Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Hospital IQR Program & Hospital VBP Program: FY 2018 Medicare Spending Per Beneficiary (MSPB)

Presentation Transcript

Moderator

Bethany Wheeler-Bunch, MSHA
Hospital Value-Based Purchasing (VBP) Program Support Contract Lead
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

Speaker

Cynthia Khan, PhD
Data Scientist
Econometrica, Inc.

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Bethany Wheeler-Bunch: Hello and welcome to the Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing Program, Medicare Spending Per Beneficiary Hospital Specific Report Overview Webinar. My name is Bethany Wheeler-Bunch and I am the Hospital Value-Based Purchasing Program Support Contract Lead from the Hospital Inpatient Value Incentives and Quality Reporting Outreach and Education Support Contractor and I will be hosting today's events.

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 website, www.qualityreportingcenter.com, in the future. If you registered for this event, a reminder email and the slides were sent out to your email about two hours ago. If you did not receive that email, you can download the slides at the inpatient website, www.qualityreportingcenter.com. If you have a question as we move through the webinar, please type your question into the chat window with the slide number associated to the question at the beginning. As time allows, we will have a short question and answer session at the conclusion of the webinar. Applicable questions that are not answered during our question and answer session will be posted to the qualityreportingcenter.com website in the upcoming week.

Now, I would like to welcome our presenter today, Dr. Cynthia Kahn. Dr. Kahn is a Data Scientist and a Project Manager of the Hospital Value-Based Purchasing Program Activities at Econometrica. Dr. Kahn has a PhD in Social and Health Psychology. Thank you to Dr. Kahn for presenting today. The floor is now yours.

Cynthia Khan: Thank you, Bethany. On today's webinar, we will be talking about the Medicare Funding Per Beneficiary measure, which we also abbreviate as MSPB. The purpose of this presentation is 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 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 the *Hospital Compare* website.

By the end of the presentation, we hope that you'll be able to identify the goals of the MSPB measure, explain MSPB measure methodology and locate the following MSPB documents: the five downloadable MSPB files posted on the *Hospital Compare* website and each hospital's HSR, or hospital specific report, and supplemental files.

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 health care providers during an MSPB episode. An MSPB episode includes all Medicare part A and part 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 2012-2013 Inpatient Prospective Payment System Final Rules, and the links are included on this slide.

So, for today's call, I will go over the goals of the measure, the measure methodology, calculation steps and example calculations. I will then go over the hospital-specific report and supplemental files to help everyone better understand the reports.

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

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, 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 a readmission.

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 hospital admission to 30 days after the hospital discharge. The hospital admission is indicated by the red triangle on this slide and it 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 two slides will define an MSPB episode and an MSPB amount.

The MSPB measure is based on all MSPB episodes and 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 the 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 admission, allows diagnostic and non-diagnostic services that are related to the index submission to be captured in the inpatient payment as well. Including services that are 30 days after discharge emphasizes the importance of care transition and care coordination in improving patient care. Before we move on to a 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 as index admissions to start an episode include: admissions that occur within 30 days of discharge from another index admission or transfers between acute hospitals that do not qualify to start an episode, and episodes where the index admission claimed was $0 in payment and admissions having a discharge day fewer than 30 days prior to the end of the performance period.

In addition to the MSPB episode, the MSPB measure is based on the MSPB amount. The MSPB amount is the sum of all standardized and risk-

adjusted spending across all the hospital's eligible episodes. This is divided by the number of episodes. Though there are 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. And 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 1.0 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 the 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. 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 VBP Program 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 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 that are enrolled in Medicare Advantage, those who have Medicare as a secondary payer or those who have died during an episode.

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

There are nine steps we will walk through over the next set of 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. Next, all extreme values produced in step 3 are winsorized. The fifth step is to calculate the residuals for each episode from step 3 so that we can identify outlier payments. Then, in step 6, the outlier payments are excluded. In step 7, we calculate the MSPB amount for each hospital. In step 8, we calculate the MSPB measure for a hospital based on the MSPB amount. And finally, in step 9, we report the MSPB measure for the Hospital VPB Program for eligible hospitals.

In the first step, claim payments are standardized to adjust for geographic differences and payments from special Medicare programs that are not related to resources, such as hospitals, graduate medical education funds for training its residents. However, payment standardization maintains differences that result from health care 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 quality website that we have listed on the slide.

In the second step, all standardized Medicare part A and part B claim payments made during an MSPB episode 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. 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 will be included. For example, if a patient is admitted to an eligible hospital, this admission triggers an MSPB episode and makes this hospital an index hospital. And

then, if this patient receives home healthcare where services began within 30 days after discharge from the index hospital, the MSPB amount of the index hospital will include home health claims. The MSPB calculation does not prorate spending on home healthcare or any other 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-mixed 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 2. Risk adjustment variables include factors such as age, severity of illness and comorbidity interactions. Severity of illness is measured using a number of indicators, including Hierarchical Condition Categories, or HCC indicators. HCC indicators are specified in the HCC Version 22 Model, which accounts for the inclusion of ICD-10 codes by mapping ICD-9 codes to condition categories and ICD-10 codes to condition categories. 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 MSDRG, of the index hospital stay.

In the fourth step, extremely low values for expected episode spending are winsorized. In the regression model in step 3, a large number of variables are included to more accurately capture beneficiary case mix. Now, risk of using a large number of variables is that the regression can produce some extreme predictive values due to having only a few outlier episodes in a given cell. For each MDC, episodes that fall below the 0.5 percentile of the MDC 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 re-normalized to ensure that the average expected spending level for any MDC is the same before and after winsorizing.

In the fifth step, we calculate the residual for each episode identified outliers. The residual is calculated as the difference between the standardized episode spending, which was calculated in step 2, and the

winsorized expected episode spending, which was calculated in step 4. In the sixth step, the outlier episodes are identified and then are excluded to mitigate the fact of high spending and low spending outliers for each hospitals' MSPB measure. High spending outliers are identified with 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 re-normalizes 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 the ratio of the risk-adjusted MSPB amount for a given hospital, as calculated in step 7 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. 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 set of 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 calculation Steps 1 through 4, we see that the hospital has one episode with a residual higher than the 99th percentile. As a reminder, the residual is calculated as the 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 6 of the calculation. The MSPB amount and the MSPB measure will then be calculated based

on the remaining 29 episodes for Hospital A. We also have an example calculation that's fully explained with sample data on MSPB on the *Quality Net* 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 over the average expected episode spending, which is then multiplied by the average episode spending across all hospitals. 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. And this MSPB amount is 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 expected example hospital would have an MSPB measure of 0.93. And in the last step, step 9, 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 has 29 episodes, its MSPB measure will be reported and used in the Hospital VBP Program.

In the next two sections of this presentation, 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 publicly in December.

Once MSPB Hospital-Specific Reports, abbreviated again 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 publicly on the *Hospital Compare* website. HSRs include six tables and three supplemental hospital-specific data files. The tables in the MSPB HSRs include results for the individual hospital as well as results from hospitals in the state and the nation. The supplemental hospital-specific data files contain information on the hospital admissions, as well as other data on Medicare payments that were included in the calculation of the hospital's MSPB measure.

Table 1, which is included in each hospital's HSR displays the hospital's MSPB measure. In this case, this hospital's MSPB measure is 1.08.

In Table 2, we see the number of eligible admissions and the MSPB amount for a given hospital. This table also provides a hospital's average, state average and US national average MSPB amount.

Table 3 displays some of the major components used to calculate a hospital's MSPB measure. It includes data such as the number of eligible admissions, MSPB amount and the national median MSPB amount.

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

Table 5 provides a detailed breakdown of the given hospital spending for the three time periods of an MSPB episode: the three days prior to the index admission, during index admission and three 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 spending by claim type and time period to the total average spending in hospitals in their state and in the nation. The cost included in Table 5 are the actual--are the average actual standardized episode spending amount. However, the spending amounts are not risk adjusted for hospital case mix, because risk adjustment is performed at the MDC level.

In this example, this hospital has an average actual spending of about $5,200 on inpatient services during the index hospital stay. This is about 32% of episode spending for the hospital.

Looking at the same excerpt of Table 5, we can also compare the percent of total average spending in the 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 about 32% of episode spending, which is lower than the percent of spending in the state, which is 47%, as well as the percent of spending in the nation, which is about 46%.

A lower percent of spending in a given hospital than the percent of spending in the state or the nation means that for a given category and claim time, the hospital spends less than the other hospitals in the state and in the nation.

Table 6 provides a breakdown of average, actual and expected spending for an MSPB episode by major diagnostic category, or MDC, so 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 or expected spending per episode.

In this example, we can look at the MDC for circulatory system and see if we have an actual and expected spending per episode in columns A and B. Since this hospital has an actual spending of about $19,000 per episode and an expected spending of about $17,000 per episode.

On this same table, you can see, you can use 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, which we see as being about 20,000 per episode. Hospitals can compare the national average expected spending per episode, which is in column F, to their hospital average expected spending per episode, which is in column B. And here we see, this hospital was a lower than average expected spending per episode in column B than the nation displayed in column F.

In addition to receiving an MSPB HSR, each hospitals receives three supplemental hospital specific data files. There is the index admission file, a beneficiary risk score file and an MSPB episode file. And in the index admission file, you'll see all of the inpatient admissions for your hospital in which a beneficiary was discharged during the period of performance, which for this user port would be based on 2016 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 MSPB episode, 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 at your hospital.

As mentioned before, hospitals may preview their MSPB measure for 30 days after the release of their HSR. MSPB measure data will be posted on CMS' *Hospital Compare* website in 2017. During this preview period, hospitals may submit questions or request for corrections to the email address on this slide. That is: cmsmspbmeasure@econometricainc.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 sent. In addition, if you have a question that we do not get to today during the call, please feel free to email us at the same email address listed on this slide. As with 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.

I am now going to turn to MSPB files that are publicly available on the *Hospital Compare* website.

On this slide, we list a few of the data files that are published and available on the *Hospital Compare* website, which is listed on the top of this slide. That is, https://data.medicare.gov/data/hospital-compare. When you go to this website, navigate to the "in category" dropdown menu, and from this dropdown menu, select "Payment and Value of Care." This will take you directly to the MSPB measures. Hospitals with at least 25 episodes will have their MSPB measures published online on *Hospital Compare*. MSPB files include the state and national average and Medicare hospital spending by claim type. The Medicare hospital spending by claim type file is very similar to the Table 5 in the hospital-specific reports 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 more in-depth description of MSPB spending breakdowns by claims type can be found as a PDF on the Hospital VBP website, which is also included as a link on this slide. The hospital MSPB measure for each hospital includes up to six

decimal places on CMS' *Hospital Compare* website for informational and research purposes.

So over this call, we went through quite a bit, including goals of MSPB measure, steps involved in calculating the MSPB measure, HSRs and the files that are available online. I hope you found this presentation helpful to better understand the MSPB measure. I will now pass the presentation back to the organizers of this webinar to discuss the continuing education approval process and to go over any questions that you may have.

Bethany Wheeler-Bunch: Thank you, Dr. Khan. There were quite a few questions that were coming in during the presentation. We will get to those shortly. Just as a reminder, we will not be using the raise hand feature. All questions must come in through the chat window in order to be addressed. Any questions that we do not address during this question and answer session will be posted to the qualityreportingcenter.com website at a later date.

First question is in reference to slide 15. "Is there a specific time immediately prior to or following the episode that is included in the MSPB?"

Cynthia Khan: I can answer that question. This is Cynthia Khan. And specifically to that question, the MSPB episode covers the period of time that is three days prior to the index admission through the - sorry - part A and part B claims that are-that take place during three days prior to the index admission, during the index admission, and then, 30 days after the-after discharge from the hospital stay.

Bethany Wheeler-Bunch: Thank you. The next few questions are actually for slide 15. "Would an observation encounter count as an index admission or is that just inpatient status?"

Cynthia Khan: No, that would not count as an index admission. This is just an observational stay.

Bethany Wheeler-Bunch: Thank you. Again, on slide 15. "So, in an extreme case, if a patient was admitted to a skilled nursing facility 29 days after the admission and stayed at that facility for 60 days, all 60 days are included in the MSPB for the patient. Is that correct?"

Cynthia Khan: That is correct, as long as that admission occurs within the 30 days after discharge from that index admission. So, in this case, it was day 29, so yes, the MSPB measure for the index hospital would reflect those 60 days.

Bethany Wheeler-Bunch: Thank you. Next question, also slide 15. "Do the services provided in the three days prior to an index admission have to be related to the index admission to count in the MSPB?"

Cynthia Khan: No, not necessarily. The reason we include services three days prior to the index admission is to again promote the consistency of, I guess - continuity of care across contexts, and some of these contexts may or may not be associated with the index admission.

Bethany Wheeler-Bunch: Thank you. Last question for slide 15. "Does the 30-day post-hospital discharge exclude skilled nursing or rehabilitation care?"

Cynthia Khan: No, it does not. It includes-skilled nursing is included in the post-discharge charges. And for more information, let's see - the questioner can also refer to their hospital-specific report, Table 5 actually lays out the different claim types that are included in their episode.

Bethany Wheeler-Bunch: Thank you. The next question is for slide 17. The question is: "Do we want our MSPB as close to one as possible or is it better to be well below one?

Cynthia Khan: So, an MSPB measure of less than one indicates that a hospital - that hospital, is spending less than the national median average. And so, on the flipside, if that hospital has an MSPB measure greater than one, that means they are spending more than the national average. I should point out that this MSPB measure is really occurring in the context of other measures to

evaluate quality of care. So, this is not the only measure of quality care, but it gives, sort of a broader idea as part of the Hospital Value-Based Purchasing Program as to the hospital's - it contributes to the hospital's overall evaluation of performance.

Bethany Wheeler-Bunch: Thank you. The next question is regarding slide 18. "What is the reason for excluding beneficiaries and Medicare Advantage?"

Cynthia Khan: I think what I'll do is, I will give this over to Rachel Liu or Amanda Swygard for more information.

Kim Spalding Bush: This is Kim Spalding-Bush from CMS. I can actually answer this one. The rationale there was that we wouldn't have a complete picture of the claims for Medicare Advantage beneficiaries, so it would be difficult to compare them to a national benchmark or even to score them comparatively against other hospitals when those beneficiaries' claims aren't paid under the fee for service program. And I don't know if the Acumen team has any more that they would like to add to that, but that's the basic reason why the MA beneficiaries' episodes are excluded from the measure.

Female Speaker: Thanks, Kim. That matches what we would have said. Thank you.

Bethany Wheeler-Bunch: Thank you. Next question is for slide 21. "Can you explain what is meant by price standardized payment?"

Cynthia Khan: So, this refers to standardizing the claims, individual claims, for geographic differences and payment for special Medicare programs that are not directly related to the actual patient care itself. For example, graduate medical education. But I should say that this standardization for geographic differences and these sorts of programs are not really the resources. It does enable us to maintain differences that are related to sending where the service is provided, specialty of health care provider, who provides the service, a number of services provided in the same encounter and outlier cases. And I would recommend the questioner

referred to *Quality Net* webpage on slide 21. For more information, there's a measured information form that provides more details.

Bethany Wheeler-Bunch: Thank you. Next question for slide 21. "From reviewing some of the MSPB materials, it appears outlier cases are excluding. However, outlier payments to hospitals for particular patients whose costs exceed normal DRG amounts are included. Is this accurate?"

Bethany Wheeler-Bunch: I know it was a little long. Do you want me to reread it again?

Cynthia Khan: Yes, that would be great.

Bethany Wheeler-Bunch: Okay. "From reviewing some of the MSPB materials, it appears outlier cases are excluded. However, outlier payments to hospitals for particular patients whose costs exceed normal DRG amounts are included. Is this accurate?"

Cynthia Khan: So, the-when the question is referring to excluding certain – well, the exclusion occurs at – for episodes whose residuals are above the 99th percentile or below the one percentile. And so, the individual DRGs, I guess it depends on the – so, that's where the exclusion comes in, but what I'll do is I'll refer to Acumen to make sure there isn't anything else I'm missing.

Rachel Liu: Thanks, Cynthia. This is Rachel. So, the question is whether or not it is an accurate statement to say that outlier cases are removed but outlier payments are made to hospitals as part of, for example, their IPPS payment is included? That is correct. So, payments made to hospitals, if they're included in the price standardized amounts, those are included. If it ends up being that the episode is an outlier in the cost distribution, then those cases or those episodes are removed.

Bethany Wheeler-Bunch: Thank you. The next question is for slide 22. "In regards to the 30 days post index, which bucket in the episode file for my hospital shows the total inpatient visits in the episode inpatient?"

Cynthia Khan: I believe this was answered by David Ruiz in response to the questioner.

Bethany Wheeler-Bunch: Okay. David, would you be able to comment on that response?

David Ruiz: Apologies. Could you repeat the question?

Bethany Wheeler-Bunch: Sure. "In regards to the 30 days post index, which bucket in the episode file for my hospital shows the total inpatient visits in the episode inpatient?"

David Ruiz: So, this – excuse me. In the episode file, there is an IP_actual_cost and IP_STB_cost variable. Those will supply you with the inpatient episode expenditures. However, they are not separated by the different time periods within the episode construct. That is, they're not separated by the three-day prior index admission during the index admission and the 30 day after day index admission, but instead, an aggregate of those inpatient costs.

Bethany Wheeler-Bunch: Thank you. Slide 23. "Does the higher HCC increase allowable payment?"

Cynthia Khan: So, this is referring to the – I'm sorry. Was someone else wanting to answer?

Bethany Wheeler-Bunch: No. Go ahead.

Cynthia Khan: Okay. What this is referring to is the risk adjustment of the Hierarchical Condition Categories. Essentially, we're adjusting the episode spending for patient case mix. So, that's what the HCC is referring to. So, it's not

related to necessarily the allowable. I guess, what the question's referring to, is that the allowable cost or allowable?

Bethany Wheeler-Bunch: They just reference allowable payment.

Cynthia Khan: Allowable payments. No. This is referring to the risk adjustment for the beneficiary case mix by age and severity of illness. That's what the Hierarchical Condition Categories are being used for.

Bethany Wheeler-Bunch: Thank you. The next question is for slide 25. Are the episodes above the 99th percentile still included in the files, and if so, how are they flagged that they are not included?

Cynthia Khan: So, episodes that-so, these are for residuals. A residual with an episode that falls above the 99th percentile, those are actually excluded from the calculation for a hospital's MSPB measure.

David Ruiz: This is David. Let me just add to that very briefly. If the questioner was asking about the episode file, itself, then in the episode file build, note that the index admissions are logged there. However, if an index admission is excluded-for example, for being an outlier episode in terms of the distribution of the payments, then it would be indicated within the file as well.

Bethany Wheeler-Bunch: Thank you. The next question is for slide 27. "Can you explain why the hospital's MSPB amount is divided by the national median MSPB and not the national average MSPB?"

Kim Spalding Bush: Yup, this is Kim from CMS and I can answer that question. The rationale behind that decision, and this goes back to the, you know, when we first introduced the measure, was that the national median is less subject to being moved by a few, you know, really high or really low dollar cases. So, if we had used a national mean or average for comparison purposes, then you would see those really high dollar, really low dollar cases

reflected. Whereas, if you take the median, which is the one in the middle, you're getting more of a picture of, sort of, a middle of the road amount, which made more sense for comparison purposes.

Bethany Wheeler-Bunch: Thank you. The next question is for slide 37. "In Table 3, it shows that the MSPB measure for the US is 0.98. How could that be? Wouldn't it always be 1, as the measure is based on the national median?

Cynthia Khan: Oh so, what's happening here is that the MSPB amount for the US is actually the average. That's MSP, that's based on the risk-adjusted spending. That's MSPB based on the average of the number of episodes divided by that so, it's not the median MSPB amount; it's the MSPB amount for hospitals across the US, and that's being divided by the MSPB national median MSPB amount. And that's why it's 0.99. It's not 1.0.

Bethany Wheeler-Bunch: Thank you. For slide 39, is the next question. "If a patient is discharged from the index admission to an inpatient rehab facility within 30 days of the index admission, where is the inpatient rehab spending included on Table 5?"

David Ruiz: Bethany, could you repeat the question, please?

Bethany Wheeler-Bunch: Sure. "If a patient is discharged from the index admission to an inpatient rehab facility within 30 days of the index admission, where is the inpatient rehab spending included on Table 5?" And Table 5 is located on slide 41 if we want to jump to that slide.

David Ruiz: Could we, please? Okay. So, the slide 41 shows a portion of the MSPB hospital reports that providers receive. Another portion to that table shows the 30 days after hospital discharge breakouts by different claim types, including inpatient. As an inpatient facility, the inpatient rehabilitation center would show up within the inpatient category. And on the actual report itself, it additionally has the during-index admission that you see as well as the three days prior and the 30 days after hospital discharge.

Bethany Wheeler-Bunch: Thank you. The next question, which we've received many in regards to carrier. "In Table 5, you refer to a claim type as "carrier." Can you please define what a carrier is and could you explain what types of claims are included in that category?"

David Ruiz: I'll take that one as well. So, the reference that has been listed in answers and there has been quite a few questions regarding this, was on the resdac.org website for the carrier research identifiable file. The carrier file was also once known as a physician supplier part B claims file. It does contain claims that are cemented on the CMS 1500 claims form. Most of these claims are from non-institutional providers, such as physicians, additional assistants, clinical social workers, nurse practitioners. Claims for other providers are also included, such as those from freestanding facilities. Generally, some examples include independent clinical laboratories, ambulance providers or freestanding ambulatory surgical centers. I will additionally note that resdac.org: you can similarly find descriptions for the other claim types that are included within the MSPB hospital reports and that can be seen, for example, on slide 41.

Bethany Wheeler-Bunch: Thank you. And I'm going to take one more question. "Is it possible to tell the timeframe, for example, three days before admission, the index admission, and 30 days after discharge breakout by MDC?"

Cynthia Khan: So, I can answer this. So, no, when you look at the Hospital HSR, we also, the supplemental file includes an episode file and that episode file provides, sort of, an aggregate of all of the inpatient or, I'm sorry, all of the claims types by episode that's aggregated across episode. We don't have references to the time period per se at the MDC level, at the major diagnostic condition level. We do have information about the claims on Table 5. So, in terms of time periods, that's what led to the claim type on Table 5.

Bethany Wheeler-Bunch: Thank you. And I want to say thank you again to Dr. Khan, the teams from Econometrica, Acumen and CMS for presenting today and answering all of the questions. If your question was not answered or you want to have a list

of the questions and answers that were answered today, a transcript containing those questions and answers will be posted to the qualityreportingcenter.com website in the upcoming weeks. Also, if you would like a copy of the slide deck, that is also available at qualityreportingcenter.com.

I will now turn the presentation over to Dr. Debra Price to present on continuing education. Thank you all for joining me today.

Debra Price: Well, thank you very much, Bethany. Today's webinar has been approved for one continuing education credit by the boards listed on this slide. We are now a nationally-approved nursing provider, and as such, all nurses report their own credits to their boards using the provider number on this slide, the last bullet. We now have an online CE Certificate process where you can receive your certificate two different ways. Right now, if you take a few minutes, and at the end of my slides, you would complete the survey. At the end of your survey, you'd be able to get your certificate. If you do not have time however to complete the survey today, we will be sending out another one within 48 hours and you can complete the survey at that time and get your certificate.

If you do not immediately get an email response to the registration you will do for your certificate, please go back and register as a new user or wait for 48 hours for the next link and do the process again, registering as a new user.

This is what your survey will look like. Excuse me. At the very bottom right-hand corner, you see the done button.

You click the done button and this page will pop open. There are two links on this page. The first one is the new user link and that's what you're going to use if you, if this is your first webinar or if you have had problems getting your CE Certificate. If you've not had any problems so far with our webinars, please click on the existing user link and that will take you to your certificate.

This is what the new user link takes you to. Put your first name, your last name and we are asking for a personal email like Yahoo, Gmail, AT&T,

what have you, and your personal phone number. Not your work email and phone number, because our links seem to be getting bumped back from hospitals. So, we are asking you to use your personal email. And if you have not had any problems, this is what the existing user link takes you to. Your user name is your complete email address, including what's after the @ sign. And if you forgot your password, just click in the password box and you will be directed how to create a new password.

And now, we'd like to thank everyone for sharing the past hour with us. We hope that you learned something and once again, if you did not get your, if we did not to your question, all questions will be posted to our website qualityreportingcenter.com at a later date. Please enjoy the rest of your day. Goodbye.