Hospital Value-Based Purchasing (VBP) Program

Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor

Reviewing Your FY 2022 Hospital VBP Program and January 2022 Public Reporting MSPB Hospital-Specific Report

Questions and Answers

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Subject-matter experts researched and answered the following questions after the live webinar. The questions may have been edited for grammar.

Question 1: **Are readmissions for elective procedures included in the Medicare Spending per Beneficiary (MSPB) measure calculation?**

An MSPB episode will include all Medicare Part A and Part B claims with a start date falling between three days prior to an inpatient prospective payment system (IPPS) hospital admission (also known as the "index admission" for the episode) through 30 days post-hospital discharge. Thus, readmissions for elective procedures are included in the measure calculations.

Question 2: **What are "carrier" claims?**

Carrier spending levels represent spending for services that appear in the Carrier Claims File, which contains claims submitted by non-institutional providers. The Research Data Assistance Center describes the carrier file as follows: "The Carrier File includes fee-for-service claims submitted by professional providers, including physicians, physician assistants, clinical social workers, and nurse practitioners. Claims for some organizational providers, such as free-standing facilities, are also found in the Carrier Claims File. Examples include independent clinical laboratories, ambulance providers, free-standing ambulatory surgical centers, and free-standing radiology centers."

Question 3: **What is included in the Inpatient claim type category during the time period "30 Days after Hospital Discharge" on Table 5, Detailed MSPB Spending Breakdown by Claim Type, of my Hospital-Specific Report (HSR)?**

The Inpatient category includes all claims in the Inpatient claims file. Regarding claims during the "30 Days after Hospital Discharge" category, this category includes all claims that fall between an episode's index admission discharge date and 30 days after hospital discharge. Accordingly, in Table 5, an MSPB episode can have an inpatient claim during this time if the patient is readmitted to the hospital after the index admission discharge. In the "30 Days After Hospital Discharge" category, this could include inpatient readmission, as well as admissions to an inpatient psychiatric or rehabilitation facility.

Question 4: **How can I verify the Number of Eligible Admissions used to calculate my hospital's MSPB performance in Tables 2 and 3 of my HSR?**

This can be verified from any of the three supplemental data files provided by looking at the variable Hosp_Episode_Count. In addition, you can filter the Index Admission File, where the Index_Admsn_Flag variable equals 1. The variable Excluded_Reason in the Index Admission File provides the reason for exclusion.

Question 5: **Will Critical Access Hospital's receive a fiscal year 2022 MSPB HSR?**

The MSPB Measure calculation only includes acute care hospitals paid under the IPPS. As a result, Critical Access Hospitals are excluded from the MSPB calculation and will not receive an MSPB HSR.

Question 6: **Why is continuous enrollment in Part A/B for the 90 days prior to the episode start date required for beneficiaries?**

The 90 days prior to an episode is used to define a beneficiary's characteristics to predict expected spending during risk adjustment. Since the measure is based on Part A and Part B claims, enrollment during this period is required so that the beneficiary's risk factors can be appropriately observed through the claims data used.

Question 7: **Can you explain "risk-adjustment"?**

Risk adjustment predicts the expected costs of an MSPB episode by adjusting for factors outside of the hospitals reasonable influence that can impact spending, such as pre-existing health conditions or age. A linear regression is used to predict the coefficients for each indicator in the model. These coefficients represent the mean difference in episode spending when the health condition is present. For example, if we observe that patients with end-stage renal disease (ESRD) are more expensive that non-ESRD patients, then the mean difference in episode spending observed in the population for ESRD patients will be added to the expected cost of an episode for ESRD patients. This adjustment prevents disadvantaging episodes that serve riskier patients.

Question 8: **Do we want a higher or lower value for the MSPB measure?**

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. Lowering of a MSPB measure score indicates improvement on the measure. 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.

Question 9: **Has the MSPB hospital measure calculation changed from last year?**

The only difference in this year's measure is the adjustment of the performance period in response to the COVID-19 pandemic. As for the measure's methodology specifically, no, there have been no changes to the MSPB hospital calculation.

Question 10: **If the beneficiary dies within the 30 day post-stay period are they excluded?**

Yes, beneficiaries that pass anytime during an MSPB episode are excluded. This includes the 30-day post discharge period.

Question 11: **If a person that is considered an inpatient is discharged but receives an expensive treatment/infusion as an outpatient, is this included in the 30-day total?**

Yes, the MSPB measure is an all-cost measure. This means all Part A and Part B services during the episode window are included. In your example, the outpatient services occurring within 30 days of the inpatient admission are included.

Question 12: **Where would acute rehabilitation facility spending fall in Table 5? Is it under Skilled Nursing Facilities (SNFs)?**

The services are defined based on the reimbursement system in which they were provided. Rehabilitation services provided by skilled nursing facilities, covered under the Skilled Nursing Facility Prospective Payment System (SNF PPS), will be presented in the skilled nursing line. Inpatient Rehabilitation Facilities (IRFs) are reimbursed through the IRF IPPS and would be presented under the inpatient line.

Question 13: **If a SNF's Level of Service (LOS) is greater than 30 days, is the SNF's cost prorated for the 30 days after the inpatient discharge?**

No, all Part A and Part B claims starting during the episode window will be included. If they extend beyond the episode end date (30 days post-discharge from the index hospital admission), they will be included without proration.

Question 14: **Can we still expect to receive a MSPB HSR in the Managed File Transfer (MFT) if the hospital had fewer than 25 episodes? If not, how would we know that we didn't meet the threshold?**

Yes, a hospital would receive a MSPB HSR for FY 2022 if the hospital had fewer than 25 episodes and measure results for the abbreviated time period.

Question 15: **Where can we find the definitions of the labels on the episode file? Some are hard to understand. "PDF file" or "Spreadsheet" does not give a definition of these columns.**

Documentation on the supplementary data files are available on this QualityNet page: https://qualitynet.cms.gov/inpatient/measures/mspb/reports The downloadable document *Hospital-Specific Data Files Descriptions* contains an overview of each supplemental data file and detailed data dictionaries that describe each field in each file. Specifically, *Table 2. Episode File Data Elements* provides the descriptions of data elements found in the episode file.

Question 16: **Our eligible discharges on the most recent report is significantly less than in prior years. Should we be concerned?**

Fully capturing and evaluating the potential reasons for decreased eligible discharges for any specific hospital require targeted review of its unique data. Given this caveat, decreases in eligible discharges will be observed across all hospital reports as a result of the modified performance period. In response to COVID-19, CMS did not use claims reflecting services provided January 1, 2020, through June 30, 2020, (Q1 and Q2 2020) in its calculations for the Medicare quality reporting and VBP programs. Shortening of the performance period is the most likely contributor to decreased eligible discharges and will be observed for all hospitals. For other contributing factors, hospitals can review their Index Admission Data, a supplementary data file delivered with their HSR, to observe all their hospital admissions. Column F, EXCLUDED_REASON, can be used to identify the reason for exclusion for each discharge and can be compared to previous years data to evaluate any changes in care practice that may contribute to fewer eligible discharges.