficiency. For example, hospitals can improve efficiency through actions, such as improving coordination with pre-admission and post-acute providers to reduce the likelihood of re-admission.

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

The MSPB measure is a claims-based measure 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 the slide and is also known as the "index hospital admission." To help further explain how the MSPB measure is calculated, it is important to understand some key terms. The next few slides will define an MSPB episode and an MSPB amount.

The MSPB measure is based on all MSPB episodes that an inpatient prospective payment system hospital, or IPPS hospital, has during a period of performance. An MSPB episode includes all services provided three days before the hospital admission through 30 days post hospital discharge. The reason why an episode includes three days prior to hospital admission is to promote consistency between services regardless of the diagnosis code and where services are provided. Including services that are three days prior to the index hospital admission allows diagnostic and non-diagnostic services that are related to the index admission to be captured in the inpatient payments, as well. Including services that are 30 days after the discharge emphasizes the importance of care transitions and care coordination 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 of another index admission; transfers between acute hospitals; episodes where the index admission claim has zero dollars payment; and lastly admissions having a discharge date fewer than 30 days prior to the end of a measure performance period.

In addition to the MSPB episode, the MSPB measure is based on the MSPB amount. An MSPB amount is the sum of all standardized and risk-adjusted spending across all of the hospital's eligible episodes divided by the number of episodes. Building on the terms we just discussed, MSPB episode and MSPB amount, the MSPB measure is defined as the hospital's MSPB amount divided by the episode-weighted median MSPB amount

across all hospitals. As we'll discuss soon, the MSPB amount is normalized so that the median MSPB measure equals 1.0. I will now go over how to interpret the measure and provide more detailed measure specifications.

An MSPB measure that is less than 1 indicates that a given hospital spends less than the national median MSPB amount across all hospitals during a given performance period. Improvement on this measure for a hospital would be observed as a lower MSPB measure value across performance periods. For example, a hospital would have improved in their MSPB measure if they had a measure value of 1.05 in 2012 baseline period and then that decreased to 1.01 in the 2014 performance period. Now, we do want to take a moment to point out that the MSPB measure alone does not necessarily reflect the quality of care provided by hospitals. 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 Value-Based Purchasing Program to provide a more comprehensive assessment of hospital performance.

Now that I've 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 included are those who are enrolled in Medicare Parts A and B from 90 days prior to the episode through the end of the episode and who are admitted to subsection (d) hospitals. Starting with 2014 data, the beneficiaries covered by the Railroad Retirement Board were also included in the hospital's MSPB measure. Beneficiaries that are excluded are those enrolled in Medicare Advantage, those who have Medicare as a secondary payer, or those who died during the episode.

The next part of this presentation will focus on the steps to calculate the hospital's MSPB measure.

There are eight calculation steps and one reporting step that we will walk through over the next several slides. The first step is to standardize claim payments so that spending can be compared across the country. The

second step is to calculate the standardized episode spending for all episodes in a hospital. The third step is to estimate the expected episode spending using linear regression and, in the fourth step, all extreme values produced in step three are Winsorized. The fifth step is to calculate the residuals for each episode from step three so that we can identify outlier payments. The sixth step is to exclude the outlier payments. The seventh step is to calculate the MSPB amount for each hospital. The eighth step is to calculate the MSPB measure for a hospital based on the MSPB amount. Finally, in step nine, we report the MSPB measure for the Hospital Value-Based Purchasing Program for eligible hospitals.

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, such as hospital graduate medical education funds for training residents. However, payment generalization 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 refer to the documents on this *QualityNet* website.

In the second step, all standardized Medicare Part A and B claim payments made during MSPB amount are summed. This includes patient deductibles and co-insurance, as well as claims based on the "from date" variable. The inclusion of claims based on the "from date" variable is based on the first day of the billing statement covering services rendered to the beneficiary. Inpatient claims are based on admission date. Now, we often get questions about post-acute care services that extend beyond 30 days after hospital discharge. All post-acute care services that have a claim "from date" within the 30-day post-hospital discharge period will be included. For example, if a patient is admitted to an eligible hospital, which triggers an MSPB episode and makes the hospital an index hospital, and then this patient receives home health care, where services begin within the 30 days after discharge from the index hospital, the MSPB

amount of the index hospital will include home health claims. The MSPB measure calculation does not prorate spending on 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 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. Risk adjustment variables include factors such as age, severity of illness, and comorbidity interactions. Severity of illness is measured using several indicators, including the Hierarchical Condition Categories, or HCC, indicators. 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 Medicare Severity Diagnosis-Related Group, or MS DRG, of the index hospital stay.

In the regression model in step three, many variables are included to more accurately capture beneficiary case mix. However, 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. In the fourth step, extremely low values for expected episode spending are Winsorized, or bottom coded. That is, for each Major Diagnostic Category, episodes that fall below the 0.5 percentile of the Major Diagnostic Category expected cost distribution are identified. Next, the expected spending of those extremely low spending episodes are set to the 0.5 percentile. Lastly, the expected spending scores are renormalized to ensure that the average expected episode spending level for any Major Diagnostic Category is the same before and after Winsorizing. This renormalization is done by multiplying the expected spending by the ratio of the average expected spending level within each Major Diagnostic Category and average Winsorized predicted spending level within each Major Diagnostic Category.

In the fifth step, we calculate the residual for each episode to identify outliers. The residual is calculated as the difference between the standardized episode spending, which was calculated in step two, and the Winsorized expected episode spending, which was calculated in step four. In the sixth step, the outlier episodes are identified and are then excluded to mitigate the effect of high spending and low spending outliers for each hospital's MSPB measure. High spending outliers are identified when the residuals fall above the 99th percentile of the residual distribution. Low spending outliers are identified when the residual falls below the first percentile. This last step also renormalizes the expected spending to ensure that the average expected spending is the same as the average standardized spending after outlier exclusions.

In the seventh step, the risk-adjusted MSPB amount is calculated as the ratio of the average standardized episode spending by the average expected episode spending. This ratio is then multiplied by the average spending level across all hospitals.

In the eighth step, the MSPB measure is then calculated as a ratio of the risk-adjusted MSPB amount for a given hospital, as calculated in step seven, and the national episode weighted median MSPB amount.

In the last step, the MSPB measure of hospitals that are eligible for the Hospital Value-Based Purchasing Program and have at least 25 episodes are reported and used for payment purposes. Hospitals with 24 or fewer episodes will not have the MSPB measures used for payment purposes.

Now that we've gone over each of the steps to calculate the MSPB measure, the next several slides will walk through the calculation for an example hospital.

In this example, Hospital A has 30 MSPB episodes ranging from $1,000 to $33,000 in standardized episode spending. After applying steps one through four of the calculations, we see that the hospital has one episode with the residual higher than the 99th percentile. Now, as a reminder, the residual is calculated as a difference between the standardized episode

spending and the Winsorized 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 for Hospital A. We will also have an example calculation as fully explained with sample data on the MSPB *QualityNet* webpage that's linked on this slide.

The MSPB amount for Hospital A is then calculated as the ratio of the average standardized episode spending, or the average expected episode spending, which is then multiplied by the average episode spending across all hospitals. So, for Hospital A the MSPB amount is $8,462.

Next, the MSPB measure for Hospital A 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. So, 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, its MSPB measure will be reported and used in the Hospital Value-Based Purchasing Program.

I will now pass the presentation back to the organizers of this webinar

Melissa Muth: Hi, everyone. I'm Melissa Muth, the Claims-Based Measure Project Manager for the Healthcare Quality Analytics and Reporting Contractor, and today I'm going to review the MSPB HSRs and supplemental files.

On slide 44, we will review the Hospital-Specific Reports, also known as HSRs, and the supplemental files that are included in the distribution of these reports.

On slide 45, the MSPB HSR contains information that can be used to assess a hospital's performance on the MSPB measure for the period of January 1, 2018 through December 31, 2018. The MSPB measure enables

hospitals to understand and take action to improve the efficiency of care they provide to the Medicare beneficiaries who are hospitalized. During the preview period, hospitals can review the MSPB measure in the HSR that is delivered in the form of an Excel file. The Excel version of the report began for 2019 distribution. The MSPB HSR displays specifics regarding hospital's performance on the MSPB measure, and it compares the hospital's performance to the performance of other hospitals in the state and nation. HSRs include six tables and three separate supplemental hospitals-specific data files. The six tables include the MSPB measure results of the individual hospitals while compared to other hospitals in the state and nation. The supplemental hospital-specific files contain information on admissions that were considered for the individual hospital's MSPB measure. Additionally, the supplemental files include data on the Medicare payments to individual hospitals and other providers that were included in the measure. Also included in the delivery is a separate PDF Hospital User Guide, also known as HUG, which will provide additional detailed information about the data in the HSRs and supplemental files. The separation of the HSRs and the user guide change for the 2019 distribution.

On slide 46, upon opening the HSR, the tab will begin with the tab titled Measure, your hospital's MSPB measure. The 0.96 displays the individual hospital MSPB measure performance rate. This is the payment standardized risk-adjusted MSPB amount for the hospital divided by the episode-weighted median MSPB amount across all hospitals. An MSPB measure greater than 1 indicates that the hospital's MSPB amount is more expensive than the US national median MSPB amount. An MSPB measure of less than 1 indicates that the hospital's MSPB amount is less expensive than the US national median MSPB amount.

On slide 47, let's switch tabs and select table 2 titled Performance Summary. Table 2 displays the summary of the hospital's MSPB performance. We will see the number of eligible admissions and the hospital's MSPB amount during the performance period from January 1, 2018 through December 31, 2018. The hospital's MSPB amount is

calculated as the sum of payment standardized risk-adjusted Medicare Part A and Part B payments included in the MSPB measure divided by the total number of episodes for the hospital during the discharge period. Table 2 also provides the state average MSPB amount and the US national average MSPB amount for that period to assist in analysis.

Moving from table 2, we will select table 3 within the HSR which is the performance comparison. Table 3 is the comparison of the hospital's MSPB performance. Table 3 displays the major components used to calculate an individual hospital's MSPB measure including the number of eligible admissions, MSPB amount, and the US national median MSPB amount.

Let's select table 4, titled National Distribution by Percentile. Table 4 displays the national distribution of the MSPB measure by percentile across all hospitals in the nation. This is a static table and appears the same in all HSRs. Look in the HSR user guide only, there is a histogram of table 4 displaying the national distribution of the MSPB measure across all hospitals.

Moving on to table 5, which is titled Detailed Breakdown by Claim Type, table 5 provides a detailed breakdown of a given hospital's spending for the three time periods of an MSPB measure. The three time periods include three days prior to index admission, during index admission, and 30 days after hospital discharge. Spending levels are broken down by claim type within each of these time periods. Hospitals can compare the hospital percent of spending by claim type and time periods to the state percent spending and the US national percent of spending. The costs included in table 5 are the average actual standardized episode spending amount. The spending amounts are not risk adjusted for hospital case mix because risk adjustments are performed at the Major Diagnostic Category, or MDC, level.

On slide 52, as we dissect table 5 a bit further, this example displays this hospital having hospital spending per episode totaling $10,656 for inpatient services during the index hospital stay. This is 50.7 percent of

episode spending for the hospital found within the Hospital Percent of Spending column.

On slide 53, as we continue to analyze table 5, we will also compare the percent of total average spending in an individual hospital to that of the percent spending at the state and national levels. 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 50.7 percent of episode spending which is higher than the percent of spending in the state which is 46.1 percent, as well as the percent of the spending in the nation which is 46.8 percent. In general, a higher percent of spending in a given hospital compared to the percent of spending in the state or in the nation means, for a given category and claim type, the hospital spends more than the other hospitals in the state and in the nation.

On slide 54, let's move on to the table 6 tab titled Detailed Breakdown by MDC. Table 6 provides a breakdown of average, actual, and expected spending for a MSPB episode by Major Diagnostic Category, or MDC. Hospitals can compare their average actual and expected spending to the state and national average actual and expected spending. The hospital can look at a specific MDC and identify the average actual and expected spending per episode.

On slide 55, in this example showing a portion of table 6, we can look at the Major Diagnostic Category for the circulatory system and see that there's an actual and expected spending per episode in columns C and D. This hospital is spending $23,454 per episode compared to an expected spending of $24,788 per episode for the circulatory system.

On slide 56, to further explain table 6, let's use columns E and H 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, let's look at columns G and H and identify the national average actual and expected spending which we will see is being approximately $23,000 per episode. Hospitals can compare the national average expected spending per episode, which is column H, to their hospital average

expected spending per episode, which is column D. Here we see that this hospital has a higher than average expected spending per episode in column D than the nation, displayed in column H.

On slide 57, in addition to receiving an MSPB HSR, each hospital receives three supplemental hospital-specific data files. There is an Index Admission File, a Beneficiary Risk Score File, and an MSPB Episode File. In the Index Admission File, the data display the inpatient admissions for the specified hospital in which a beneficiary was discharged during the period of performance. For the 2019 HSR distribution, the report is based on 2018 data. The Beneficiary Risk Score File identifies beneficiaries and their health status based on the beneficiary's claim history in the 90 days prior to the start of an episode. In this file, the data display what was used in the risk adjustment regression model. Lastly, in the MSPB Episode File, the data display the type of care and the spending amount in the top five billing providers in each care setting for each MSPB episode at the respective hospital. This concludes the MSPB HSR and supplemental file overview. Now, I'd like to turn it over to Maria for the question-and-answer portion of the presentation.

Maria Gugliuzza: Thank you, Melissa, for your presentation. As a reminder to participants submitting questions into the chat window, please include the slide number associated with your question. We received many good questions today, so let's jump right in. Is there a specific time immediately prior to or following the episodes that is included in the Medicare Spending per Beneficiary?

MSBP Contractor: An MSPB episode will include all Medicare Part A and Part B claims with the start date following between three days prior to an IPPS hospital admission, also known as the index admission for the episode, through 30 days post discharge.

Maria Gugliuzza: Thank you. Our next question: Could you clarify the following on slide 25? Hospital admissions that are not considered as index admissions include admissions having discharge dates fewer than 30 days prior to the end of the performance period.

MSBP Contractor: Index admissions with discharge dates within 30 days from the end of the performance period are not included in measure calculations, as those episodes could contain costs not incurred during the period of performance. Period of performance spans January 1 to December 31. So, for example, a beneficiary discharged on December 20 would not have their index admission counted towards the MSPB measure calculation because the 30-day post discharge period for this episode would end on January 9, which is outside the period of performance for that year.

Maria Gugliuzza: Thank you. The next question: What is included in the outpatient claim type?

MSBP Contractor: The outpatient file contains final action fee-for-service claims data submitted by institutional outpatient providers. Examples of institutional outpatient providers include hospital and outpatient departments, oral health clinics, renal dialysis facilities, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities, and community mental health centers. In fact, additional information on outpatient claim types is available on the ResDAC.org website.

Maria Gugliuzza: The next question: Are claims in the Medicare Spending per Beneficiary measure included even if the hospital is not an IPPS hospital?

MSBP Contractor: Admission to hospitals that Medicare does not reimburse through IPPS, for example cancer hospitals, critical access hospitals, hospitals in Maryland, are not considered index admissions and are therefore not eligible to begin an MSPB episode. Now, if an acute-to-acute hospital transfer or a hospitalization in an IPPS-exempt hospital type happens during the 30-day window following and including index admission, however, it will be counted in the measure. So, for more information, MSPB measure information can also be found on *QualityNet.*

Maria Gugliuzza: Our next question: Why are Medicare Advantage patients excluded?

MSBP Contractor: The exclusion of Medicare Advantage patients from the measures is due to a data limitation. The measure excludes beneficiaries enrolled in Medicare Advantage during an episode to ensure that a complete picture of resource

use can be accounted for through the duration of an episode. The system of validating and counter data differs between services under Medicare Advantage and services under the fee-for-service system, and such differences make it difficult to compare claims data across patients who are and patients who are not enrolled in Medicare Advantage.

Maria Gugliuzza: Thank you. Our next question: We see a lot of MDC zero pre-MDC episodes. What does this mean?

MSBP Contractor: The MDC of an episode is determined by the Medicare Severity Diagnosis-Related Group, or MS DRG, of the index hospital stay. The pre-MDC represents hospital stays related to transplants given that the MDC is determined from a number of diagnosis or procedure situations. Specifically, pre-MDC DRGs include organ transplants, bone marrow transplants, tracheostomy cases. This is because transplants tend to be very expensive and can be needed for a number of reasons that do not come from one diagnosis domain. The explanation of the pre-Major Diagnostic Category, or MDC, is also explained in a footnote of table 6 in the HSR.

Maria Gugliuzza: Thank you. Our next question: Are planned readmissions included in the inpatient category of the post-acute portion of the episode?

MSBP Contractor: The 30 days after hospital discharge category includes all Medicare Parts A and B claims for services furnished from an index hospitalization discharge up to and including 30 days post discharge. Given that readmissions would be an inpatient claim, they would show up in the inpatient category of the 30 days after hospital discharge category in table 5 of the HSR.

Maria Gugliuzza: Thank you. The next question, we received this question several times: Is inpatient rehab spending included in the index hospital visit or post-acute?

MSBP Contractor: Since inpatient rehabilitation services would be billed as an inpatient claim, they would show up in the inpatient category of the 30 days after a hospital discharge category in table 5 of the HSR.

Maria Gugliuzza: The next question: What if the post-acute care goes past the 30 days after an index stay? In other words, how is payment included in the episode of care calculations if the end claim of the post-acute claim is beyond 30 days post discharge from the hospital.

MSBP Contractor: This is a good question. We do get this often. So, the MSPB measure associates index hospitals with the cost of all claims that start within 30 days after discharge from the index admission, and costs are not prorated. Thus, if a patient admitted to the hospital triggers an MSPB episode and then receives home health care that is billed within 30 days after discharge, the index hospital is responsible for the full cost of that home health claim. Again, the measure calculation does not prorate the cost of home health care. Another example is if a patient is admitted to the hospital, triggers an MSPB episode, and is then discharged to a skilled nursing facility and remains in the skilled nursing facility for more than 30 days. For example, say, they're there for 90 days, then the index hospital is responsible for the full cost of the skilled nursing facility stay.

Maria Gugliuzza: Thank you. Our next question is a great question. Can you explain why the hospital's MSPB amount is divided by the national median MSPB and not the national average MSPB?

MSBP Contractor: So, the median score represents the score that falls in the middle of the distribution scores going from lowest score to highest score, and the median is less influenced by scores in the high or low ends of the distribution than if you took the average score. This is why we use the MSPB median score as opposed to the MSPB average score.

Maria Gugliuzza: Great. Our next question: Can you explain what is meant by price standardized payments?

MSBP Contractor: So, price standardization accounts for payment differences in geographic locations and special Medicare programs that are unrelated to care, for example, guided medical education, while retaining other aspects and differences in Medicare payments. For more information, you can refer to the MSPB measure information form which is located on the *QualityNet*

Measure Methodology reports webpage, and that same webpage also provides documentation describing payment standardization.

Maria Gugliuzza: Thank you. I think we have time for a few more questions. Can you explain what is meant by risk adjustment?

MSBP Contractor: The MSPB risk-adjustment methodology adjusts the MSPB measure for age, severity of illness, and enrollment status indicators. Specifically, the methodology includes 12 age categorical variables and 79 Hierarchical Condition Category variables, or HCC, that are derived from the beneficiary's claims during the period 90 days prior to the start of the episode to measure of severity of illness, as well as the Medicare Severity Diagnosis-Related Group, MS DRG, of the index hospitalization. The risk adjustment methodology also includes HCC interaction variables, status indicator variables, whether the beneficiary qualifies for Medicare through disability or end-stage renal disease, ESRD, and whether a beneficiary resides in a long-term care facility. For more information, please refer to the MSPB measure information form which is located on the *QualityNet* Measure Methodology web page.

Maria Gugliuzza: Thank you. Our next question: Do we want our MSPB as close to 1 as possible or is it better to be well below 1?

MSBP Contractor: An MSPB measure of greater than 1 indicates that your hospital's MSPB amount is more expensive than the US national median MSPB amount. An MSPB measure of less than 1 indicates that your hospital's MSPB amount is less expensive than the US national median MSPB amount. The MSPB measure should be viewed in the context of other measures to evaluate the quality of care. The MSPB measure is not the only measure by which CMS evaluates hospitals. It is actually, instead, one part of the Hospital Value-Based Purchasing Program that contributes to overall evaluation of a hospital's performance.

Maria Gugliuzza: Our next question: Since most hospitals do not have access to the Medicare numbers and since hospitals are paid based on Diagnostic-Related Group payments, how do you expect hospitals to do performance

improvement? The second half of that question is, nationally, what areas do you see the best areas to focus on for improvement?

MSBP Contractor: All right. Starting with the first question, the Hospital-Specific Reports provide each hospital with a wealth of information to assess its performance in the current period performance to compare against previous HSRs and evaluate their performance against other hospitals in their state and in the nation. In addition to the MSPB measure, the HSRs present the major components used to calculate the MSPB measure for the hospital, state, and the US, including average spending per episode, average risk-adjusted spending, or the MSPB amount, the number of eligible admissions, the national MSPB amount. In addition, the HSR includes the national distribution of the MSPB measure and tables, and they provide a breakdown of the MSPB spending by seven claim types, three time period: three days prior to next admission, during index admission, and 30 days after hospital discharge. These HSRs also provide a breakdown of spending, actual and expected, by the Major Diagnostic Category. Now, alongside the MSPB HSRs, each hospital is given three supplemental hospital-specific data files that enable hospitals to explore the driving forces behind our MSPB measure. So, for example, a hospital can analyze the breakdown of its spending by service type and period of service and figure out the most expensive providers from the episode file. With this information, the hospital can identify the areas where the spending is most concentrated and coordinate with other healthcare providers to improve efficiency. So, by improving care coordination and efficiency and reducing delivery system fragmentation, the provider can improve its relative performance. So, I guess, moving on to sort of the second question, given that the main drivers of MSPB spending will vary by hospital, there is an improvement that will be hospital-specific, but more generally, most of the variation in MSPB spending tends to come from post-discharge spending, specifically, skilled nursing facilities followed by inpatient readmissions. So, better care coordination in the post-discharge setting is one of the areas to focus on for improvement.

Maria Gugliuzza: That's all the time we have for questions today. If your question was not answered or if you would like to review all of the questions and answers covered today, please go to the *QualityReportingCenter.com* web site in the upcoming weeks to find the question-and-answer summary.

On the next slide, there is a link to review the CE process. Our webinar today was approved for one continuing education credit.

I would now like to thank all of the presenters and the participants for today's webinar, and I would like everyone to have a great day.