

Post Call Clarification from the February 9, 2012 Medicare Spending per Beneficiary (MSPB) National Provider Call (NPC)

Within the transcript, we have identified several places where we feel clarification is needed. Below, we offer explanations of these issues.

1. On Page 13 of the transcript, within the description of the process for calculating the Medicare spending per beneficiary measure, there is a minor correction.

CLARIFICATION: The word “sum” should have been stated as “average.” The sentence should have said, “In step 2, the average expected spending is the average of the 11 episodes that are output from step 3, which are the expected spending. In this example we assume that the average standardized episode cost across the nation is \$9,000. So this would be the average of step 2 across all hospitals in the nation, across all episodes [*emphasis added*].”

2. On Page 27, a caller asked about Table 5 in the Hospital-Specific Report. Specifically, the caller asked why skilled nursing facility spending appears during an inpatient stay. We would like to clarify our response to this question.

CLARIFICATION: A Medicare Spending Per Beneficiary (MSPB) episode includes all claims whose discharge 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. CMS believes that inclusion of Medicare payments made outside the timeframe of the hospital inpatient stay will reinforce the need to reduce the provision of unnecessary services to Medicare beneficiaries and to reduce the occurrence of adverse outcomes, including readmissions. Table 5 of the MSPB Hospital-Specific Report (HSR) breaks down your hospital’s MSPB episode spending into three categories: 3 Days Prior to Index Admission, During-Index Admission, and 30 Days After Hospital Discharge.

The “During-Index Admission” category in Table 5 displays all claims that fall between an episode’s index admission date and discharge date. Because the prior/during/after breakdown does not consider the time of day at which a patient was discharged, any claim that begins on the discharge date of the index admission will be considered a “During-Index Admission” claim. For instance, if a patient is discharged from an IPPS hospital and then admitted to a skilled nursing facility on the same day as the index admission discharge, that skilled nursing facility claim is classified as falling into the “During-Index Admission” category in Table 5. We recognize that this has led to confusion and will consider whether there is a way to more clearly distinguish claims that occur during the hospital stay in the future.

For certain claim types, a large share of claims appearing in the “During-Index Admission” category begin on the date in which the patient was discharged. Nationally,

- **Skilled Nursing Facility (SNF) Claims:** 99.9 percent of SNF claims that appear in the “During-Index Admission” category begin on the discharge date;
- **Hospice (HS) Claims:** 92.5 percent of HS claims that appear “During-Index Admission” category begin on the discharge date;
- **Home Health (HH) Claims:** 78.9 percent of HH claims that appear “During-Index Admission” category begin on the discharge date; and
- **Durable Medical Equipment (DME) Claims:** 54.2 percent of DME claims that appear “During-Index Admission” category begin on the discharge date.

It is important to remember, however, that the MSPB Measure evaluates a hospital’s performance over the entire episode, rather than separately by the three categories presented in Table 5. Table 5 simply breaks down your hospital’s MSPB episode spending for informational purposes to allow your hospital to evaluate its episode spending before, during, or after the index IP admission for your hospital’s own information.

3. On page 28 of the transcript, a caller asked a question about subtracting out bad debt from the MSPB measure. We would like to clarify our response to that question.

CLARIFICATION: The MSPB methodology includes the deductible and coinsurance listed on the claim. No assumption is made about whether or not the beneficiary actually paid the hospital. The methodology measures spending incurred by the provider regardless of whether the beneficiary actually paid their share.

4. On page 33, a caller asked a question about how CMS handles transfer cases in the MSPB episode. We would like to clarify our response to this question.

CLARIFICATION: An MSPB episode includes all claims whose discharge date falls between 3 days prior to an inpatient PPS hospital admission (index admission) through 30 days post-hospital discharge. Admissions which occur within 30 days of discharge from another index admission are not considered to be index admissions. Acute-to-acute transfers (where a transfer is defined based on the claim discharge code) will not be considered index admissions. In other words, these cases will not generate new MSPB episodes; neither the hospital which transfers a patient to another subsection (d) hospital, nor the receiving subsection (d) hospital will have an index admission attributed to them. Should an acute-to-acute transfer, as described above, occur during the episode surrounding an index admission, then the Part A and Part B payments for the transfer case would be included in the calculation of the Medicare spending per beneficiary amount for that index admission.