Hospital Value-Based Purchasing (VBP) Program

Support Contractor

Medicare Spending per Beneficiary (MSPB) Measure

Presentation Question & Answer Transcript

Moderator:

Bethany Wheeler, BS
Hospital VBP Program Support Contract Lead
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR) Contractor

Speaker:

Rachel Yong, MSPH
Senior Research Analyst
Acumen, LLC

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The following questions and answers are generally categorized by the order of the MSPB Measure presentation. The first section provides responses to questions related to how hospitals can improve on the MSPB Measure. The next three sections are answers to questions related to the measure methodology, specifically how the index admission is defined, what claims are included, and the calculation steps (e.g., risk adjustment and price standardization). The fifth section includes responses to questions about the MSPB Hospital-Specific Reports and review period. The sixth section includes answers regarding the downloadable files available on CMS webpages. The seventh section details responses to questions about the Hospital Value-Based Purchasing Program.

I. MSPB Measure Improvement

Question 1: How do you expect a hospital to do concurrent ongoing performance improvement?

Answer 1: A hospital can improve their MSPB Measure by reducing Medicare spending and delivery system fragmentation. One of the ways to do so is to improve coordination with post-acute providers to reduce the likelihood of hospital readmissions, reduce unnecessary inpatient services (e.g., multiple CT scans), reduce unnecessary post-acute services, and shift post-acute care from more expensive services (e.g., Skilled Nursing Facilities (SNFs)) to less expensive services (e.g., home health (HH)) when appropriate.

Question 2: If we want to approximate our values concurrently, how closely do the national values (denominators) trend?

Answer 2: If your hospital would like to evaluate how the national median MSPB Amount trends across years, your hospital will want to look at the row for "U.S. National Median MSPB Amount" in Table 3 of the Hospital Specific Report across years. This is the value used in the denominator of the MSPB Measure.

Question 3: 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 expected hospitals to do performance improvement and 2) nationally, what areas do you see as the best areas to focus on for improvement.

Answer 3: The Hospital-Specific Reports (HSRs) provide each hospital with a wealth of information to assess their performance in the current period of performance, to compare against previous HSRs, and to 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 U.S. (Average Spending per Episode, Average Risk-Adjusted Spending or MSPB Amount, Number of Eligible Admissions, and National Median 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)
- a breakdown of spending (actual and expected) by Major Diagnostic Category (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.

Given that 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, 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 4: If the acute care hospitalization is paid on DRG, where is the opportunity to reduce spending in the acute care stay?

Answer 4: While the inpatient claim is paid based on DRG, other claim types during the index inpatient admission also count towards your hospital's MSPB Amount, such as Carrier (Physician/Supplier Part B) or Durable Medical Equipment (DME claims). Note that the "During-Index Admission" category includes all claims that fall between an episode's index admission date and discharge date.

Question 5: How are hospitals able to improve efficiency if they aren't able to direct patients to specific providers rather than give them a list of providers in the community?

Answer 5: A hospital can improve efficiency by reducing Medicare spending and delivery system fragmentation. Even if a hospital is not able to direct patients to specific providers, it can reduce unnecessary post-acute services and shift post-acute care from more expensive services (e.g., SNFs) to less expensive services (e.g., home health) when appropriate. It can improve coordination with post-acute providers to reduce the likelihood of hospital readmissions and reduce unnecessary inpatient services (e.g., multiple CT scans).

II. Measure Methodology: Index Admission Criteria

Question 6: Slide 13: Admission occur within 30 days of discharge from an index admission. Will the expense of this admission be counted toward/summed to the Index IP Admission?

Answer 6: The cost of an admission that occurs within 30 days of discharge will be included in the episode cost calculation. However, costs from this admission will be shown in the 30 days post-discharge period in the report. Costs from 3 days pre-index admission, index admission, and 30 days post-index admission are aggregated for the measure.

Question 7: Could you clarify the following (Slide 13): 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.

Answer 7: Index admissions with discharge dates within 30 days from the end of the performance period are not included in measure calculation, as those episodes could contain costs not incurred during the period of performance. For example, a beneficiary discharged on December 20th would not have their index admission counted towards the MSPB Measure calculation. The 30-day post discharge period for this episode would end on January 9th which is outside the period of performance.

Question 8: Can the index admission be an observation stay?

Answer 8: Index admissions are only counted in the measure if the beneficiary is admitted as an inpatient to the hospital. If a beneficiary is not admitted as an inpatient as a result of the observation stay, that will not be categorized as an index admission.

Question 9: What is the definition of a subsection (d) hospital? Thank you!

Answer 9: Subsection (d) hospitals are hospitals in the 50 States and D.C. other than: hospitals located in Maryland, psychiatric hospitals, rehabilitation hospitals, hospitals whose inpatients are predominantly under 18 years old, hospitals whose average inpatient length of stay exceeds 25 days, and hospitals involved extensively in cancer treatment or research.

Question 10: For a transferred patient, if neither the transferring, nor the receiving hospital can start an episode, is the episode excluded?

Answer 10: For acute-to-acute transfers, an episode will not be created because the MSPB Measure calculation excludes acute-to-acute transfers from consideration as index admissions. In other words, these cases do not generate new MSPB episodes; neither the hospital, which transfers a patient, nor the receiving subsection (d) hospital will have an index admission attributed to them.

It is possible, though, for the patient to see more than one hospital during the length of the episode (e.g., during the 30 days post discharge). The costs accrued during the episode length will be reported and included in the MSPB Measure because an MSPB episode includes all claims whose start date falls between 3 days prior to the index admission through 30 days post-hospital discharge.

III. Measure Methodology: Included Claims

Question 11: On Table 5, what does the line titled "Carrier" in claim type mean?

Answer 11: Carrier spending levels represent spending for services that appear in the Carrier claim file (old file name Physician/Supplier Part B), which contains claims submitted by non-institutional providers. Examples of non-institutional providers include physicians, physician assistants, clinical social workers, nurse practitioners, independent clinical laboratories, ambulance providers, and free-standing ambulatory surgical centers.

Question 12: 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?

Answer 12: The MSPB measure associates index hospitals with the cost of all claims that are billed within 30 days after discharge from the index admission. Thus, if a patient is admitted to the hospital, triggers an MSPB episode, and then

receives HH care that is billed within the 30 days after discharge, then the index hospital is responsible for the full cost of the HH claim. The measure calculation does not pro-rate the cost of HH care (or any post-acute care). Another example: if a patient is admitted to the hospital, triggers an MSPB episode, and is then discharged to a SNF and remains in the SNF for more than 30 days (e.g., 90 days), then the index hospital is responsible for the full cost of the SNF stay.

Question 13: I believe I heard that the hospital is "responsible" for home health charges during 30 days after dismissal. I am guessing I misheard. Comment?

Answer 13: A 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, including home health charges with an admission date within 30 days post-hospital discharge. CMS believes that the inclusion of Medicare payments made outside the timeframe 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 14: Are planned readmissions included in the inpatient category of the post-acute portion of the episode?

Answer 14: 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 show up in the "Inpatient" category of the "30 Days After Hospital Discharge" category in Table 5 of your Hospital-Specific Report.

Question 15: If post-acute care includes an LTAC, in which category are these charges included?

Answer 15: Since Long-Term Care Hospitals (LTCH) are paid using the Inpatient Prospective Payment System (PPS), their charges are included in the "Inpatient" Category.

Question 16: Are Part B services not related to the index admission excluded from this calculation?

Answer 16: All Part B services are included in the MSPB Measure calculation. A MSPB episode includes <u>all</u> claims whose start date falls between 3 days prior to an Inpatient Prospective Payment System (IPPS) hospital admission (index admission) through 30 days post-hospital discharge. Including these claims emphasizes the importance of care transitions and care coordination before, during, and after an inpatient stay.

Question 17: We have lower than normal costs for our inpatient stay (index admission) and quite a higher percentage post discharge spending in the SNF level than the state and national level. Our hospital has a wonderful Inpatient Rehab unit that is billed for under a separate CCN and many patients/physician choose to utilize our hospital for their inpatient visit so that they can easily move to the Inpatient Rehab unit post discharge. Is there any consideration in your methodology that would incorporate this type of relationship between the index admission and post level of care?

Answer 17: The calculation of the MSPB Measure does not account for this type of relationship between inpatient hospital and rehabilitation units.

Question 18: Is inpatient rehab spending included in the index hospital visit or post-acute?

Answer 18: Since inpatient rehabilitation services would be billed as an inpatient claim, they would show up in the "Inpatient" category of the "30 Days After Hospital Discharge" category in Table 5 of your Hospital-Specific Report.

Question 19: If a patient is discharged to a long term care center (nursing home) or home health how is a payment made and to whom?

Answer 19: The MSPB Measure associates index hospitals with the cost of all claims that are billed within 30 days after discharge from the index admission. Thus, if a patient is admitted to the hospital, triggers an MSPB episode, and receives HH care that is billed within the 30 days after discharge, then the index hospital is responsible for the full cost of the HH claim. The measure calculation does not pro-rate the cost of HH care (or any post-acute care).

Question 20: When an episode of care is excluded from MSPB, payment is then based on DRG?

Answer 20: MSPB impacts the hospital payments through the Hospital Value-Based Purchasing (VBP) Program, under which a certain percentage of hospital's base-operating DRG payment is withheld each fiscal year (e.g., 1.75% for the FY2016 Hospital VBP Program). The MSPB MeasureMeasure, which is the efficiency domain of the Hospital VBP program, along with other quality measures, is used to calculate the value-based adjustment factors. These factors determine the proportion of the withheld payments the hospital earns back or loses. These adjustment factors are applied to the inpatient claims to adjust the payments accordingly. Please note that these adjustment factors are applied after the inpatient payment has been determined on the DRG. Thus, regardless of whether an episode is included or not in the MSPB Measure, hospital payment is based on the DRG. If the hospital is eligible for the Hospital VBP program, hospital payment will be adjusted based on its performance on measures included in the program.

If you would like to know the impact of your MSPB measure on your hospitals value-based incentive payment percentage, you can find detailed

information on the CMS Hospital Value-Based Purchasing webpage. The Hospital VBP National Provider Calls (NPC) also provides an overview of how the MSPB measure impacts your payment adjustment. The FY2015 Hospital VBP NPC can be found here and FY2016 Hospital VBP NPC can be found here.

Question 21: For folks who are having pre-op clearance, such as by a cardiologist, who sees the patient 2 weeks before the procedure, where does that clearance fall in regards to MSPB?

Answer 21: If the claim is not within 3 days prior to the index admission for the episode, then it will not be included in the MSPB Measure calculation.

Question 22: If a claim is denied through RAC is it removed from the eligible episodes and/or costs?

Answer 22: The MSPB Measure uses Medicare Parts A and B claims data that are pulled annually in early April and the corrections processed before April are included. The current MSPB Measure calculation for FY2016 performance/ FY2018 baseline occurred in the second quarter of 2015, and the claims were extracted as of April 8, 2015. Thus, the corrections processed before April 2015 are included in the MSPB calculation.

Question 23: Are readmissions included? Wouldn't this be a double "hit" if a hospital already receives a readmission penalty?

Answer 23: The purpose of MSPB Measure under the Hospital VBP program is to enhance efficiency by improving care transitions and care coordination surrounding the hospital index admission. All claims, including readmission claims, occurring within 30 days post-discharge from the index admission are included in the Measure. It is possible that a hospital with excessive readmissions may receive a readmission penalty under the Hospital Readmission Reduction (HRR) program as well as lose money under the Hospital VBP program.

IV. Measure Methodology: Calculation Steps

Question 24: How does an inpatient test vs. an outpatient test affect the calculation?

Answer 24: A MSPB episode includes all claims whose start date falls between 3 days prior to an IPPS hospital admission (index admission) through 30 days post-hospital discharge. As such, whether a test is done in the inpatient or outpatient setting does not affect its inclusion or weighting in the measure, given that all costs from this time period are aggregated to calculate the MSPB Amount.

Question 25: What does truncating mean?

Answer 25: The truncation process is used to trim any extremely low predicted episode of spending. Specifically, all episodes with expected spending below the 0.5th percentile have expected spending "truncated," or set to the expected spending of the 0.5th percentile.

Question 26: Can you provide the link for the risk adjustment variables (HCCs) used for each MDC?

Answer 26: The hierarchical condition category (HCC) indicators are calculated using Part A and Part B claims data from the 90 days prior to the start of the MSPB episode, or 93 days prior to the date of the index admission.

For more details on risk adjustment and a complete list of risk-adjustment variables used, please see the "MSPB Measure Information Form" at this QualityNet webpage.

Question 27: We see a lot of MDC 0 (Pre-MDC) episodes. What does this mean?

Answer 27: The MDC of an episode is determined by the Medicare Severity Diagnosis-related group (MS-DRG) of the index hospital stay. MDC 0 (Pre-MDC) represents hospital stays related to transplants given that the MDC is determined from a number of diagnosis/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 a number of reasons that do not come from one diagnosis domain.

Question 28: Where can we find a table link with the MDC to the MS-DRG?

Answer 28: The mapping of MDC to MS-DRG can be found in the Table 5 of the IPPS Final Rule or the Correction Notice tables for the given fiscal year. For example, the mapping for the FY2015 IPPS Rule can be found in Table 5 of this CMS IPPS webpage.

Question 29: I think I missed how they derive the "expected amount"... Can you clarify?

Answer 29: The MSPB Measure is risk-adjusted for age and severity of illness to account for case-mix variation among hospitals. Severity of illness is measured using 70 HCC indicators derived from a beneficiary's claims during the period 90 days prior to the start of the MSPB episode, HCC interactions, and the MS-DRG of the index hospitalization. These variables are regressed against price-standardized episode cost. The predicted values from this regression are used to measure expected spending for each episode. In other words, expected episode spending is a conditional expected value given the values of the risk adjustment variables.

Question 30: Please clarify whether the MSPB is risk adjusted; there was a CMS Fact Sheet with MSPB that suggested it was not risk-adjusted. Also, where can we find the MSPB "Amount" and MSPB "Measure" on the website? Thank you

Answer 30: The MSPB Measure is risk-adjusted for age and severity of illness to account for case-mix variation among hospitals. Severity of illness is measured using 70 HCC indicators derived from a beneficiary's claims during the period 90 days prior to the start of the MSPB episode, HCC interactions, and the MS-DRG of the index hospitalization. These variables are regressed against price-standardized episode cost.

The fact sheet clarifies that cost data for service categories on the Hospital Compare website shows non-risk-adjusted values for two reasons: first, so that the public can evaluate service costs based on non-risk-adjusted amounts and determine appropriate next steps; and second, because risk adjustment is done at the episode level rather than at the service category/claim level. The MSPB Measure is available on this Hospital Compare webpage.

Question 31: Do I understand that risk adjustment is performed using part A and part B claims data up to 90 days prior to the index admission?

Answer 31: Severity of illness is measured using 70 HCC indicators derived from a beneficiary's Part A and Part B claims during the period 90 days prior to the start of the MSPB episode, as well as the MS-DRG of the index hospitalization. Given that an MSPB episode starts 3 days prior to the index admission, claims data up to 93 days prior to the index admission is used to construct the HCCs for risk-adjustment.

Question 32: Are claims payments standardized by geographic location [on] the state level or more locally?

Answer 32: Payment standardization is the process of adjusting the allowed charge for a Medicare service to facilitate comparisons of resource use across geographic areas. As a result, standardization is not calculated by geographic location. For example, the methodology eliminates differences that result from regional variation in hospital wage indexes and geographic practice cost indexes. For an overview of price standardization, also known as payment standardization, please see the "Basics of Payment Standardization" document available at this QualityNet webpage. For a detailed description of the methodology applied to each setting, please see the "CMS Price Standardization Methodology" document that is also available on the QualityNet webpage.

Question 33: In calculating the standard amount in Step 1 are DSH payment adjustments & Wage Index adjustments also removed similar to IME?

Answer 33: Yes, the CMS price standardization methodology eliminates differences that result from regional variation in hospital wage indexes and disproportionate share hospital (DSH) payment adjustments. For an overview of price standardization, also known as payment standardization, please see the "Basics of Payment Standardization" document available at this QualityNet webpage. For detailed description of the methodology applied to each setting,

please see the "CMS Price Standardization Methodology" document that is also available on the QualityNet webpage.

V. Hospital-Specific Reports and Review Period

Question 34: Are we receiving MSPB Hospital-Specific Reports now?

Answer 34: The MSPB Hospital-Specific Reports were released on QualityNet on June 9th for hospital review.

Question 35: Where is the Hospital-Specific Report found?

Answer 35: The Hospital-Specific Reports will be available on QualityNet, and be sent directly to your hospital's QualityNet account.

Question 36: Do hospitals have access to the Detailed MSPB Spending Breakdown by MDC Report?

Answer 36: Yes, the Detailed MSPB Spending Breakdown by MDC is provided as Table 6 in the Hospital-Specific Report.

Question 37: If we missed our HSR from 2014, are we still able to get a copy?

Answer 37: If you need a copy of your HSR sent to your hospital again, please submit your request by calling 866-288-8912 or emailing qnetsupport@hcqis.org. Please provide the name of your hospital and your hospital's CMS Certification Number (CCN) (previously referred to as the OSCAR provider number). If you have questions about whether your HSR is available or was sent to your hospital, please contact HSRrequest@iaqio.sdps.org.

Question 38: When is the last date when any changes to claims data are accepted?

Answer 38: The MSPB Measure uses Medicare Parts A and B claims data that is pulled annually in early April and the corrections processed before April are included. The current MSPB Measure calculation for FY2016 performance/ FY2018 baseline occurred in the second quarter of 2015, and the claims were extracted as of April 8, 2015. Thus, the corrections processed before April 2015 are included in the MSPB calculation.

Question 39: How often do hospitals actually find an error in the calculations?

Answer 39: To date, hospitals have not found errors in the MSPB calculations.

Question 40: Is the HSR that we will get this summer for our hospital the same timeframe (measurement) that will be used in the FY 2016 VBP Final Score?

Answer 40: The HSRs your hospital received on June 9, 2015 is based on data from January 1, 2014-December 1, 2014. This is the timeframe for the performance

period for the FY2016 Hospital VBP Program and the baseline period for the FY2018 Hospital VBP Program.

Question 41: Why are late corrections ultimately not allowed? Doesn't accuracy of the data matter?

Answer 41: When calculating the MSPB Measure, the claims are extracted in early April to allow a three month run-out period for correction to the claims to be submitted before they are used in the measure calculation. Thus, any corrections processed before April are included in the calculation.

As with other measures, CMS provides hospitals a review and correction period to evaluate their HSRs for the MSPB Measure. This year, the review and correction period is from June 9, 2015 until 11:59 p.m. PT on July 9, 2015. This review and corrections process does not allow hospitals to submit additional corrections related to the underlying claims data used to calculate the rates, nor add new claims to the data extract used to calculate the rates. Instead, the HSRs are designed to allow hospitals the opportunity to review measure results and the discharge data used in the calculation of the claims-based measures and to replicate their results.

VI. Downloadable MSPB Files on Data.Medicare.Gov and Hospital Compare

Question 42: What is the reporting period for the MSPB reports that will be published in October 2015?

Answer 42: The MSPB data released on Hospital Compare in October 2015 will be on data from January 1, 2014-December 1, 2014, which constitutes the performance period for the FY2016 Hospital VBP Program and the baseline period for the FY2018 Hospital VBP Program.

Question 43: Please clarify – what MSPB data is available now vs in July vs in October? Thank you.

Answer 43: The MSPB Hospital-Specific Reports and accompanying data files based on the timeframe of January 1, 2014-December 1, 2014 were sent to hospitals on June 9th. This is the performance period for the FY2016 Hospital VBP Program and the baseline period for the FY2018 Hospital VBP Program. After the 30 day review and correction period, the MSPB Measure and spending breakdown by claim type will be made available in October 2015 on the Hospital Compare website. The MSPB data on Hospital Compare website is refreshed annually, and the data currently available is based on January 1, 2013-December 1, 2013, which is the baseline period for the FY2017 Hospital VBP Program.

Question 44: What is the difference between the hospital specific reports and the downloadable files?

Answer 44: The MSPB Hospital-Specific Reports provide high level aggregate information on the hospital's performance for the whole year. The downloadable files available on Hospital Compare provide the MSPB score for each hospital, state, and for the nation. In addition, each hospital's spending breakdown by claim type is also available for download.

VII. Impact on Hospital Value-Based Purchasing Program

Question 45: The reports that will be released this summer will impact which fiscal year (FY) of the Hospital VBP Program?

Answer 45: The reports will be based on data from January 1, 2014-December 1, 2014, and will be used as the performance period for the FY2016 Hospital VBP Program and the baseline period for the FY2018 Hospital VBP Program.

Question 46: The episode count of 25 cases is over what time line? Monthly?

Answer 46: Hospitals must have at least 25 cases annually to be included the MSPB Measure in the Hospital VBP program.

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