Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Clinical Episode-Based Payment (CEBP) Measures

Questions & Answers

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Support Contractor

Question 1: **We are a multi-hospital system with facilities in Ohio and Michigan. One of our Michigan hospital's CEBP Hospital-Specific Report (HSR) has different U.S. national median CEBP amount for all three categories than the rest of our hospitals in both states. What would be the reason for this?**

On August 16, 2017, the Centers for Medicare & Medicaid Services (CMS) announced the release of HSRs for the claims-based Clinical Episode-Based Payment (CEBP) measures for informational purposes only. **Revised** CEBP HSRs that correct a singular statistic have been uploaded with file names that are suffixed with the date 081817. Table 3 of these revised HSRs has been updated to report the national episode-weighted median episode amount instead of the unweighted national median episode amount. Please note that this revision does not affect other values displayed on the report such as measure scores for episodes, as the inclusion of the unweighted national median amount was limited to a display issue in Table 3 and did not affect calculations.

For HSR-related questions, please email cmscebpmeasures@econometricainc.com. In your email, please include your hospital name and CMS Certification Number (CCN) so that we can better address your questions.

Question 2: **Which reporting program is the CEBP under?**

The CEBP measures will become part of the Inpatient Quality Reporting (IQR) Program measure set for payment determination starting fiscal year 2019.

Question 3: **What would be the penalty for scoring above 1.0 in the CEBP measures?**

A CEBP measure of greater than 1.0 indicates that your hospital's CEBP amount for a given condition or procedure is more expensive than the U.S. national episode-weighted median CEBP amount for that condition or procedure. A CEBP measure of less than 1.0 indicates that your hospital's CEBP amount is less expensive than the U.S. national episode-weighted median CEBP amount. Please note that resource-use measures, such as CEBP measures, are most meaningful when presented in the context of other quality measures to provide a more comprehensive assessment of hospital performance.

Question 4: **In the CEBP spending breakdown under the "clinically related post-discharge services," what does the inpatient category cover?**

This category covers any inpatient claims that occur in the post-discharge period. These could be inpatient (IP) readmissions that are clinically related according to the grouping process detailed in the CEBP measure specifications

and grouping rules. The clinically related determination could be made based on just the Diagnosis-Related Group (DRG) or, in cases where clinical experts felt that the DRG by itself wasn't sufficient, the DRG in combination with particular diagnoses.

The inpatient admissions here could be of a wide array of possibilities, depending on the grouping rules for the specific clinical episode. Information about CEBP measures grouping rules can be found at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228775614447.

More information on inpatient services can be found at https://www.resdac.org/cms-data/files/ip-rif

Question 5: **For acute-to-acute transfers, are the patients excluded from the receiving hospital, as well as from the sending hospital?**

Yes. If there is an acute-to-acute transfer, then that episode would not trigger an episode for the purposes of the CEBP measures. Neither the receiving hospital nor the sending hospital is assigned an episode for the CEBP measure in this case.

Question 6: **Since claims are based on a DRG, how do the measure developers determine what care during the inpatient admission is considered "unrelated" to a condition? In other words, how is the separation between filled and unfilled triangles determined?**

The easiest way to think about the components of the measure is to think of two types of services being distinguished: Treatment services and clinically related post-discharge services. Treatment services are for the initial treatment of the condition. Treatment services include the services during an inpatient stay, as well as pre-trigger services such as diagnostics related to the inpatient stay. Clinically related post-discharge services are services that could include routine follow-up care after discharge. Clinically related post-discharge services could also include complications, such as those manifested through readmissions to inpatient facilities. For treatment services, all cost of Part A claims during the inpatient stay are included in the measure. Treatment services also include the standardized allowed amounts of Part B physician supplier claims during the inpatient stay. For pre-trigger services and clinically related post-discharge services, our clinicians and externally contracted clinicians have done an extensive review of services occurring in these time periods in order to determine clinical relatedness and un-relatedness.

To complete the review, the measure developers gathered clinicians with expertise in the given areas. For example, we used gastroenterology and colorectal experts for the gastrointestinal (GI) hemorrhage episode. For the kidney/urinary tract infection (UTI) episode, we had general medical and surgical practitioners and nephrologists. For cellulitis, we had general practitioners in medical and surgical specialties. We constructed these episodes and brought up the services occurring during the episodes, along with a diagnoses, in front of the clinical experts. The clinical experts reviewed the services and made determinations according to a series of rules that are spelled out in detail on the methodology document. Whether those services are likely to be clinically related and influenced by the hospital determined the trigger admission and attributed the measure.

The clinicians then reviewed these services and determined whether services were clinically related. The clinicians counted only the standardized allowed amounts associated with the related admissions that are represented in clinically related post-discharge services and pre-trigger services in the total spending amount.

More information about the determination of clinically related services (grouping rules) can be found at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228775614447.

Question 7: **Are CEBPs defined by MS-DRGs?**

CEBP episodes may be defined by Medicare Severity (MS)-DRGs, International Classification of Diseases (ICD)-10, and/or Current Procedural Terminology (CPT) codes. Please refer to documentation on the following link, which provides specific codes for condition and procedure CEBP episodes: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228775614447.

Question 8: **The website given above for additional information on the IP claim type is not valid. It shows a "page not found" error message.**

For IP services, please try https://www.resdac.org/cms-data/files/ip-rif.

Question 9: **Can you define "Carrier"?**

The Carrier file (also known as the Physician/Supplier Part B claims file) contains final action fee-for-service claims submitted on a CMS-1500 claim form. Most of the claims are from non-institutional providers, such as

physicians, physician assistants, clinical social workers, and nurse practitioners. Claims for other providers, such as free-standing facilities, are also found in the Carrier file. Examples include independent clinical laboratories, ambulance providers, and free-standing ambulatory surgical centers. Additional information can be found at https://www.resdac.org/cms-data/files/carrier-rif.

Question 10: **Why are Medicare Advantage patients excluded?**

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 encounter data differs between services under Medicare Advantage and services under the fee-for-service system. Such differences make it difficult to compare claims data across patients who are and patients who are not enrolled in Medicare Advantage.

Question 11: **A patient may come into the hospital with one primary condition; however, during evaluation, additional problems are often diagnosed — present on admission. A condition may not be clinically related to the primary condition, but perhaps clinically related to one of the additional diagnoses. Does this methodology take into account all conditions clinically related to any diagnosis present on admission, or only the primary diagnosis?**

In assigning clinically related services, the clinical experts are examining the attributed hospitals inpatient stay and trying to determine what services are reasonably under the influence or affected by the attributed hospital's treatment during that inpatient stay. If there are conditions that have comorbidities present on admission, and **those** are conditions are not directly a part of the inpatient stay and not necessarily under the influence of the hospital, they would not be used to assign clinically-related services in the pre-trigger, post-discharge period.

This is to ensure that the episode spending does not include services that are part of comorbidities that the hospital is not accountable for in providing treatment for the specific DRG. The focus is on grouping services to the episode that are clinically related to the specific DRG and episode type that we're looking at in the measure. At the same time, the comorbidities will be accounted for in risk adjustment to the extent that they are present in the patient during the 90-day look-back period from the start of a CEBP episode. If these comorbidities are present in the 90-day look-back period, they are

included in the risk-adjustment model to ensure that hospitals are not penalized for complex patients.

Question 12: **Where do we find our hospital-specific payment amount for the conditions and procedures? Do we just add and average?**

To find the payment amount for your specific inpatient stay at your hospital just for the triggering inpatient stay, look for average spending per episode in Table 5 of the HSR. It will be listed under the treatment section under the inpatient row. The information is also available in the supplementary Comma Separated Value (CSV) files that are provided as an accompaniment to the HSRs. For payment amounts across all claims that are grouped to the episodes, claims from the triggering inpatient stay (i.e., index inpatient stay) pre-trigger period of three days, and post-discharge period of 30 days, are displayed as the average episode payment amount in Table 3 in the HSRs. The HSRs only list condition measures this year. Procedural measures will be included in HSRs starting in 2018.

Question 13: **If my HSR for cellulitis diabetes has no data, does that mean that we had no cellulitis patients with a diabetes code?**

That is correct. Your hospital did not have any episodes for that subtype. However, it is important to keep in mind that the exclusion criteria discussed in the presentation have been applied. These exclusion criteria are included in the methodology documents in the *QualityNet* webpage at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228775614447. For instance, if you had a Medicare Advantage patient for cellulitis with diabetes, that patient and their episode would not be included in the measure. So your HSR for cellulitis diabetes would have no data reported.

Question 14: **Slide 11: Does the patient population include encounters that did NOT meet 2 Midnight criteria (intended inpatient, but billed as outpatient)?**

The measures only include admissions to inpatient prospective payment system (IPPS) hospitals that are billed on IP claims under the given trigger rules. If they're billed on an outpatient (OP) basis, then they would not be able to trigger an episode.

Question 15: **Slide 18: To clarify if a case has the subtype ICD-10 code but not a DRG for cellulitis, is this considered a trigger event? If so, is this a primary or secondary ICD-10 diagnosis code?**

No. The subtype ICD-10 codes would not be sufficient to trigger a CEBP episode for cellulitis. These codes would need to occur with a trigger DRG listed in the methodological documentation.

Another question asked if CEBPs are defined by MS-DRGs. This related question concerns the opening or triggering of CEBP episodes. All CEBP episodes are triggered by an MS-DRG found on an inpatient claim. In addition, there are identification of clinical subtypes that can happen through the presence of ICD-10 diagnosis codes or through the presence of CPT Procedure Codes. It is also possible for the procedural episodes to have complementary trigger rules that depend on CPT codes, on Part B claims.

Question 16: **Is CEBP a claims-based measure?**

Yes. The measure is based fully on claims and no registry information is included.

Question 17: **If these measures are risk-adjusted, would reviewing the Hierarchical Condition Category (HCC) for additional diagnosis help ensure the patient is coded correctly to allow for correct calculations of the risk-adjusted payment amount?**

The index admission (i.e., triggers for CEBP episodes) and grouping rules were determined through clinician review.

The risk adjustment model includes independent variables for age, severity of illness, and enrollment status. Specifically, the methodology includes age-categorical variables, HCC variables derived from the beneficiary's claims during the period 90 days prior to the start of the episode, and the MS-DRG of the index hospital admission. The risk adjustment methodology also includes the HCC interaction variables, status indicator variables for 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. The inclusion of MS-DRGs in the risk adjustment accounts for variations in the expected cost of treatment for patients with different medical conditions and patient illness severity within a DRG family (e.g., patients with complications and comorbidities versus patients with no complications or comorbidities).

For more information about the clinical determination of CEBP measures index admissions, grouping rules, and risk adjustment, please refer to the measures specifications document on https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPub

lic%2FPage%2FQnetTier4&cid=1228775614447. More information about the HCC model can be found at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html.

Question 18: **In the transition from slide 44 to 45 there was a comment about an aspect that is not risk adjusted. Please explain in more depth.**

There are lines in Table 5 of the HSRs that show breakdowns of episode spending by various service settings (e.g., skilled nursing facility, inpatient, outpatient) to provide more information about specific areas of spending. During the presentation, we pointed out that these values are not risk adjusted. However, risk adjusted payment amounts are included at the clinical subtype level shown in Table 6. The CEBP measures are risk adjusted at the clinical subtype level, which is why values under the "Average Expected Spending per Episode" in Table 6 are risk adjusted.

Question 19: **How will this data be abstracted?**

For 2017, CEBP condition measures are provided in HSRs for informational purposes only. They will not be publicly posted on *Hospital Compare*. However, starting in 2018, CEBP condition and procedural measures will be included in HSRs and posted publicly on *Hospital Compare*.

Question 20: **So any hospitals that are currently in the IQR program will have to submit these measures?**

Hospitals do not submit CEBP measures. CEBP measures are based on Medicare claims data.

Question 21: **So does the CEBP take the focus off of All-Cause Readmissions?**

The CEBP measures include post-discharge claims that were determined by clinician review to be clinically related to the CEBP condition or procedural episode in question. The CEBP measures are distinct from other measures.

Question 22: **Were new updated CEBP HSRs released due to a calculation error? If so, our hospital still has not gotten new updated HSRs through the Secure File Transfer. Who do we contact to get the new files on the Secure File Transfer in *QualityNet*?**

On August 16, 2017, CMS announced the release of HSRs for the claims-based CEBP measures for informational purposes only. **Revised** CEBP HSRs that correct a singular statistic have been uploaded with file names that

are suffixed with the date 081817. Table 3 of these revised HSRs has been updated to report the national episode-weighted median episode amount instead of the unweighted national median episode amount. Please note that this revision does not affect other values displayed on the report, such as measure scores for episodes, as the inclusion of the unweighted national median amount was limited to a display issue in Table 3 and did not affect calculations. For questions related to HSRs, please email cmscebpmeasures@econometrica.com. In your email, please include your hospital name and CCN so that we can better address your questions.

Question 23: **When will the facility-specific data for the procedure-based measures be available?**

Starting in 2018, CEBP condition and procedural measures will be included in HSRs and posted publicly on *Hospital Compare*.

Question 24: **Does this also pertain to pediatric hospitals?**

Hospitals that Medicare does not reimburse through IPPS (e.g., cancer hospitals, critical access hospitals, hospitals in Maryland) are not eligible to begin CEBP episodes and therefore do not receive HSRs. Moreover, an eligible provider must have at least one eligible CEBP episode for any of the CEBP measures provided in a CEBP HSR to receive a report. For more information about inclusions and exclusions from CEBP measures, please refer to the measures specifications document on https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228775614447

Question 25: **Will CEBP added to MSPB in 2018, will this measure be added to MSPB or replace indicators currently reported on MSPB?**

CEBP measures and the MSPB measure are distinct measures. CEBP measures reflect claims for clinically-related services. CEBP measures are not part of the Hospital Value-Based Purchasing Program (HVBP). The MSPB measure reflects claims for all services provided during a measure episode and is in the HVBP. As such, one kind of measure does not replace the other. In 2018, CEBP measures and the MSPB measure for eligible hospitals will be reported in separate HSRs.

Question 26: **Will it be part of HVBP?**

Any measures to be included in the HVBP Program must first go through a rule-making process. At this time, CEBP measures are only in the Inpatient

IQR Program.

Question 27: **You may want to amend slide 16 to not have any "unfilled triangles" appearing during the inpatient stay.**

We appreciate the feedback on the presentation and will note it for future reference.

Question 28: **Are there Excel versions of the multiple tables in the HSR?**

No, not at this time.

Question 29: **Are procedural measures included (aortic aneurysm, cholecystectomy, spinal fusion)?**

The CEBP measures HSR only includes the condition measures this year. However, starting in 2018, the CEBP measures HSRs will include both condition and procedural measures.