Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Fiscal Year 2019
Medicare Spending per Beneficiary
Measure Overview

Questions and Answers

Speaker

Cynthia Khan, PhD
Data Scientist
Econometrica, Inc.

Moderator

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

June 5, 2018
2 p.m. ET

DISCLAIMER: This presentation question-and-answer transcript was current at the time of publication and/or upload onto the *Quality Reporting Center* and *QualityNet* websites. Medicare policy changes frequently. Any links to Medicare online source documents are for reference use only. In the case that Medicare policy, requirements, or guidance related to these questions and answers change following the date of posting, these questions and answers will not necessarily reflect those changes; given that they will remain as an archived copy, they will not be updated.

The written responses to the questions asked during the presentation were prepared as a service to the public and are not intended to grant rights or impose obligations. Any references or links to statutes, regulations, and/or other policy materials included are provided as summary information. No material contained therein is intended to take the place of either written laws or regulations. In the event of any conflict between the information provided by the question-and-answer session and any information included in any Medicare rules and/or regulations, the rules and regulations shall govern. The specific statutes, regulations, and other interpretive materials should be reviewed independently for a full and accurate statement of their contents.

Webinar attendees asked the following questions and subject-matter experts provided the responses. Questions and answers may have been edited for grammar.

Question 1: **Is there a specific time, immediately prior to or following the episode, that is included in the Medicare Spending per Beneficiary (MSPB)?**

An MSPB episode will include all Medicare Part A and Part B claims with the start date falling between three days prior to an Inpatient Prospective Payment System (IPPS) hospital admission, also known as the index admission for the episode, through 30 days post discharge.

Question 2: **Could you clarify the following (Slide 15), "Hospital admissions that are NOT considered as index admissions include: Admissions having discharge dates fewer than 30 days prior to the end of the performance period."**

Index admissions with discharge dates within 30 days from the end of the performance period are not included in measure calculations, as those episodes could contain costs not incurred during the period of performance. A period of performance spans January 1 to December 31.

For example, a beneficiary discharged on December 20 would not have their index admission counted towards the MSPB measure calculation because the 30-day post discharge period for this episode would end on January 9, which is outside the period of performance for that year.

Question 3: **On Table 5 of the Hospital Specific Report (HSR), what does the category "Carrier" represent?**

From the research data assistance center website (https://www.resdac.org/cms-data/files/carrier-rif), the Carrier file, also known as the Physician or Supplier Part B Claims file, contains final action fee-for-service claims submitted on a Centers for Medicare & Medicaid Services (CMS)1500 claim form. Most of the claims are from non-institutional providers, such as physicians, physician assistants, clinical social workers and nurse practitioners.

Question 4: **What is included in the Outpatient claim type?**

The Outpatient file contains final action fee-for-service claims data submitted by institutional outpatient providers. Examples of institutional outpatient providers include hospital and outpatient departments, oral health clinics, renal dialysis facilities, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities and community mental health centers. In fact, additional information on outpatient claim types is available at https://www.resdac.org/cms-data/files/op-rif.

Question 5: **Are claims in the MSPB Measure included even if the hospital is not IPPS?**

Admissions to hospitals that Medicare does not reimburse through IPPS, (e.g., cancer hospitals, critical access hospitals, hospitals in Maryland) are not considered index admissions and therefore not eligible to begin an MSPB episode.

However, if an acute to acute hospital transfer or a hospitalization in an IPPS exempt hospital type happens during the 30-day window following an included index admission, it will be counted in the measure. More information can be found in the MSPB measure information, which is on the following *QualityNet* webpage: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350.

Question 6: **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 who are not enrolled in Medicare Advantage.

Question 7: **We see a lot of major diagnostic category (MDC) 0 (Pre-MDC) episodes. What does this mean?**

The MDC expense episodes is determined by the Medicare Severity Diagnosis-Related Group, or MS-DRG, of the index hospital stay. The pre-MDC represents hospital stays related to transplants given that the MDC is determined from several diagnosis or procedure situations.

Specifically, pre-MDC DRGs include organ transplants, bone marrow transplants, and tracheostomy cases. This is because transplants tend to be very expensive and can be needed for several reasons that do not come from one diagnosis domain. The explanation of the pre-MDC is also explained in a footnote of Table 6 in the HSR.

Question 8: **Are planned readmissions included in the Inpatient category of the post-acute portion of the episode?**

The 30 Days After Hospital Discharge category includes all Medicare Parts A and B claims for services furnished from an index hospitalization discharge up to and including 30 days post-discharge. Given that readmissions would be an inpatient claim, they would appear under the inpatient category of the 30 Days After Hospital Discharge category in Table 5 of the HSR.

Question 9: **Is inpatient rehab spending included in the index hospital visit or post-acute?**

Since inpatient rehabilitation services would be billed as an inpatient claim, they would appear under the inpatient category of the 30 Days After Hospital Discharge category in Table 5 of the HSR.

Question 10: What if the post-acute care goes past the 30 days after an index stay? In other words, how is payment included in the episode of care calculations if the end time of the post-acute claim is beyond 30 days post discharge from the hospital?

The MSPB Measure associates index hospitals with the cost of all claims that start within 30 days after discharge from the index admission, and costs are not prorated. Thus, if a patient is admitted to the hospital, triggers an MSPB episode and then receives home health care that is billed within 30 days after discharge, the index hospital is responsible for the full cost of that home health claim.

Again, the measure calculation does not prorate the cost of home health care. Another example is if a patient is admitted to the hospital, triggers an MSPB episode, and is then discharged to a skilled nursing facility and remains in the skilled nursing facility for more than 30 days (e.g., 90 days spent in the facility), then the index hospital is responsible for the full cost of the skilled nursing facility stay.

Question 11: Can you explain why the hospital's MSPB amount is divided by the national median MSPB and not the national average MSPB?

The median score represents the score that falls in the middle of the distribution scores going from lowest score to highest score, and the median is less influenced by scores in the high or low ends of the distribution than the average. As such, we use the MSPB median score as opposed to the MSPB average score.

Question 12: Can you explain what is meant by price-standardized payments?

Price standardization accounts for payment differences in geographic locations and special Medicare programs that are unrelated to care (e.g., graduate medical education), while retaining other aspects and differences in Medicare payments. For more information, you can refer to the MSPB Measure Information form which is located on the *QualityNet* measure methodology reports webpage: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350. That same webpage also provides documentation describing payment standardization.

Question 13: Can you explain what is meant by risk-adjustment?

The MSPB risk adjustment methodology adjusts the MSPB Measure for age, severity of illness and enrollment status indicators. Specifically, the methodology includes 12 age categorical variables and 79 Hierarchical Condition Category variables (HCC) that are derived from the beneficiary's claims during the period 90 days prior to the start of the episode to measure the severity of the illness, as well as the MS-DRG, of the index hospitalization.

The risk adjustment methodology also includes HCC interaction variables, status indicator variables, whether the beneficiary qualifies for Medicare through disability or end-stage renal disease (ESRD) and whether a beneficiary resides in a long-term care facility. For more information, please refer to the MSPB measure information form, which is located on the *QualityNet* measure methodology webpage: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350.

Question 14: Do we want our MSPB as close to one as possible, or is it better to be well below one?

An MSPB measure of greater than one indicates that your hospital's MSPB amount is more expensive than the US national median MSPB amount. An MSPB measure of less than one indicates that your hospital's MSPB amount is less expensive than the US national median MSPB amount.

The MSPB measure should be viewed in the context of other measures to evaluate the quality of care. The MSPB measure is not the only measure by which CMS evaluates hospitals. It is instead one part of the Hospital Value-Based Purchasing Program (HVBP) that contributes to the overall evaluation of a hospital's performance.

Question 15: **Since most hospitals do not have access to the Medicare numbers and since hospitals are paid based on Diagnostic-Related Group (DRG) payment, 1) how do you expect hospitals to do performance improvement and 2) nationally, what areas do you see as the best areas to focus on for improvement?**

Starting with the first question, the HSRs provide each hospital with a wealth of information to assess their performance in the current period performance to compare against previous HSRs and evaluate their performance against other hospitals in their state and in the nation. In addition to the MSPB Measure, the HSRs present the major components used to calculate the MSPB Measure for the hospital, state, and the US. These components include average spending per episode, average risk-adjusted spending or the MSPB amount, the number of eligible admissions, the national MSPB amount.

In addition, the HSR includes the national distribution of the MSPB Measure and tables that provide a:

- Breakdown of the MSPB spending by seven claim types and three time periods (3 days prior to index admission, during-index admission, and 30 days after hospital discharge).
- Breakdown of spending (actual and expected) by MDC.

Alongside your MSPB HSRs, each hospital is given three accompanying hospital-specific data files that enable hospitals to explore the driving forces behind their MSPB measure. For example, a hospital can analyze the breakdown of its spending by service types and period of service (from the HSR) and figure out the most expensive providers (from Episode file). With this information, the hospital can identify the areas where the spending is most concentrated and coordinate with other healthcare providers to improve efficiency. Thus, by improving care coordination and efficiency and reducing delivery system fragmentation, the provider can improve its relative performance.

Speaking to your second questions, the main drivers of MSPB spending will vary by hospital, the areas of improvement will be hospital-specific. More generally, most of the variation in the MSPB spending comes from post-discharge spending; specifically, skilled nursing facilities (SNFs)

followed by inpatient readmissions. Thus, better care-coordination in the post-discharge setting is one of the areas to focus on for improvement.

Question 16: What is the difference between the Hospital Specific Reports (HSRs) and the downloadable files on the *Hospital Compare* website?

The MSPB HSRs basically provide information on your specific hospital's performance during a given performance year and enables you to compare your hospital performance to that of hospitals in your state and the nation. The downloadable files available on *Hospital Compare* provide the MSPB measure scores for all hospital stays and the nation. However, unlike the HSRs, the downloadable files do not include hospital's MSPB amounts (shown in Table 2 of the HSR) or a breakdown in spending by the measure diagnostic category (shown in Table 6 of the HSR).

Question 17: When will the downloadable MSPB files be available?

Downloadable MSPB files based on the 2016 claims date are currently available on *Hospital Compare's* website, however, the MSPB files based on 2017 claims data may not be available on *Hospital Compare* until early next year.

Question 18: Are SNF residents excluded from the measure? Or is there any adjustment?

Beneficiaries are not excluded based on the SNF status. There is not any adjustment for SNF residents.

Question 19: **Do you have a definition sheet with the abbreviations on them?**

The abbreviations for the variables in the Comma Separated Values (CSV) Files stand for:

- IP: Inpatient Claims
- OP: Outpatient Claims
- PB: Physician/Supplier Part B (also known as Carrier) Claims
- SN: Skilled Nursing Facility Claims
- DM: Durable Medical Equipment Claims
- HH: Home Health Claims
- HS: Hospice Claims

For additional information, feel free to contact us at cmsmspbmeasure@econometricainc.com.

Question 20: **Does the MSPB Measure include the DRG payment for the index admission?**

Unfortunately, Econometrica is not in a position to provide additional breakdowns and/or provide custom data extracts to providers. However, the three Hospital-Specific Data files that your hospital received in conjunction with its HSR provide episode-level detail. These data files can help your hospital verify the calculation of its MSPB measure and assist you in examining the MSPB measure patterns among your patients.

Question 21: **How can the National MSPB be less than 1?**

The national MSPB Measure is calculated by dividing the U.S. MSPB Amount (Avg. Risk-Adjusted Spending) by the U.S. National Median MSPB amount. Although the average score and median score are expected to be similar, there are likely to be differences depending on the distribution of scores.

The average score can be influenced by high and low scores because these scores are taken into account when calculating the average. The median score represents the score that falls in the middle of the distribution of scores, going from lowest score to highest score, and is less influenced by scores in the high or low ends of the distribution than the average. As a result, the average score may be slightly different from the median score.

Question 22: **How can we easily cross-reference the provider ID and National Provider Identifier (NPIs)?**

The Episode file you also received with your HSR lists the top five providers for care provided in all provider settings. The following shows where to find a crosswalk between provider ID and their information:

- Inpatient, Outpatient, Home Health, Hospice, and Skilled Nursing all use CMS Certification Numbers (CCNs), previously referred to as the Medicare OSCAR provider number. They can be linked to a name (and other information) using the most recent Clinical Laboratory Improvement Act (CLIA) at http://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/index.html. Please be aware that the CLIA file is a very large file, which can take time to open as Excel file.
- Physician and DME Supplier NPI can be linked to a name using this website: http://www.hipaaspace.com/Medical_Billing/Coding/National_Provider_Identifier/NPI_Number_Lookup.aspx.
- Durable Medical Equipment Supplier Number: The same site as for Physician and DME Supplier NPI http://www.hipaaspace.com/Medical_Billing/Coding/National_Provider_Identifier/NPI_Number_Lookup.aspx. Note that this supplier number will not show up in the search result heading. If

you select the result, it most often appears further down the page in the Legacy Identifiers table.

Question 23: **How does this MSPB compare to the MSPB used in the Quality Payment Program (QPP), i.e., MIPS?**

The MSPB Measure used in the QPP evaluates solo practitioners and groups of practitioners, including physicians on their efficiency and is specialty-adjusted to account for the group's specialty mix. Solo practitioners and groups of practitioners, including physicians are identified by their Taxpayer Identification Number (TIN). MSPB-TIN Measure is included in the Quality and Resource Use Reports (QRUR). More information about the QRUR, including the help desk contact for accessing physician reports, can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html.

Question 24: **If claims are sent from physician offices or ambulance providers, which are not associated with hospital admissions, why are they attributed to hospitals under Carrier type in 3 days prior to index admission?**

An MSPB episode includes spending from all Medicare Part A and B claims for a beneficiary from 3 days prior to an inpatient hospital admission (also known as the "index admission" for the episode) through 30 days post-hospital discharge. CMS believes that the inclusion of Medicare payments made outside the time frame of the hospital inpatient stay encourages hospitals to evaluate the necessity of the services they provide and to reduce the occurrence of adverse outcomes, including inappropriate readmissions.

Question 25: Is it all or nothing for the MSPB domain in VBP?

No. The Fiscal Year 2019 Hospital VBP Program adjusts hospitals' payments based on their performance on four domains that reflect hospital quality: (1) the clinical care domain, (2) the patient- and caregiver-centered experience of care/care coordination domain, (3) the safety domain, and (4) the efficiency and cost reduction domain. Each domain is weighted at 25% of the Total Performance Score (TPS). If a hospital receives domain scores in at least 3 of the 4 domains (but not all domains), the domain weights will be proportionately re-weighted to the scored domains. The MSPB measure is part of the Efficiency Domain. For the fiscal year (FY) 2019 Hospital VBP Program, the Efficiency Domain makes up between 25%–33% of your Total Performance Score, depending on whether or not you have sufficient cases in the other domains. A lower MSPB measure would contribute to a Higher Efficiency Score, but this does not necessarily correlate with a change in payment due to the effect of the other domains on a hospital's Total Performance Score. More information about the Total Performance Score used for payment determination under the HVBP can be found at: https://www.medicare.gov/HospitalCompare/Data/total-performance-scores.html .

Question 26: Is MSPB determined for critical access hospitals (CAHs)? Where would a CAH find that measure for their facility?

No. The MSPB Measure evaluates hospitals paid under IPPS. Because CAHs are not acute care hospitals paid under IPPS, MSPB measure scores and HSRs are not created for CAHs.

Question 27: On slide 14, where you discuss 3 days before episode start, we have a large service area and many helicopter transports from outlying areas. Are these included as a "prior to admission" expense?

An MSPB episode will include all Medicare Part A and Part B claims with a start date falling between 3 days prior to an IPPS hospital admission (also known as the "index admission" for the episode) through 30 days post-hospital discharge. The only exception is if the beneficiary visited the ED in your hospital and then was admitted to your hospital; the costs of an ED visit would be included with the inpatient costs under the Index Admission category (see *IP_actual_cost* and *IP_std_cost* in your Episode File to see the total inpatient hospital costs in a given episode). Otherwise, ED visits

are considered as outpatient costs (see *OP_actual_cost* and *OP_std_cost* in your Episode File) for whichever time-period (pre- or post-index).

Question 28: **On slide 22 did you indicate that the home health claim would include the payments that extended beyond the 30 days? Or just the portion within the 30-day period?**

An MSPB episode will include all Medicare Part A and Part B claims with a start date falling between 3 days prior to an IPPS hospital admission (also known as the “index admission” for the episode) through 30 days post-hospital discharge. The MSPB measure calculation does not pro-rate the cost of care that extends beyond the 30 days post-hospital discharge.

Thus, if a patient is admitted to the hospital, triggers an MSPB episode, and then receives home health care, that is billed within the 30 days after discharge, the index hospital is responsible for the full cost of the home health claim, even if the payments extend beyond the 30-day post-discharge period. The measure calculation does not pro-rate the cost of home health care or any post-acute care.

Question 29: **To go along with the example that you provided regarding the patient going to SNF (and/or home health) following the hospital discharge. How does the time prior to the hospital affect the MSPB if they were admitted from the SNF or home health?**

An MSPB episode will include all Medicare Part A and Part B claims with a start date falling between 3 days prior to an IPPS hospital admission (also known as the “index admission” for the episode) through 30 days post-hospital discharge. An episode includes the 3 days prior to a hospital admission to promote MSPB episode consistency regardless of the diagnosis code on the preadmission services and where these complementary services took place. This is because diagnostic services and non-diagnostic services related to the reason for admission are captured in the inpatient DRG payment for the hospitalization when they are performed by the hospital during the 3 days prior to admission. However, if during the 3 days prior to a hospital admission, a beneficiary receives diagnostic services from a provider other than the index hospital or non-diagnostic services that appear to be unrelated to the reason for the index admission, those services are paid separately under Medicare.

Question 30: What is represented by the Ungroupable Episodes on Table 6 Detailed MSPB Spending Breakdowns by MDC?

You can identify Ungroupable Episodes in the three supplemental files provided with the HSR. The Index Admission file, the Episode file, and the Beneficiary Risk Score file contain information on Medicare beneficiaries' admissions that were considered for inclusion in the MSPB Measure for your hospital. We suggest filtering each file on the MDC column and examining the following information provided in the rows that have "U" (for ungrouped) under the MDC column:

- In the Index Admission file: Examine list of diagnosis codes
- In the Episode file: Examine episode per spending
- In the Beneficiary Risk Score file: Examine DRGs

Question 31: What is the definition of SNF? Does this include swing bed programs?

The MSPB Measure uses the SNF file that contains final action, fee-for-service, and claims data submitted by SNF providers. The SNF services covered by Medicare include, but aren't limited to:

- Semi-private room (a room shared with other patients)
- Meals
- Skilled nursing care
- Physical and occupational therapy (if they're needed to meet the patient's health goal)
- Speech language pathology services (if they're needed to meet the patient's health goal)
- Medical social services
- Medications
- Medical supplies and equipment used in the facility
- Ambulance transportation (when other transportation endangers health) to the nearest supplier of needed services that aren't available at the SNF
- Dietary counseling

Medicare covers swing bed services when the hospital or CAH has entered into a Swing-Bed Agreement with the Department of Health and Human Services (HHS). With a Swing-Bed Agreement, the facility can "swing" its beds and provide either acute hospital or SNF-level care, as needed. When swing beds are used to furnish SNF-level care, the same coverage and cost-sharing rules apply as though the services were furnished in a SNF. For more information, see https://www.medicare.gov/coverage/skilled-nursing-facility-care.html.

Question 32: **What type of corrections [during Review and Correction period] would be requested?**

If hospitals have questions about their CEBP measures scores, they can email us at cmscebpmeasures@econometricainc.com to request additional information. If there are any errors in the CEBP Measure calculations, then hospitals can request a calculation correction. To date, we have not received any requests for measure calculation corrections.

However, hospitals cannot request measure calculation corrections due to errors in the underlying claims or by submitting:

- Additional corrections to underlying claims data
- New claims to be added to the calculations

Question 33: **What would be the reasons that our unadjusted MSPB amount is less than the national average, yet our adjusted MSPB is a higher dollar amount? If patients are not seen by a primary care physician (PCP) in the 3 months prior to admission, do they get any risk adjustment other than that from the indexed admission(s)? Is dual eligible [Medicare & Medicaid] percentage factored into MSPB at this time?**

The MSPB risk adjustment methodology adjusts the MSPB measure for age, severity of illness and enrollment status indicators. Specifically, the methodology includes 12 age categorical variables and 79 HCCs that are derived from the beneficiary's claims during the period 90 days prior to the start of the episode to measure of severity of illness, as well as the MS-DRG of the index hospitalization. To answer your specific questions:

1. Your hospital's risk-adjusted MSPB amount can be higher or lower than the national median amount depending on your hospital's case-mix and other factors
2. If the beneficiaries don't have any claims during the period 90 days prior to the start of the episode, their episodes will be risk-adjusted based on the MS-DRG of the index admission and non-claims risk-adjustment factors such as age
3. The percentage of dual eligibility is not factored into MSPB at this time.

Question 34: **Where do observation status claims fall? Inpatient or Outpatient categories?**

If a patient is under observation status and is then formally admitted to inpatient status, the observation service costs are not separately paid and are bundled into the inpatient payment. If the patient is not admitted to inpatient, the costs could be part of outpatient costs in either pre- or post-index period.

Question 35: **The link listed for the MSPB Spending Breakdown by Claim Type doesn't work. Can you tell us where to find this file?**

This file can be found on https://data.medicare.gov/data/hospital-compare?sort=relevance&tag=medicare%20payment. Alternatively, you can go to https://data.medicare.gov/data/hospital-compare, and "In Category", select "Payment and Value of Care" from the pull-down menu.