



Hospital Value-Based Purchasing (VBP) Program

Support Contractor

Medicare Spending per Beneficiary (MSPB) Measure

Presentation Transcript

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Matt McDonough: Hello everyone and welcome to today's web event. My name Matt McDonough and I'm going to be your virtual host for today's event.

Before I turn things over to our presenters today, I'd like to take a moment to cover some housekeeping items with you so that you know how you can interact with our presenters during the course of today's event and how you can listen to the audio program we're offering today.

As you can see on your screen, audio for this event is available via internet streaming, and if you're hearing voice my right now, you know that. What this means is that no telephone line is required to hear our speakers today. However, you do have to connect computer speakers or headphones in order to hear the audio portion of today's event.

Now, during today's event, you may encounter some audio troubleshooting issues, and I'd like to cover how to resolve some of the most common issues with you right now. If at any point your audio stops for some reason, simply click the "Pause" button that's located in the upper left portion of your screen, wait about five seconds, and then click the "Play" button. Your audio program should resume. If you're currently hearing an echo on my voice today, this most likely means that you're connected to today's event in two separate browsers or two browser tabs. Simply close one of those browser tabs or one of those browser windows, and your echoing audio should clear up.

Now, if none of those solutions solves your audio problem, we do have a very limited number of telephone lines available that you can use to dial in

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to hear today's audio program. Simply send us a chat message and ask for today's phone number, and we'll be happy to provide it to you.

Now, as noted, the audio for today's session is over computer speakers or headphones, which means that you're not able to ask verbal questions today, but that doesn't mean that you can't interact with our presenters throughout the course of today's event. You'll notice on the side of your screen that there is a chat panel, and at the bottom of that chat panel, there is a window where you can type in your question and click "Send." Now, when you type a question and click "Send," that question is sent to all of our panelists who are connected today. As time and as resources allow throughout the course of today's event, your questions may be handled in the chat window via our subject matter experts, but all questions are being archived and saved for future notes.

That's going to do it for my introduction for today's event, so without further ado, I'd like to turn it over to our first speaker of the day. Thank you.

Bethany Wheeler: Hello and welcome to our monthly Hospital Value-Based Purchasing webinar. My name is Bethany Wheeler and I will be your host for today's event. Before we begin, I would like to make a few announcements. This program is being recorded. A transcript of the presentation, along with the questions and answers will be posted to our Inpatient website, www.qualityreportingcenter.com, again, that's www.qualityreportingcenter.com, within two days and will be posted to *QualityNet* at a later date.

If you registered for this event, a reminder email, as well as the slides, were sent to your email one hour ago. If you did not receive the email, you can download the slides at the Inpatient website. Again, that's www.qualityreportingcenter.com.

And now I'd like to introduce our guest speaker, Rachel Yong. Rachel Yong has a Master's of Science in Public Health degree and is a senior research analyst at Acumen. Ms. Yong is currently the lead project coordinator for the Hospital Value-Based Purchasing Program project where she coordinates all project activities, including managing the calculation of the Medicare Spending per Beneficiary Measure, application of the payment exchange function to the hospital Total Performance Scores used in the Hospital Value-Based Purchasing Program, and payment standardization of Medicare claims. In addition to her work on the Hospital Value-Based Purchasing Program project, Ms. Yong works for the Grouper project where she evaluates the CMS episode grouper software and develops supplemental quality and resource use reports for physician groups.

Rachel, the floor is yours.

Rachel Yong: Thank you, Bethany. On today's webinar, we will be talking about the Medicare Spending per Beneficiary Measure, also abbreviated as MSPB.

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The MSPB measure evaluates the efficiency of a hospital to the efficiency of a national median hospital. Specifically, the MSPB measure evaluates the cost to Medicare for services provided by hospitals and other health care providers during an MSPB episode. An MSPB episode includes all Medicare Part A and B claims during the periods immediately before, during, and after a hospital stay.

The MSPB measure is an efficiency measure in the Hospital Value-Based Purchasing program, also known as Hospital VBP program. The measure was included starting in Fiscal Year 2015. The MSPB measure was required for inclusion by the Social Security Act and is endorsed by the National Quality Forum. Full measure details are included in the Fiscal Year 2012 and Fiscal Year 2013 IPPS Final Rules. The links to these rules are at the bottom of the slide.

Over today's call, I will go over the goals of the MSPB measure, the methodology used to calculate the MSPB measure, the calculation steps, and [an] example calculation. I will then go over the hospital-specific reports and supplemental files that each hospital receives during the summer of each year. At the end, I will: provide an overview of the publicly-available files on [<https://data.medicare.gov>], [and] discuss the goals of the MSPB measure in conjunction with other Hospital VBP program quality measures. The MSPB measure aims to promote more efficient care for beneficiaries by financially incentivizing hospitals to coordinate care and improve efficiency. For example, hospitals can improve efficiency through actions such as improving coordination with preadmission and post-acute [care]for readmission, or by reducing unnecessary post-acute services, or by shifting post-acute care for more expensive services such as skilled nursing facility services to less expensive ones such as home health agency services in cases that would not affect the patient outcome. Next, I will provide a measure methodology as well as 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 depicted by the red triangle on the slide is also known as the Index Admission. To further explain how the MSPB measure is calculated, it is important to understand some key terms. The next two slides will define what an MSPB measure and an MSPB amount is, and what the MSPB measure is in terms of these two constructs.

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

Somebody asked why an episode includes three days prior to a hospital admission? The reason why is to promote consistency between services provided regardless of the diagnostic code or where the services are

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provided. This is because there are services that can be captured in the inpatient diagnostic-related group or DRG payment for the hospital, and there are services that are billed and paid separately from the hospital payment. So, on one hand, when the Index Admission performs diagnostic or non-diagnostic services that are related to the reason for admission, the services are captured in the inpatient DRG payment. On the other hand, however, when other providers perform diagnostics services, or when the index admission performs non-diagnostic services that appear to be unrelated to the reason for admission, those services are paid separately under Medicare. To capture all of those claims, the MSPB episode includes services three days before the hospital admission.

Similarly, some may ask why an episode includes three days after a hospital discharge. The episode includes 30 days after to emphasize the importance of care transitions and care coordination and improving patient health care.

Before we move on to the definition of MSPB Amount, I would like to clarify what type of hospital admissions qualifies to start an MSPB episode. Hospital admissions that are not considered as Index Admissions to start an episode include admissions which occur within 30 days of discharge from another Index Admission or transfer between acute-to-acute care (also not included). In other words, neither the hospital which transferred a patient nor the hospital which received the patient will qualify to start an episode. Admissions that have \$0 payment will also not be allowed to start an episode. Last, episodes with a discharge date fewer than 30 days during the end of the performance period will not count as index admission.

Now that we have gone over the definition of an MSPB Episode, I will next define what an MSPB Amount is. An MSPB amount is the sum of all standardized, risk-adjusted spending across all of the hospital's MSPB episodes divided by the number of episodes. The equation included on the slide provides this definition in easy to understand mathematical format.

Last, building on the terms we just defined, the MSPB Measure is defined as the hospital's MSPB amount divided by the national episode-weighted median MSPB amount. In other words, the denominator is a median MSPB amount across all hospitals weighted by episode account.

Next, I will go over how to interpret the measure and provide some more detailed measure specifications.

How should hospitals interpret their MSPB measure? An MSPB – that is less than one indicates that the 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 in their MSPB measure if they had a measure value of 1.05 in the 2011 baseline period, and that

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decreased to 1.01 in the 2013 performance period. Note that the MSPB measure alone does not necessarily reflect the quality of care provided by hospitals. A decrease in MSPB measure across performance period, as in the hospital, have lower Medicare spending per beneficiary across years should not be necessarily be interpreted as better care. The MSPB measure is most meaningful when presented in the context of other quality measures. This is why the MSPB measure is combined with other measures in the Hospital VBP program to provide a more comprehensive assessment of a hospital's performance.

Now that I have gone over the definition of key terms and how to interpret the MSPB measure, this slide discusses what populations are included and excluded when calculating a hospital's measure. Beneficiaries that are included are those that are enrolled in Medicare Parts A and B from 90 days prior to the episode through the end of the episodes, and are admitted to subsection D hospitals. Starting with 2014 data, the beneficiaries covered by the Railroad Retirement Board will also be included in the hospital's MSPB measure. Beneficiaries that are excluded are those that are enrolled in Medicare Advantage, have Medicare as a secondary payer, and died during the 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 payment so that cost of MSPB episode and that's a – an episode – a hospital's MSPB Amount and Measure can be compared across the country. This is because standardization removed biographic differences and claim payments. The second step is to calculate the standardize funding for all episodes a hospital has. The third step is to estimate the expected episode spending using a linear regression. Next, all extreme values produced by the regression in step three are truncated.

The fifth step is to calculate the residual for each episode. And identify outlier episodes. And then the outlier episodes are excluded in step six. The seventh step is to calculate the MSPB Amount for each hospital. And step eight, we calculate the MSPB Measure. And then the last step is to report the MSPB Measure for the hospitals VBP program.

And the first step claim payments are standardized to adjust for geographic differences and payments from special Medicare programs that are not related to resource use. For example, Medicare pays hospitals – the graduate medical education funds for training residence. This is not directly related to a hospital's choice and resources, so that is removed in calculating when standardizing payment. Price standardization, also referred to as payment standardization, maintains differences that result from health care delivery choices, such as the setting where the service is provided, the specialty of the provider, the number of services provided in

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the same visit, and outlier cases. Full details of this methodology are available on the *QualityNet* webpage link on the slide.

In the second step, all standardized part Medicare Part A and B claim payments made during MSPB episode is summed together. This includes patient deductibles and coinsurance and claims based on the “from date” variable. (This include in criteria) as defined by the “from date” variable and claims, which is the first day on the billing statement covering service rendered to the beneficiary. For inpatient claims, the inclusion criteria is based on the admission date on the claim.

We often get questions about post-acute care services that extend beyond the 30 days after hospital discharge. All post-acute care services that have a claim from date within the 30 days post hospital discharge will be included. For example, if a patient is admitted to the hospital triggers an MSPB episode and then received home health care that begins within 30 days after discharge, the index hospital is responsible for the full cost: the home health care, home health claim. The measure calculation does not prorate the cost home health care 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 mix variation and other factors across hospitals, a linear regression is used to estimate their relationship between a number [of] risk variables and [the] standardized episode cost calculated in step two. The regression model (for probably) follows the CMS-HCC risk adjustment methodology which [is] derived by the Medicare Part A and B claims and is used in the Medicare advantage program. The expected spending for each episode is calculated by using a separate model for episodes within each Major Diagnostic Category or MDC. The MDC of an episode is determined by the MS-DRG of the index hospital stay.

In the fourth step, the extremely low-cost expected values of episodes calculated in step three are truncated. In the regression model, using step three, a large number of variables are included to more accurately capture beneficiary case mix. A risk of using a large number of variables in that regression is that the regression can produce some extreme predicted values – or having only a few outlier episodes in a given cell. This step truncates expected values at the 0.6 percentile. The process of truncating extremely low-cost expected values is listed here. First for MDC, which is defined by the MS-DRG of the index hospital admission, episodes that fall below the 0.6 percentile of the MDC expected cost distribution are identified. Next, the expected cost of extremely low-cost episodes are set to the 0.6 percentile. And last, the expected cost are re-normalized to ensure that the average expected episode spending level for any MDC is the same before and after truncating.

Next the fifth slide – the fifth step calculates the residual for each episode to identify outliers. The residual is calculated as a difference between the

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standardized episode spending, which was calculated in step two, and the truncated expected episode spending, which was calculated in step four.

In the next step, the outlier episodes identified in the fifth step are excluded to mitigate the effect of high-cost and low-cost outliers on each hospital's MSPB measure. High-cost outliers are identified when the residual falls above the 99th percentile of the residual cost distribution for any MS-DRG-admission category. Low-cost outliers are identified when the residual falls below the first percentile. This step also re-normalizes the expected cost to ensure that the average expected cost are the same as the average standardized cost after outlier exclusions.

In the seventh step the MSPB Amount is calculated as the ratio of the average standardized episode spending over the average expected episode spending. Multiply this by the average spending across all hospitals. The equation included on the slide hopefully helps explain this definition.

In the eighth step, the MSPB Measure is calculated as the ratio of the MSPB amount for the hospital which was 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 VBP program and have at least 25 episodes are reported and used for Hospital VBP program payment purposes.

Now that we've gone through each of the steps to calculate the MSPB Measure, the [next] set of slides will walk through the calculation for an example hospital. The next three slides will go over how the MSPB Amount and the MSPB Measure is calculated for an example hospital.

In this example, our hospital has 12 MSPB episodes ranging from \$1,000 to \$33,000 in standardized episode spending. That spending amount is calculated in steps one and two where we calculate standardize payments and sum it across the episode period. Next we apply step three and four where we calculate the expected episode spending and truncate extremely low-cost episodes. After the steps we see that the hospital had one episode with the residual higher than the 99th percentile. As a refresher, the (mid) residual is calculated as a difference between the standardized episode spending and then truncated expected episode spending. This episode is excluded in step six. The MSPB Amount and the MSPB Measure will then be calculated based on the remaining 11 MSPB episodes. Please note that this example calculation is fully explained with sample data on the MSPB QualityNet webpage link on the slide.

As I explained a few minutes ago the MSPB Amount for our example hospital is calculated as the ratio of the average standardize episode spending over the average expected episode spending. Multiplied by the average episode spending across all hospitals, I've shown on this slide are example hospitals MSPB Amount would equal 8,462.

Next the MSPB Measure for our example hospital is calculated as the ratio of the MSPB amount which was calculated on the previous slide divided

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by the national episode-weighted MSPB Amount. Let's pretend that the National Episode-Weighted Median MSPB Amount is 9,100. As a result our example hospital would then have an MSPB Measure of 0.93. Last we're going to determine if the MSPB measure of our example hospital will be reported for payment purposes. To be eligible for payment purposes, the hospital's 25 MSPB episodes during the period of (inaudible). Since our example hospital only has 11 episodes, this hospital's MSPB Measure will not be reported or used in the hospital VBP program.

In the next two sections of this call, I will provide an overview of the MSPB hospital specific reports and supplemental files that each hospital receives during the summer [and which] will be released publically in the fall. This year's reports will be sent to the hospitals in early to mid-July.

Once the MSPB hospital specific reports, abbreviated as HSRs, are sent to hospitals, there is a 9–0-day preview period where hospitals can review and submit questions or comments before their MSPB measure is released publically on the hospital compare website. Hospitals receive an HSR which includes six tables and three supplemental hospital-specific data files. The table from the MSPB-HSR includes results for the individual hospital as well as for hospitals in the state and nation. The supplemental hospital-specific data files contain report information on the hospital admissions considered, as well as other data on Medicare payments [that] are included in the calculation of the hospital's MSPB Measure.

Here we see Table One shows the individual hospital's MSPB Measure. Table Two provides the number of eligible admissions and MSPB Amount for the given hospital and the averages in the state that they are in and then nation.

Table three displays detailed statistics related to the hospital's MSPB Measure. This includes data such as the number of eligible admissions, average spending per episode, and MSPB Amount.

As we saw in the previous slide the MSPB Measure is calculated using the MSPB Amount as a numerator. And the National Median MSPB Amount as a denominator. As a result, [a] hospital can calculate their MSPB Measure by using the row for MSPB Amount for their hospital and divide that amount by the U.S. National Median MSPB Amount. I would like to apologize. The U.S. National Median MSPB Amount is not the same across all three columns in this slide. The second to last row should have the same example value of \$18,017.19 for the hospital's stay in U.S. column.

Table Four in your MSPB-HSR displays a national distribution of an MSPB Measure across all hospitals in the nation. Figure one depicts this in graphical form.

Table Five provides a detailed breakdown of the – of a given hospital spending for the three time periods of an MSPB episode which are three

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days prior to an index admission during-index admission and 30 days post hospital discharge. Spending levels are also broken down by claim type within each of those three time periods. Hospitals can compare a percent of total average episode spending by claim type and time period to the total average spending at hospitals in their state and in the nation. The cost included in Table Five are the average actual standardized episode spending amount. The spending amounts included are not risk-adjusted for hospital case mix because risk adjustment is performed at the MDC level.

Here on the slide you can see an excerpt of Table Five. In this example the hospital has an average actual spending amount of \$5,200 on Inpatient services during the index hospital stay. This is about 32 percent of episode spending for the hospital. You can see this highlighted in the boxes on the slide. Looking at the same excerpt of Table Five on the slide, we can also compare the percent of total average spending in the hospital to the average in the state and in the nation. The red box highlights a comparison we can make for the percent of spending on inpatient services during the index hospital admission. We see that this hospital spends about 32 percent of episode spending, which is lower than the percent of spending the state, which is 47 percent, and the percent of spending in the nation, which is about 46 percent. A lower percent of spending in the given hospital than the percent of spending in the state or in the nation means that for the given category and claim type, the hospital spends less than other hospitals in the state and in the nation.

Table Six shows similar information as in Table Five, but instead it provides a breakdown of average actual and expected spending for an MSPB episode by MDC. Hospitals can compare their average actual and expected spending to the state and national average actual and expected spending. The expected spending shown in these tables are risk adjusted for beneficiary case mix.

Here we can look at an excerpt of Table Six. In this example, hospitals can look at a specific MDC and identify the average actual and expected spending per episode. For this example hospital, we look at the MDC for circulatory system and see that they have an actual and expected spending per episode in columns A and B. This is also highlighted in the red box on the slide. As you can see, this example hospital has an actual spending of about \$19,000 per episode and an expected spending of about \$17,000 per episode.

Looking at the same table on the last slide, we can look at column C through F to compare the spending level of the hospital to the spending level in the state and in the nation. For episodes in the MDC for circulatory system we can look at columns E and F and identify that the national average actual and expected spending is about \$20,000 per episode. Hospitals can compare the National Average Expected Spending per Episode as shown in column F to their Hospital Average Expected Spending per Episode which is shown in column B. Here we see at the

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example hospital [they] have a lower average expected spending per episode in column B than in column F.

In addition to receiving an MSPB-HSR, each hospital receives three supplemental hospital specific data files: an Index Admission File, a Beneficiary Risk Core File, and an MSPB Episode File. The Index Admission File presents all inpatient admissions for the given hospital in which a beneficiary was discharged during the period of performance. 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. This provides data in the risk adjustment regression model. Last but not the part – the third file, the MSPB Episode File, shows the type of care the spending amount and top five billing providers in each care setting for each MSPB episode.

Hospitals – I've mentioned before, hospitals may preview their MSPB Measure for 30 days after release. During the preview period hospitals may submit questions or request for correction to cmsMSPBmeasure@acumenllc.com. Please be sure to include your hospital's CMS Certification Number so that we can easily analyze your hospital's question against the data we send. In addition, if you have questions that we cannot get to the day of the call, please feel free to email this address [cmsMSPBmeasure@acumenllc.com]. As with other claims based measures, hospitals may not submit additional corrections to the underlying claims data or submit new claims to be added to the calculations.

There are [a] few data files [that] are published and [will be] available on *Hospital Compare* and [<https://data.medicare.gov>] web pages later in the fall. The MSPB Measure for all eligible hospital VBP hospitals with at least 25 MSPB episodes will be published online. The State and National Average MSPB Amount is also published and downloadable online. There is also a downloadable file called the Medicare Hospital Spending by Claim Type. This file provides a breakdown of each hospital's MSPB spending level by time period and by claim type. This is very similar to Table Five that you see in your MSPB-HSR. A description of this file can be found on the CMS Hospital VBP webpage link included on the slide. CMS makes available [all] of the hospital MSPB Measure up to six decimal places on [<https://data.medicare.gov>], for informational or research purposes.

Over this call, we went through quite a bit; from the goals of the MSPB Measure to the steps involved to calculate the MSPB Measure to an overview of the reports hospitals receive each year, to the files that are already made available for the general public. I hope you find this presentation helpful in better understanding the MSPB Measure. I'll now pass the presentation back to Bethany to discuss Continuing Education Approval process and go over any questions that you may have.

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Bethany Wheeler: Thank you for that excellent presentation, Rachel. It was very informative. As we prepare to answer some of the questions that were submitted during the presentation, I will turn the call over to Deb Price who will cover how to receive continuing education credits for this presentation. Deb, the floor is yours.

Deb Price: Thank you, Bethany. And I would also like to thank our speaker for the information that she shared with us today. Before we have our subject matter expert read questions that were sent in, I want to remind you that today's webinar has been approved for one continuing education credit by the boards listed on this slide. Professionals in other states other than Florida can take their certificates and send it in to their respective boards.

We now have an online CE certificate process. If you registered through the webinar – for the webinar through ReadyTalk[®], a survey should automatically pop up when this webinar closes. We will also be sending out the survey link in an e-mail within the next 48 hours. If there are others listening to the event but are not registered in ReadyTalk[®], please pass this survey to them.

This is what the survey – the end of the survey will look like. These are questions 10, 11, and 12. And, if you note on the bottom in a little gray box is the word "Done." You click on that word when you are done with the survey.

And this is a box that pops open after you click “Done.” If you have already attended our events and have received your certificates, that means that you can click on the “existing user” link. However, if you have been in our events and have clicked on “existing user” and have not received a certificate, that means that your healthcare facility or whatever email that you are using has some sort of a firewall blocking our automatic responses. What you should do in that case is to go back to this particular link and click on the “new user” link. When you do that, do not register a healthcare facility [email account], register a personal email account like Yahoo or Gmail. And those personal accounts do not have firewalls up that block our automatic responses.

This slide shows you what a new user site screen look like. You put in your first name, your last name, the personal email account, and a phone number. Again, within five minutes, you should be receiving the automatic response and certificate. If you don't then there is a problem with a firewall being up.

This is what the existing user screen looks like. If you're an existing user and you have been receiving our certificates, great. Sometimes, even if you have been receiving certificates, maybe this time there is a firewall that was put up. And I know where I work here at HSAG, every week or so we have our I.T. department working to make sure that there are not any spams or phishes going through our computers. So we do have changes in our firewall access. Again, this is an existing user screen, your

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username is your entire email address and, of course, the password is whatever you put in when you registered.

Okay, now I'm going to drop the ball back into Bethany's hands to finish off our event. Take it away, Bethany.

Bethany Wheeler: Thank you, Deb. I would now like to turn the presentation back over to Rachel Yong [for] some of the questions that were submitted during the presentations. If your question was not answered during the presentation, go to the [www.qualityreportingcenter.com] website around the middle of the month to view all of the questions that were submitted during the call, in addition to the answers. Rachel, the floor is yours.

Rachel Yong: Thank you, Bethany. We did receive a lot of questions asking when the reports for this year will be released. We are expecting to release them in – around [the] middle of July.

There was also a question about some of the more detailed risk adjustment variables that are used in the regression model that we described earlier. All of this information is included in the measure information form that is posted on the *QualityNet* web page that was linked on of the earlier slides.

There was a few – couple [of] questions about the post-acute care that occurs within 30 days after hospital discharge. To help clarify that, we can go back to one of our slides that describe this. All post-acute care that starts – that have a “from date” within the 30 days after the hospital discharge are included. Post-acute care is not prorated. So, an example I was discussing earlier, if a home health – if a patient is discharged from a hospital and received home health care starting on the 20th day after discharge, higher home health claims will be included in the MSPB episode spending amount.

There is also a question about the – one changes to claims data are accepted. Again, changes to the underlying claims data is not accepted, but questions and requests for correction to the MSPB Amount calculation is accepted 30 days after the hospital receives the reports.

There is also a question about readmissions and whether or not that's included. In Table Five that you'll see in your hospital specific report which is broken down by time period and claim type, you will see that in the 30 days after hospital discharge there will be an inpatient service section. And so any readmission cost are included in there, as well as any other type of rehab services that are provided in the inpatient setting.

There are a few questions about how – whether or not a – (whether the) hospital will receive their hospital specific report. A hospital needs to have an active *QualityNet* account to receive it, and they will – the reports will be sent directly to their account.

Any questions that you have can be submitted again to the CMS-MSBP Measure email address that is listed on the slide.

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Thank you for your patience. We're slowly reading some of the questions that we're receiving in real time and seeing which ones would be most appropriate to answer for the whole group.

There is a quick question about what carrier means in Table Five? We can jump back to an example on this slide that shows carrier. Carrier is all Part B provider services. So, physician services that are billed on a part B claim.

There is also another question about inpatient – where inpatient rehab spending would be included. And you will see that in the inpatient section of the – in Table Five, in the post 30-day discharge period. Since that's filled [in] on an inpatient claim, that will be included as an inpatient service.

There is also a question about transfers and whether not that is eligible [to] start an episode. As I mentioned before, transferees between acute care hospitals are not eligible to start. So, in other words, the receiving hospital will not be able to start an episode or the transferring hospital will not be able to start an episode. Those specifications are also included in the Measure Information Form included on the hospital – on MSPB *QualityNet* web pages.

I see there is also a quick question about the difference between the hospital specific reports and the downloadable files. I'm not entirely sure the downloadable file is referring to those [which] are publically available on data.medicare.gov, but we would like to clarify that the hospital specific report includes a lot more detailed information that is not publically available. So for example, the files [that] are publically available will only show the MSPB measure of the hospital and a spending breakdown similar to Table Five, but it won't show that breakdown that you see in Table Six where you have the breakdown of the actual and the expected spending by MDC.

There is a question about whether or not, if you miss your HSR from a previous year, how do you get the copy? You would email. You can email the cmsMSPBmeasure@acumenllc.com and we can direct you to the *QualityNet* help desk, and they'll be able to help you locate or send you a copy of your previous year HSRs.

I see a follow-up question related to transfers. And the question is for a transferred patient, if neither the transferring nor the receiving hospital can start [an] episode, is the episode excluded? Yes, that is accurate. The episode is excluded because it does not start. The hospitals do not start an episode.

Plan readmissions, there's another question about plan readmission and where that would show up in the spending and breakdown by claim type and time period. If you have a plan readmission and if it's into – that will [be] included in the inpatient category of the post 30-day discharge period.

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Bethany Wheeler: Thank you, Rachel. I think that's all the time we have for today. So thank you, Rachel, for presenting that on our webinar today. We are very grateful that Rachel and Acumen agreed to join us today to give us this wonderful overview of the Medicare Spending Per Beneficiary Measure.

I want to give the reminder that the slides used for today's representation are available on [our] inpatient website www.qualityreportingcenter.com. And we'll all – [hope you] will all join us for the next Hospital Value-Based Purchasing Program webinar in July covering the Fiscal Year 2016 Hospital VBP Program in anticipation of the Fiscal Year 2016 Percentage Payment Summary Report release. This webinar is currently schedule for July 22nd. Please keep an eye out on the IQR ListServe for the registration flyer and slide. If you've not signed up for the IQR Listserv, you may do so on the qualitynet.org website.

I would like to thank you for joining today's webinar, and I hope you have a fantastic remainder of your day. Thank you.

END

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