

**CENTERS FOR MEDICARE AND MEDICAID SERVICES  
MEDICARE SPENDING PER BENEFICIARY MEASURE  
NATIONAL PROVIDER CALL**

**Moderator: Geanelle Herring**

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Holley: At this time I would like to welcome everyone to the Medicare Spending Per Beneficiary Measure conference call. All lines will remain in listen-only until the question and answer session. This call is being recorded and transcribed. If anybody has any objections, he may disconnect at this time. Thank you for your participation in today's call. I will now turn the call over to Geanelle Herring. Thank you, ma'am, you may begin.

## **Introduction**

Geanelle Herring: Thank you. Hello, everyone and welcome to the Medicare Spending Per Beneficiary Measure national provider call. My name is Geanelle Griffith Herring and I'll serve as your moderator today. CMS subject matter experts will provide an overview of the background of the Medicare Spending per Beneficiary Measure as well as an explanation of how the measure is calculated, including the approach to risk adjustment and payment standardization.

At the conclusion of the formal presentation, the phone lines will be opened to allow you to ask questions of the CMS subject matter experts gathered here today. If you haven't already done so, today's presentation can be found at <http://www.cms.gov/npc/call/list.asap#> top of page within the 2/9/12 National Provider Call: Medicare Spending Per Beneficiary Measure link. The presenters today are Ms. Kim Spalding Bush with the Performance Based Payment Policy Group in the Center for Medicare; Dr. Jason Shafrin, Ph.D. Research Associate with Acumen, LLC; and Peter Hickman, Senior Analyst with the Policy and Data Analyst Group and the Center for Strategic Planning here at CMS. I'll now turn the call over to Ms. Spalding Bush.

## **Background of the Medicare Spending Per Beneficiary Program**

Kim Spalding Bush: Thank you, Geanelle, and thank you to all the participants who are interested in Medicare Spending Per Beneficiary Measure and for joining us for the presentation today. Medicare is transforming from a system that rewards volume of service to one that rewards efficient, effective care and

reduces delivery system fragmentation. In order to further this transformation and to help address the critical issue of health care cost, we have added a measure of Medicare Spending Per Beneficiary to the Hospital Inpatient Quality Reporting Program measures set. The Medicare Spending Per Beneficiary Measure is required for inclusion in the Hospital Value-Based Purchasing Program by Section 1886(o) of the Social Security Act, which was added by Section 3001 of the Affordable Care Act. The Hospital Value-Based Purchasing Program applies to Subsection D IPPS Hospitals, and further details on the Hospital Value-Based Purchasing Program as a whole can be found in the April 2011 Inpatient Hospital Value-Based Purchasing Final Rule, which is CMS 3239-F.

The Medicare Spending Per Beneficiary Measure was finalized for inclusion in the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program in the fiscal year 2012 Inpatient Prospective Payment System Final Rule. The measures specifications and risk adjustment methodology were included in that rule. We subsequently suspended the effective date of the Medicare Spending Per Beneficiary Measure for the Hospital Value-Based Purchasing Program in the calendar year 2012 Outpatient Prospective Payment System Final Rule with comments. The effective date of the measure was suspended in order to give full effect to the process of posting hospital data for one year and after consideration of the public comments we received. CMS will propose the Medicare Spending Per Beneficiary Measure for inclusion in future years of the Hospital VBP Program through notice and comment rulemaking. And, of course, we encourage all interested parties to submit your comments through the rulemaking process.

On the next slide, slide six we will cover the Medicare Spending Per Beneficiary Measure Data Preview and Posting. The measure preview period for the Spending Per Beneficiary Measure began on February 1 of this year and it runs through March 1. By this time, all subsection (d) hospitals should have received notice that their Medicare Spending Per Beneficiary Measure Hospital Specific Preview Reports are available for downloading through My QualityNet. In addition to the Hospital Specific Report, hospitals received an

index admission file, a beneficiary risks score file, and a Medicare Spending Per Beneficiary episode file specific to the hospital. Measured data will be posted on Hospital Compare in April of this year. The data which will be displayed there is the hospital's individual Medicare Spending Per Beneficiary ratio. That ratio is the hospital's own Medicare Spending Per Beneficiary amount divided by the median Medicare Spending Per Beneficiary amount across all hospitals. During the data preview period, hospitals may submit questions or requests for correction to the CMS calculation of their Medicare Spending Per Beneficiary rate. I'll now turn the call over to Jason Shafrin from Acumen who will present on the Medicare Spending Per Beneficiary measures calculation and risk adjustment methodology.

## Calculating the Measure

Jason Shafrin: Hello, this is Jason Shafrin. I'm a research associate at Acumen, LLC. I will be taking you through the steps we use to calculate the Medicare Spending Per Beneficiary measure. As you can see on slide eight, there are seven steps that we use to calculate the Medicare Spending Per Beneficiary measure, which are also called the MSPB.

The first step is to construct the MSPB episode which is just which claims should be included in an episode, which beneficiaries should be included in the episode, and which hospitals are eligible to be included. The second step, once we figure out which claims are included in the episode, is to calculate the standardized episode spending, and Peter Hickman will talk about that later in the presentation, the exact methodology. The third step calculates the expected spending for each of these episodes. The expected spending, basically, is based on the patient case mix of each hospital. So cases where the patients are older, or sicker, or generally have higher expected cost compared to the episodes where the patient is, you know, younger or less sick. The fourth step, we exclude outliers. Outlier episodes so the episodes where the standardized cost is much, much more than the expected cost or much, much less, and I'll go into how we define that. The fifth step calculates the MSPB amount for each hospital, which you can think of as a risk-adjusted spending amount per episode. The sixth step calculates the MSPB measure,

which is what is reported on the hospital-specific reports, and that is just the MSPB amount divided by the median across all hospitals. And finally we report the MSPB measure for hospitals that qualified to be reported.

So that I've given the overview of broadly what takes place in the MSPB calculation, let's move on to see each of the steps, how they work in detail. So in slide nine, step one we first construct the MSPB episode. An MSPB episode includes all Part A and B claims that occur between the three days prior to an index admission and the 30 days after the hospital's discharge. The claims are included based on the "from" days, which is basically the day which the claim started, or in the case of inpatient claims that occur in the post-discharge period, just based on admission dates.

There are some admissions that are not calculated as index admissions, meaning they cannot start an episode, trigger an episode. Admissions which occur three days prior to within 30 days of the discharge of another index admission, basically those are considered re-admissions so they are grouped together with the first episode. Also, cases where there are acute transfers where hospitals transfer from one hospital to another in the same day, those are also excluded, they are not counted as MSPB episodes. Episodes where the index admission has zero dollar payments—those are excluded as well. And admissions that have discharges fewer than 30 days prior to the end of the performance period cannot be index admissions. The reason for this is that we will now have a complete 30-day window to evaluate the hospital. There is not a full 30-day discharge period in the cases where the index admission would fall closer to the end of the performance period than 30 days.

Moving on to slide 10, there are certain types of beneficiaries that are included and others that are excluded. Beneficiaries have to be enrolled in Parts A and B from the 90 days prior to the episode through the end of the episode. The 90-day requirement is so that we have a complete 90-day history of the patient's health conditions and a number of other variables that are used in our risk adjustment method in step 3, which I will talk about in more detail. Also, the hospitals have to admit to subsection (d) hospitals. These are basically short-term acute hospitals. They exclude cancer hospitals, inpatient

psychiatric facilities, inpatient rehabilitation facilities, so it's basically focused on the short-term acute hospitals. The hospitals such as critical access hospitals and hospitals paid under the Maryland demonstration are not included currently, as well.

Beneficiaries are excluded if they are enrolled in Medicare Advantage at any point during the time period; if Medicare is their secondary provider; if they died during the episode, so this is if they die either during the admission or during the post-discharge period; or if they're covered by the Railroad Retirement Board, these individuals are also excluded from the MSPB.

So once you figure out who is eligible to be included, which hospitals can be included, and which claims should be grouped together into an episode, step two figures—calculates the standardized episode spending for each episode. The standardization adjusts claims for geographic payment differences, hospital-specific rates, payments for disproportionate share hospitals, and indirect medical education payments. And the goal of this is to—so hospitals in one area could be compared to hospitals in another area based on utilization rather than price differentials. Peter Hickman will discuss the specific method used to standardize episode spending later in the presentation, but the general concept again is that we want to focus on the differences in utilization by hospitals during the admission and in the post-discharge period across all providers and normalize for the spending of these different payment policies.

Then step two calculates an overall spending level for the episode, which is the sum of the standardized episodes spending for all Part A and B claims during the time period. The standardized spending amounts are standardized based on Medicare payments, patient deductibles, and co-insurance. So these are basically three sources where the payments can come from, and again these are standardized to counter geographic differences in payment policies.

In step three, on slide 12, we discussed how we calculated the expected episode spending. You can think of this as a risk adjustment module. The point of the risk adjustment modules is to counter variation in patient case mix across hospitals. Case mix can be measured by a number of factors such as age and severity of illness. And to measure risk adjustment, we use a linear

regression model, also known as ordinary least squares or OLS, and this regression estimates our relationship between all the risk adjustment variables and the standardized episode spending in step two.

We create a separate risk adjustment model for each major diagnostic category, so these are grouped the MS-DRG into MDC the major diagnostic categories. This methodology allows for the effect of certain illnesses to vary based on which MDC is located, so certain illnesses may be more predictive of cost for certain MDCs compared to others. And using this methodology, we allow the disease, the health conditions, the age to have differential effects on spending, depending on MDC. The specific risk adjustment variables that are used to predict episode spending include age, the hierarchical condition categories, disability and ESRD enrollment status, long-term care status, interactions between the HCCs and enrollment status variables, and the MS-DRG of the index admission. For those of you who are familiar, the HCCs are upper condition categories. Those use similar algorithms based on the Medicare Advantage Program, but these are calculated specifically for the MSPB episodes based on the diagnoses of the patient in the 90 days prior to the start of the MSPB episode.

One other step that we do after we calculate the predicated values from the regression, is that we reset or winsorize the expected cost for some extremely low-cost episodes. So some episodes will have the regression—may produce a very low estimate of what the cost should be. We do not want hospitals to be compared against these very low benchmarks, so we do adjust or reset these low expected costs.

Slide 13 describes how we do this resetting or winsorizing of the extreme low-cost expected values. In step i for each MS-DRG we identify episodes that fall below the 0.5 percentile of the MS-DRG expected cost distribution. So if your episode—the expected costs below this threshold we—in step ii—we reset it so the expected cost of these episodes is equal to the expected episode cost threshold. In other words, for these very low costs—low-expected costs, we move them up so that hospitals aren't compared against the very, very, very low benchmark. In step 3 we normalize the expected cost and within

each MS-DRG so that the average expected costs in each MS-DRG remain unchanged. The resulting reset values represent each hospital's expected episode spending. So when we refer to expected episode spending, these are the predicated values of the regression that are reset as described here.

The next step described in slide 14, step 4, and that is the exclusion of outliers. Statistical outliers are excluded from the MSPB calculation in order to mitigate the affect of high- and low-cost outliers on each hospital's MSPB score. The way that we define outliers is based on a residual, and the residuals are basically the standardized episode spending minus the expected episode spending. In other words, this is—for each episode—the difference between step 2, the standardized spending, and step 3. We calculate a residual for each individual episode.

The next step is once we calculate this residual we find out which episodes are defined as high-cost outliers and which ones are low-cost outliers. The high-cost outliers are any episodes where the residual falls above the 99th percentile of the residual cost distribution within any MS-DRG admission category. This means that the residual is higher than 99 percent of the episodes within each MS-DRG. Similarly the low-cost outliers, we define those any residual that falls below the first percentile of the residual cost distribution within any MS-DRG admission category. Again, so the goal of this is to make sure that the extreme episodes do not overwhelm the MSPB score.

Step 5, we calculate the MSPB amount for each hospital. You can think of this is a kind of risk-adjusted average spending amount. The MSPB amount as I am describing in slide 15 for each hospital is calculated as the ratio of the average standardized episode spending divided by the average expected episode spending, multiplied by the average episode spending across all hospitals. In other words, for any hospital, we calculate the average standardized spending, which is step 2, for each of their episodes.

We also calculate their average expected spending, which is the predicated values of the regression that I described in step 3, and create a ratio. Now this ratio, in order to get a dollar amount, we multiply that by the average

standardized spending across all hospitals. And so this average spending across all hospitals, that term is the same for every single hospital, whereas the—each hospital's average standardized spending and average hospital expected spending differ across the hospitals.

In step 6 we calculate the MSPB measure. As described in slide 16, the MSPB measure for each hospital is calculated as the ratio of the MSPB amount for the hospital divided by the median MSPB amount across all hospitals. So the MSPB amount again is calculated in step 5. You can think of that as a risk-adjusted spending level. The median MSPB amount is calculated as a weighted median, where we give more weight to scores at the—that have more episodes. This ratio gives us the MSPB measure which measures your risk-adjusted spending compared to the median risk-adjusted spending across all hospitals.

Step 7 described in slide 17 describes which hospitals' MSPB measures are reported. The MSPB measures are only reported for hospitals that are opened as of November 9, 2011, so it's possible for us to have created a score for you, but then you could have since closed. So we only report measures for hospitals that are open. Second, the hospitals have had at least 10 MSPB episodes. The reason for this is, by using the cut-off of 10, this reduces the likelihood that a hospital's MSPB's measure will be skewed by just a few very high- or low-cost episodes. So hopefully, walking you through these steps, you have a good idea of how your MSPB measure is calculated. However to give you an even more—a deeper understanding, in slide 18 we will provide an example of how your MSPB measure is calculated. The example will follow the same seven steps described above; however, it will be the hypothetical episodes to calculate MSPB measure for a sample hospital. Again these numbers are not real numbers—they are made up just to illustrate how one could calculate their own MSPB measure.

Slide 18 provides a list of seven steps again for your memory and you will see how each of these steps is used in our example. In step 1 we construct an MSPB episode. To save time we don't display how each claim is linked to an episode, but you can see in this example there are 12 episodes. These 12

episodes are across six MS-DRGs which we made up numbers of one, two, three, four, five, six for the MS-DRGs. MS-DRG one and two are in MDC one; MS-DRG three and four are MDC two; and MS-DRG five and six are an MDC three. So we have a hospital with 12 episodes during the course of the performance period.

Moving on to step 2, in slide 20 we calculate the standardized episode spending. So standardized episode spending again is the sum of all the claims from three days prior to the index admission to 30 days after the discharge. These claims are adjusted for geographic payment differentials and other payment adjustments so that they are comparable across all hospitals. You can see that the first three columns are the same as in slide 19 and the fourth column lists the standardized episode spending which is the outcome of step 2.

In step 3, so in slide 21, we now look at the expected episode spending. So the first four columns are the same as the previous table but now we add the expected episode spending. These numbers come from our risk-adjustment model so we use the risk adjustment variable described above, such as the HCCs, the age, the MS-DRG of admission, et cetera, and use those the—each patient's characteristics to predict the cost of an episode given their characteristics. You can see in column five this is the expected episode spending before we reset the episode spending. If you look at episode number one we see that the expected episode spending is only \$50. In this example we assume that the \$50 range is below the 0.5 percentile of the expected spending distribution for MS-DRG one. If the 0.5 percentile for MS-DRG one is \$1,000, then we will reset the \$50 expected value to \$1,000. We then will reset all the values to ensure that the average spending is the same within any MS-DRG across all hospitals. In this example we assume that there are many, many episodes of MS-DRG one so the renormalization produces a negligible effect. In other words, the last column of this table where it says expected episode spending reset, this is the expected episode spending that we are using as the final output of step 3.

In step 4 we exclude outliers. You recall that to exclude outliers we need to calculate the residuals for each episode. In slide 22 we show how to calculate these residuals. The first three columns describe the episodes, the fourth column gives the standardized episode spending, and the fifth column gives the expected episode spending after we reset. The residuals in step 4 are simply the fourth column minus the fifth column, or step 2 minus step 3. So here we have the residuals calculated for each episode. Again, the residuals are only used to determine if an episode account is an outlier.

Moving on to step 4, we exclude outliers based on where they fall in the distribution of the residuals within each MS-DRG. So the first four columns, you should be familiar with, they are the episode descriptions and the residuals in step 4. The last two columns give the distribution of residuals within any MS-DRG. So for episode one, the MS-DRG residuals at the 1st percentile are negative \$3,000, meaning that the spending is \$3,000 less than the expected spending and the 99th percentile is positive \$3,000, which means that the spending is \$3,000 more than the expected spending. You can see that \$50 falls within that range so it's not considered an outlier. Similarly, for episode number two, the \$100 falls within the range and it's also not considered outlier.

You can see that episode number ten is highlighted. The reason for this is that episode is an outlier. If you look at the residual for episode ten, it's \$27,500. The residual distribution for MS-DRG number five, at the 1st percentile it's negative \$13,000 and at the 99th percentile it's \$23,000. So while episode number nine with the residual of \$2,000 falls within this range, episode ten has a higher residual in the 99th percentile residual for the MS-DRG. Thus episode ten will be excluded from the hospital's MSPB measure calculation. Now to—on step 5, step 5 calculates the MSPB amount for each hospital. Right now we're on slide 24. The first three columns, again, give you the episodes, the fourth column gives us the step 2 standardized episode spending, and the fifth column gives us step 3, the expected episode spending.

As you recall, that episode ten is no longer counted in the hospital's MSPB score. If we move on to slide 25 we can see how to calculate the MSPB

amount for each hospital. The highlighted portions in the column within step 2 give the episodes that we are using to calculate the average standardized episode spending for this hospital. So basically we just average all the highlighted amounts to get an average standardized episode spending. You can see that we are not averaging the outlier. To get the average expected episode spending, just average all the numbers and use the final column for step 3, and also we don't average the excluded outlier episode, and then we'll get an average expected episode spending. On slide 26 we show how this is calculated. You can see that the average standardized spending is \$9,368.18. Again, this is the average of the eleven eligible episodes.

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 just be the sum of step 2 across all hospitals in the nation, across all episodes. You can see the calculation below, and this is how we calculate the MSPB amount, which again you can think of as a risk-adjusted spending amount. This is the average standardized spending, \$9,368, divided by the average expected spending, which is \$9,963, times the average standardized episode cost nationally, which is \$9,000. For this hospital, their medical spending for beneficiaries amounts is \$8,462.14.

In step 6 we calculate the MSPB measure to determine how well this hospital is performing compared to the median hospital. Slide 27 gives this result. Again, the first column of this table gives the step 5 output, which is \$8,462. This is the MSPB amount calculated previously. In this example we assume that the median MSPB amount is \$9,000. In this case, the median MSPB amount is the same as the average standardized episode cost nationally, but that does not need to be the case. Then we calculate the MSPB amount measure in step 6, which is just the ratio of the MSPB amount divided by the median MSPB amount, and when we do that we get an answer of the MSPB measure for this hospital is 0.94. In other words, you can think of this as saying the hospital spending per beneficiary is, on average, 6 percent lower than the median hospital.

Finally, in step 7 we report the MSPB measure for eligible hospitals. In this example, let's assume that the hospital is open currently so it has a chance to be reported. Also, it has 11 eligible episodes. These are the 12 episodes minus the one episode that is excluded because it's an outlier. Thus this hospital will have its MSPB measure reported. If it only had nine episodes we would not report the MSPB measure.

So those go through the seven steps of how we calculate the MSPB measure, and we've given you an example of how it's done with the simplified version of a hospital. Hopefully this has been informative; however, we have left out one key important step. How do we standardize payments for standardized episode spending? For that I'll turn over to Peter Hickman, and he will give you more detail about our payment standardization process for Medicare claims data.

Peter Hickman: Thank you, Jason. By way of background, my group within CMS has been using payment standardization for analytic purposes to explore variation in Medicare spending at the hospital referral level. Our standardized payments are being used currently by the Institute of Medicine as part of their study of geographic variation. Payment standardization has been used by researchers like Dartmouth and congressional agencies like MedPAC, and hospital-specific preview report sent out in February are based on standardized dollars. So today I'm going to be talking about kind of why standardization is necessary, what it means with regard to Medicare payments, and then to provide some simple examples so you get a sense of how standardization actually works. And, of course, at the end we're available for questions.

I'm now on slide 30. If what we were trying to do was to examine utilization of services, of particular service across geographic areas, then there would be no need to standardize since we could compare something like, you know, inpatient stays per thousand beneficiaries or E&M services per thousand beneficiaries. Things become more complicated when you want to take a number of different services and have some type of single measure of service use. Within the Medicare Program, once you try to go across services you get into some problems. For example, in the post-acute care world, there are

various utilization measures which wouldn't necessarily be comparable, and we pay snips on a per diem basis and home health episode basis, or long-term care hospitals on a stay basis, outpatient therapy on a visit basis, so the question is how do you make those things comparable when you're just looking at kind of utilization of services?

You also have an issue of services can be provided by different practitioners within the Medicare Program, or particular services can be provided by physician or physician assistant or nurse practitioner. Services can also be provided in different settings in a physician's office or in an institution and/or in as part of a single procedure or multiple procedures being provided at the same time.

Now on slide 30—31, I'm sorry. To address the limitations and utilization measures and to better capture service use and health care spending—is often used—however, once you start using health care spending to capture service use, you have a whole new set of questions that you have to deal with. First of all, how do you deal with differences in wages or practice expenses across geographic areas? Within the Medicare Program some of our payments aren't really directly related to patient care but serve a broader social purpose—for example, our payments for indirect medical education to hospitals or our payments for disproportionate share payments to the hospitals. In the physician world, we make additional payments for physicians who are operating in health professional shortage areas. So the question is what, what do you do with those types of things? We also have a question of how do you adjust when you have the services provided in different settings? Going back to my post-acute care example, you have services that are being provided on a day basis, episode basis, stay or visit dollars has the advantage of providing a single measure for service use across these potentially similar services.

Medicare payment can vary for the same service based on who provides it. So again, a physician or practitioner can provide a service or physician can, so when you're using dollars as a measure of service use, you face the question of whether you retain those types of differences. Similarly, Medicare pays differently based on when a procedure is performed alone or is provided in the

context of a number of procedures. So again, you face the question of whether you retain those, those differences or not, and finally when you're dealing with dollars you have the question of how do you deal with an underlying health status or the differences in case mix among, among beneficiaries?

Now on slide 32: So payment standardization is the process of adjusting Medicare-allowed charges in order to be able to make comparisons of service use within or across geographic areas. It is separate from the question of risk adjustment, which deals with differences and allowed charges due to variation in beneficiary health status or differences in case mix.

Now in slide 33, how does the standardization effect—what does it do to payments in the hospitals? First of all, it excludes adjustments that are made in actual payment to reflect differences in regional labor cost, as measured by the hospital wage index. It also excludes payments that support larger Medicare Program goals such as the indirect medical education payments, disproportionate share payments, and graduate medical education payments. The additional payments that we might make to a sole community hospital or Medicare-dependent hospital. It also adjusts outlier payments to the extent that they, that they exist.

In a physician world, standardization excludes, again, the differences in payment that result from differences in regional labor or other costs as measured in this case by the geographic practice cost indices. It also excludes payments that support Medicare Program goals, the larger program goals such as the add-on to physicians in health professional shortage areas, the differential that exists in the payments whether physician is participating or not.

On slide 35: Now within the physician world it does maintain differences in payments resulting from the choice of setting and in which a service is provided so the, the differences that exist in actual payment between when the service is provided at physician's office and versus when it's provided in a hospital outpatient department are retained. Similarly, differences resulting from who provides the actual service, the physician or physician's assistant, those differences are retained. Also the impact on payment that results from

when the procedure is provided singly or is provided with other procedures at the same time, those types of adjustments are also retained.

Turning to slide 36, with regard to other payment systems standardization would eliminate the adjustments due to various wage indices or in certain cases cost-of-living adjustments. It removes the rural add-ons that are paid on actual payments to inpatient rehab facilities and inpatient psych facilities. In cases such as DME or lab or there are regional or state fee schedules, they are substitute to national amount for those, for those regional amount, and again for the systems that have outlier payments, it adjusts the outlier payments to reflect differences, differences in wages.

So now you look at the hospital formula on page 37. Again, this is a simplified formula for our payment for a PTS hospital or Medicare-allowed amount is a function of base rate, the hospital's wage index, the wage for the particular MS-DRG, and then certain add-on payments, if applicable, such as IME and DSH payments, and potentially there might be an outlier payment based on the particular situation of that case. In a standardized world, you see that we are removing the impact of the wage index from the formula, and we also do not include the IME or DSH payments to the extent that there is an outlier payment that we would be adjusting that for differences in wages using the wage index.

Turning to slide 38 we've a simple numeric example. This is MS-DRG 194 for simple pneumonia. As you see we have three hospitals in three geographic areas—hospital A in Philadelphia, hospital B in Austin, Texas, hospital C in Chicago—and you go all the way over to the right column, you see that the total payment varies from \$5,732 in Austin for hospital B, to \$9,199 for hospital A in Philadelphia. And you can see that part of the reason for the difference in payment is that hospital A is the teaching hospital and, as part of its payment, received \$2,400 indirect medical education payments. And you also see that it has a higher share with regard to disproportionate shares; it receives the higher payment there.

Otherwise, differences in the operating and capital payment are a function of the wage index of the particular hospital. For the standardized payment,

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again we remove the impact of the wage adjustment. We do not have, we don't include IME or DSH, so the standardized payment for all of these hospitals for this DRG-194 would be \$5,669, again assuming there is no outlier payment here. And you see that \$5,669 falls between the payments for the hospitals that are above. So that's the simplified hospital example.

If we go to slide 39 we see a simplified formula for physician payment, and here Medicare's allowed amount is a function of the conversion factor, the particular RVUs for the service provided, the GPCI and then payment modifiers enter in, for example, with a services provided with others, procedures provided with other services, and there is an impact of the services provided by a physician assistant rather than a physician there would be another impact on the payment. In a standardized world what we do basically is just to remove the impact of the GPCI, and we attempt to mimic all of the effects of the payment modifiers in the, in the actual payment.

And if we go to slide 40, we have a simplified example of payment for CPT 99214, an office visit for an established patient, and in this case we have our same three cities: Philadelphia, Austin, and Chicago. The service, this particular service is provided in an office, physician's office in Philadelphia and Austin, so you see the actual payment ranges from \$101.55 to \$109.16. In Chicago the service is provided in the facility, so there is a payment for the practice expense is adjusted and the payment there would be \$81.94. In a standardized world, there would be one payment for the service being provided in the office and that would be \$102.27. You see that's between the Austin payment and Philadelphia payment and the standardized payment for the service provided in the facility, \$75.77, which is below the payment that you see provides the actual payment for Chicago because Chicago's GPCI is above 1.0.

The second example is on slide 41. This is a CPT 17000, destruction of a pre-malignant lesion. Again, we have the same three cities and in this case, in

Philadelphia and Austin, this particular procedure is performed by itself, so you see the range in payment is \$78.85 to \$86.11. In Chicago this procedure is provided with at least another procedure that's more expensive, so it's discounted and the payment is \$43.13. In the standardized world the payment for the procedure performed by itself is \$79.50, which as you see is between the payment for Austin and Philadelphia based on those the impact of taking the GPCI out, and the payment if this procedure was performed with others where this would not be the most expensive would be \$39.75. Again it's below what is shown for Chicago, because the Chicago GPCI is above 1.0. So those are my examples then. I guess I'm turning it back over to Kim at this point, and I'll be happy to answer any questions you might have later on.

Kim Spalding: Thank you, Peter. So we are moving on to slide number 42, where we provided some resources related to the Medicare Spending Per Beneficiary Measure. So in addition to the hospital-specific report and the hospital-specific file which hospitals have received on February 1, we made a number of resources related to the measure publicly available on QualityNet, and you will find them at that length on your slide and additional questions regarding the medical spending for beneficiary—Medicare Spending Per Beneficiary Measure, and the hospital preview data can be sent to the e-mail address on the slide, which will go to Acumen, and we will answer those questions for you. Thank you and I'll turn the program back to Geanelle.

## **Question and Answer Session**

Geanelle Herring: Thank you, Ms. Spalding. Thank you, Ms. Spalding Bush. At this time we'll pause for a just few minutes to complete keypad polling so that CMS can obtain an accurate count of the number of participants on the line with us today. Please note there will be a moment of silence while we tabulate the results. Holley, we're ready to start polling.

Holley: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line. Today we would like to obtain an estimate of the number of participants and attendants to better document how many members of the

provider community are receiving this valuable information. At this time, please use your telephone keypad and enter the number of participants that are currently listening in.

If you are the only person in the room enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine. Please hold while we complete the polling.

Once again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If they are nine or more of you in the room, enter nine. Again, please continue to hold while I complete the polling.

Geanelle Herring: We will begin the question and answer portion of the call very shortly. First, I would like to remind everyone that this call is being recorded and transcribed, so please state your name and the organization which you represent prior to asking a question. In an effort to get as many questions asked and answered as possible, we ask that you just ask one question. Holley, when you're ready, we are ready to take our first question.

Holley: Thank you, please continue to hold while we poll the participants. Thank you for your participation. We will now move into the Q&A session for this call. To ask a question, press star followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question, and pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you're asking your question so anything you say or any background noise will be heard in the conference. And your first question comes from the line of Mike Wisely.

Mike Wisely: This is Mike Wisely with Jefferson Regional Medical Center in Arkansas. We had a question on the preview report. There is a table five that does the spending right down by claim type, and we're wanting clarification on what the claim type carrier represents. I don't know if that, is that pro fees? We're not sure what category that represents.

Jason Shafrin: So the carrier claim type is basically the, the Part B not DME the physician file.

Mike Wisely: Thank you.

Jason Shafrin: Sure.

Holley: And your next question comes from the line of Joyce Francis.

Victor: Hi, this is Victor from Lincoln Hospital. I am looking at Lincoln's piece, and it looks like we have very low, much below. I am thinking we will not be affected at all by this?

Kim Spalding Bush: Does that mean that your measure ratio, that you...?

Victor: ...86, so we recognize the very cheap and very efficient so we wouldn't be affected by this at all, right?

Kim Spalding Bush: Well, right now the measure's just being publicly reported on the Hospital Compare Web site.

Victor: Yes, eventually, yes.

Kim Spalding Bush: The ratio that we will be...

Victor: When we get through the punitive phase of this whole thing, I would assume that hospitals below 100 will not be affected.

Kim Spalding Bush: We'll have to propose the measure for inclusion in the Hospital Value-Based Purchasing Program through future notice and comment rulemaking, and so this measure, if that were included in that program, would be a piece of the total performance score. So you would have performed well on this measure, and that would be incorporated into your total performance score that then will be reflected in the Hospital Value-Based Purchasing Payment adjustment.

Victor: OK. Thanks.

Kim Spalding Bush: OK. Thank you for the question.

Holley: And your next question comes from line of Shauna Thompson.

Shauna Thompson: Yes, this is Shauna Thompson of Saint Luke's Health System in Kansas City. Can you tell me if payments to the community-based organizations will be included in the MSPB calculations?

Kim Spalding Bush: Those payments will be included in the measure calculation for including all Medicare Part A and Part B claims.

Kim Spalding Bush: Thank you. Next question.

Holley: Your next question comes from the line of Edwin Tong.

Edwin Tong: Hello, my name is Edwin Tong from Mills Peninsula Health Services. If we go back to slide 38, could you clarify what falls under operating and what falls under capital? Thank you.

Peter Hickman: I believe reflecting what's in the base rate is separated into an operating rate and a capital rate.

Edwin Tong: Correct, yes.

Peter Hickman: Well that's all that's—what it's showing.

Edwin Tong: Oh, OK. OK. OK.

Peter Hickman: So if the operating rate is on top, multiply by the DRG weight, multiplied by the wage index, and similarly on the capital and down below, that same rate is only multiplied by the weight for the MS-DRG.

Edwin Tong: OK.

Holley: And the next question comes from the line of Edward Coyle.

Edward Coyle: Yes, I just wanted to ask you about slide 6, talking about the preview period to check the hospital compare data I guess for the information. Is that something that you would need a login to check for multiple hospitals, or can you look at multiple hospitals across the area?

Kim Spalding Bush: Hospitals would only have access to their own hospital's specific preview report, and I believe that they were distributed based on who the QualityNet user is that's designated for the hospital that reviews the report.

Edward Coyle: OK, let me ask a different question, because I'm at the corporate office, where we have 18 different acute-care hospitals. I'm not that hospital quality person. I just want to be able to view my 18 hospitals, but I guess I would have to go through each individual hospital to get that information.

Kim Spalding Bush: Yes, you would have to coordinate that with your hospitals.

Edward Coyle: So there is no way I can do that on my own without having to go through each person? OK. Thanks.

Kim Spalding Bush: OK, thank you.

Holley: The next question comes from the line of Deborah Newton. And it looks like Deborah's question has been withdrawn. Your next question comes from the line of Grace Bi.

Gloria Kupferman: Hi, this is Gloria Kupferman from HANYS, Health Care Association of New York State. I want to clarify my understanding of this. So Medicare Spending Per Beneficiary is really Medicare spending for beneficiaries that have shown up in an inpatient setting, not all beneficiaries. So if a beneficiary stayed out of the hospital, that's not figured into this Medicare Spending Per Beneficiary? And then I guess my corollary to that is just that the episodes are being built with no consideration given to patient care that was provided 30 days post-discharge that was not related at all to the original indexed admission. Am I correct on both points?

Kim Spalding Bush: Yes, you are correct on both points.

Gloria Kupferman: So then my follow-up question real quick is: Here at HANYS we really try to work with our hospitals to keep them ahead of their data needs. Up until now we have not been able to get the 100 percent version of all of the standard analytic files needed to check and calculate these measures for our hospitals. Will the 100 percent file, including the 100 percent carrier file, be made available to the industry so that we can track and check?

Jason Shafrin: So right now the, you have in addition to the hospital-specific reports there are three data files which is not 100 percent. However, it has a detailed list of all your indexed admissions, all the episodes and the characteristics of your beneficiaries that are used in risk adjustment. So although it's not 100 percent, it is fairly detailed data that you can use to see how these were calculated. Again, it has the—because one file that get's every index admission stay, one file that gives you every episode (like of what the costs are associated with each episode)—and then the patient-level file, which has just for each beneficiary what is their, what were the characteristics that went into risk adjustment.

So again, it's currently not 100 percent, however I encourage you to take a look at those files to see, because they are fairly detailed too, to see if those meet your needs.

Gloria Kupferman: But we cannot re-create the methodology. We cannot re-create the regressions, and we cannot serve our membership as a hospital association to look at all the data that CMS is using.

Jason Shafrin: That's correct. You will not be able to re-create the risk-adjustment coefficients.

Gloria Kupferman: And we will not be able to do—as a hospital association, we're not able to do the calculation at all. We've got this request in to CMS quite some time that the industry needs to have—for transparency, the industry needs—the true transparency would be being able to re-create CMS's methodology.

Jason Shafrin: I think that there was a trade-off between the—well, I'd like to thank you for your comment. We appreciate that.

Holley: And your next question comes from the line of Aoevanda Goodman.

Aoevanda Goodman: Yes, our organization would like to know if provider-based rural health clinics all be affected by this?

Don Thompson: So the hospital that the clinic is provider-based to, again as Kim mentioned, we get a report, but that's all this is at the moment. It is just the report and, as Kim mentioned, we would be proposing to roll this into the Hospital Value-Based Purchasing Program, which would affect payments to the hospital.

Aoevanda Goodman: Thank you.

Holley: And your next question comes from the line of Addie O'Brien.

Larry: This is Larry, the quality officer of Northeast Healthcare, the Medicare QAO from Maine, New Hampshire, and Vermont. Um, my question is actually a very high-purpose level. We're making the assumption that the reason for calculating a Medicare Spending Per Beneficiary around a hospitalization measure is to drive efficiency. Assuming that's correct, we didn't see a purpose or a method for why step 3 was initiated, essentially adjusting very low costs submitted for payment, and then even after adjustment, then outliers are cut off again on the low side.

So essentially the low side is double adjusted. What's the reason for not winsorising? Extremely high cost values do it for both. It seems like you're regressing to the mean, and we would suggest that actually your results support that, because the national distribution, the segregation is so small that almost nobody falls out away from the mean. But we're just missing the sort of the purpose. It seems like if the purpose is to be efficient, the analysis drives to such standardization that leads to almost no distribution that's meaningful, and you're biasing against the low costs. Unless there is some rationale here that wasn't articulated.

Don Thompson: So I guess—Jason, you want to take it?

Jason Shafrin: Well, yes, I think that by increasing the expected cost on the bottom end that actually, that means that the, if you were very, very low cost, value would be seen as even more low cost because you're being compared against the higher benchmark. And so the point was, just in case, that the regression output, things that were so small that was not even feasible for hospitals and to reach that we would adjust. And then the comments of the extreme outliers when the axes are discarded, again that, the reason that that was chosen was because just to not have the extreme high-cost and low-cost affect the hospital's score overall. Obviously there are trade-offs of that, but that is the reason we use that approach.

Holley: And your next question comes from the line of Terri Savino.

Terri Savino: Yes, Terri Savino, Middlesex Hospital Connecticut. My question is regarding table five in the hospital report. I'm curious, during index admission what the skilled nursing facility spending per episode would stand for?

Jason Shafrin: I think we, in the table we just had a comprehensive list of all the claims that appear. So that gives any spending that occurs for that beneficiary during each period—the before, the during, and the after.

Terri Savino: But during, like on our report, during the index admission we have dollars under skilled nursing facility spending per episode during that index admission. So they are in an acute care hospital. So I'm not understanding why that would be there.

Jason Shafrin: That would indicate that there would be some spending in that skilled nursing facility during your hospitalization. Obviously I'd have to look at the specifics.

Don Thompson: It sounds like something, if you could e-mail, there was the mailbox that Kim mentioned.

Terri Savino: Yes, I have that.

Don Thompson: It would probably be worthwhile. You could e-mail specific to that situation and then we can take a look at it.

Terri Savino: Thank you very much.

Holley: And your next question comes from the line of Karen Heller.

Karen Heller: Hi, this is Karen Heller from the Greater New York Hospital Association. I have many, many questions. So I'm going to sneak in two because one is just yes, no. When you mention the deductibles in co-insurance, I assume what you mean is that you're not subtracting on paid bad debt. That's a yes or no. In other words, you're assuming that all of it was paid. So it's yes, no?

Jason Shafrin: Well, I think what we're doing is the co-insurance and the deductibles, whether it was paid or not, that shouldn't be in there, because we're just trying to measure the kind of utilization. So it should be....

Karen Heller: All right, that's what I thought. And then just my other question is: when you were calculating the, I forget what you call it, the risk ratio in the 94 percent, and you're saying, why are you using the mean to do the first risk ratio, but then you're using the median, and both of them you assumed at \$9,000 in your slides? I'm not aware that in any other of CMS's other risk-adjusted models they are using the median. Since it's weighted, what does that mean?

Jason Shafrin: So the average spending across all hospitals does not provide any real information, because also it's in the numerator and the denominator. So that's not getting cancelled out. The question is just whether you would want to compare your performance to the average hospital or the typical hospital, and in this case the comparison is against the typical hospital.

Karen Heller: Well, maybe you can publish the difference then between the mean and the median somewhere, just to get a sense, because generally you use the same denominator.

Jason Shafrin: OK.

Kim Spalding Bush: OK, thank you for that suggestion.

Holley: And your next question comes from the line of Bob Halinski.

Bob Halinski: Yes, hi. It's Bob Halinski from Universal Health Services. So slide 14, step 4, the outlier calculation, and you mentioned a little bit early that you wanted to exclude extreme outliers. I just wanted to know sort of the rationale as why taking the first percentile and 99 percentile is determining outliers as opposed to maybe some standard deviation off the mean or something like that, and so what was the rationale behind that? Because it just seems under this one you really probably limit the number of claims that are for outliers, and maybe that's the intent—to get as many claims in there as possible. So I just want to hear a little bit more about how we came up with the 99th and 1st percentile? Thank you.

Jason Shafrin: So I think there are kind of two things. One is why 99 and 1, and there is a trade-off between—the lower you get, the more narrow, to get 98 and 2 you are throwing out more episodes, but then you can be getting rid of more of the distribution. So there is that balance. And the reason that we use percentiles compared to basically the standard deviation is that typically the episode spendings are not normally distributed. They are right skewed, so that there is a big tail of very expensive episodes. So using the standard deviation would not give you kind of a balanced number of outliers on both sides. So by doing the 99th and 1st we can account for the shape of the spending distribution and also get rid of the same amount of high- and low-cost outliers on both sides.

Bob Halinski: Thank you.

Holley: And your next question comes from the line of Rafael Campo.

Rafael Campo: Thank you. Rafael Campo from the University of Miami Health Systems, and my question is very similar to one that was formulated a couple of questions ago, and it has to do with slide 16, page 16 where the MSPB measure is the ratio of a mean to a median. It seems to me that the distribution curve for the MSPB is not normally distributed, the mean for any one hospital will immediately fall either to the right or to the left of the national median, so that from the start there will be a skewing of the measure. Any comments about that beyond what you already stated a few moments ago?

Jason Shafrin: Well, I think basically what I was trying to say is just we're trying to figure out what the average spending is, the risk-adjusted spending for that hospital, and then just what the comparison is for that, and we decided that the comparison in the rule was that it was the typical hospital rather than the average hospital. So that's pretty much the same reasoning as before.

Rafael Campo: Yes, and as before, I think it would be important for all of us to see how the measure performs. Whether you are comparing mean to mean or mean to median, it would be important for us to be able to see that during the comment period, so that we could perhaps formulate a more constructive response to what you are proposing.

Jason Shafrin: Thanks for your comment.

Holley: Your next question comes from the line of William Sullivan.

William Sullivan: I have a question regarding, assuming the observation stays are excluded in index submissions—is that true?

Jason Shafrin: Excuse me, which stays?

William Sullivan: Observation stays. They are excluded as indexed admissions?

Don Thompson: Only IPPS admissions are trigger admissions.

William Sullivan: All right. So is there certainly a possibility that if you have a percent of observation stays greater or less than the average, this could skew your average costs compared to the national average?

Don Thompson: If one hospital had more use of observations stays than others, then that hospital would be advantaged or disadvantaged.

William Sullivan: I mean that it could skew what the average costs were or their cost ratio?

Don Thompson: I guess I'm not understanding your question. You're saying that there are observation stays that shouldn't have been observation stays or inpatient stays

that shouldn't have been inpatient stays? I guess I'm not following the question.

William Sullivan: If the percentage of the overall stays were either greater than or less than average in terms of the percent that were observation versus inpatient.

Don Thompson: Right, but if those observation stays were appropriate, and the inpatient stays were appropriate, the measure is constructive of the inpatient stays.

William Sullivan: Right, so you're making that assumption that everyone is typical across the country in terms of that standard?

Don Thompson: I guess the assumption wouldn't be their capability; the assumption would be that the observation stays are appropriate, but this measure is constructed around inpatient stays.

William Sullivan: OK, I think that answers my question.

Holley: Your next question comes from the line of David Menashy.

David Menashy: Yes, my question is the following: I just wanted to confirm where do we need to go to get our hospital-specific information?

Kim Spalding Bush: It should have gone to whoever is the—you should have notified whoever is your registered My QualityNet user.

David Menashy: OK, so it's going to—OK, so it wasn't an e-mail that would have gone to our CFO, anything like that, right?

Kim Spalding Bush: If that was who it was registered to receive QualityNet e-mails, but if not I think you would have to coordinate internally.

David Menashy: OK.

Kim Spalding Bush: With that person.

David Menashy: They would be the only ones who would have received this, right? It wasn't the facility?

Kim Spalding Bush: As far as I know, yes.

David Menashy: OK, OK, thank you.

Kim Spalding Bush: Thank you.

Holley: Your next question comes from the line of Lisa Corley.

Dr. Becker: Hi, Dr. Becker in Medical Center Health System in Odessa, Texas. Just clarifying—so the carrier in that report under Part B is the physician charges or the PA or whatever in the office or inpatient or post-discharge, correct?

Jason Shafrin: Correct.

Dr. Becker: OK, and the next table, table six, talks about if my hospital's average expected spending per episode—i.e., column B is larger than the national average expected spending per episode, column F—and that is based on age and observable that my patients have a higher expected spending level. I understand that. So do I have a target or a goal somewhere down the road that I need to be looking at, make some useful dent into this data, one range or the other?

Jason Shafrin: You are talking about comparing your expected spending against the nation? Is that what you're...?

Dr. Becker: Right, right. Column B and Column F.

Jason Shafrin: That's just for informational purposes, that—you know, do I have a more sick case mix compared to other people? Because we're trying to get the expected spending, but it's sometimes hard to understand what does that mean, so just so—you know, how, what is the expected spending that your inpatients have compared to other people? So it's just for informational purposes.

There is no, like, goal that you should hit. If you have a lot of sick patients, that's the way it is. If you have a lot of healthy patients, that's the way it is. Obviously, both can never be healthy, but this is more just what is your case

mix of the people that you are treating compared to everything else? And, again, it's calculated, the case mix is calculated based on the 90 days before they were admitted, but it's seen before the three-day pre-period. So this is kind of the health before you even see them show up.

Dr. Becker: Right, I understand that. So at this point, use it for information, if there is anything I can glean from it, do it, but otherwise—thank you very much.

Holley: And your next question comes from the line of Mary-Michael Brown.

Kendall Smith: Hi, this is Kendall Smith at Washington Hospital Center. Quick comment or question. In reviewing this, if this is geared towards value and quality, what was the rationale for excluding patients who expired from the calculation? It would seem that hospitals that had inherently sicker populations and spent more and had higher death rates might come up with a different calculation by including these patients.

Don Thompson: As an initial matter for the kind of the first year of this measure we were examining episodes where we had kind of a complete claims history for the entire length of the episode. So again, as an initial implementation matter we did not include the deceased patients because they would not have kind of the complete episode. However, that is an issue that we may visit in future rulemaking with respect to whether to include or exclude deceased beneficiaries, and if we did that, again, that would be open for notice and comments. So people would be able to comment one way or another.

Kendall Smith: And you also excluded from the calculation patients that were transferred from the acute setting. Is there a calculation, or how are patients handled with split DRGs, where they spend multiple days in one facility and then are transferred not on the same day but days later to an outlying or to a central facility, to a tertiary care center? How is that dealt with in the calculation?

Don Thompson: Is it a transfer case?

Kendall Smith: Yes. Patient comes in the hospital A, spends four days, and then subsequently is transferred to a tertiary care center for ongoing care and discharge. So there is a split DRG between the two hospitals.

Don Thompson: If the transfer cases are excluded?

Kendall Smith: OK as I understood it, they had same-day transfers, but any transfer cases excluded?

Don Thompson: No.

Kendall Smith: All right.

Kim Spalding Bush: That's correct. A transfer from acute to acute, it would not be on the same day they are admitted.

Kendall Smith: OK.

Kim Spalding Bush: If they are transferred during that day, it won't be counted as an index admission for the purposes of creating an episode of this measure.

Kendall Smith: OK, so I think it's pivotal if this is going to be a discussion of quality that we go back and re-examine the issue of mortality and outcomes, because to say that without true outcomes data, the number of patients leaving the hospital alive really is ultimately useless and a disservice to the people who are going to be looking at it.

Kim Spalding Bush: OK, well, thank you for that comment, and it is something that we would consider in future rulemaking.

Holley: And your next question comes from the line of Beth Kern-Skrapits.

Beth Kern-Skrapits: Yes, thank you very much. Actually one of my questions was just answered with regard to transfers. My other would be associated with AMA discharges that are admitted to our or another facility afterwards. Are they also excluded?

Jason Shafrin: Currently I think they are not being excluded.

Beth Kern-Skrapits: Oh therefore, well, even though we would have no control over the care that they would receive afterwards at another facility or another. OK, then that excluded, you answered my question. Thank you.

Holley: And your next question comes from the line of Nisrine Khazaal.

Nisrine Khazaal: Thank you. You have answered all questions.

Holley: And your next question comes from the line of Deb Bartel.

Stan Pedant: Thank you. This is Stan Pedant at St. Mary's Hospital in Enid, Oklahoma. My question really centers around the, in the development of this, with the understanding that this will be used to be incorporated into our value-based purchasing score in the future, there are a number of elements that are involved for which we will have no control over, yet we could be penalized or incentivized either way, relative to what their score turns out to be. Why would we include data other than the hospital's?

Don Thompson: When we first proposed the measure, and we went through rulemaking we emphasized that we believe this measure would help incentivize care coordination between the different players not just during the hospital stay, but also post-discharge. There was also discussion of what the length, the time period should be post-discharge, going to a certain extent to that issue. We, in the final rule, after going through the public comments, settled on a 30-day post-discharge, again with the idea being that we want to incentivize all the players during the episode—the hospital, and all the post-acute care and the positions during the stay. We want to incentivize coordination between those parties to deliver high-quality, efficient care.

Stan Pedant: Well, that's fine. But don't you think you ought to incentivize them the same way, so that we have the same goals in mind?

Don Thompson: There are a number of quality initiatives the agency is pursuing across the different sectors, of which the Hospital Value-Based Purchasing Program is just one, and this is one measure is part of that program.

Stan Pedant: OK. Thank you.

Holley: And your final question comes from the line of Aoevanda Goodman.

Aoevanda Goodman: Yes, this is Aoevanda Goodman calling from Alliance Healthcare in Holly Springs, Mississippi. Could you turn to slide 34 and elaborate a little further on the excluded payments that support larger Medicare program goals?

Peter Hickman: Sure. This is Peter Hickman again. What we're talking about here, you are talking about slide 34?

Aoevanda Goodman: Yes, sir.

Peter Hickman: OK, this is more with regard to physician services.

Aoevanda Goodman: To physicians in health professional shortage areas.

Peter Hickman: Yes, we make additional payment to physicians or other practitioners providing services in health shortage areas, and since those payments are meant to be kind of an incentive for them to provide service in those areas, we don't think that it's appropriate to include that additional amount in calculating standardized payments. Similarly, the par and unpar differential on the payments we do not include.

Aoevanda Goodman: OK.

Peter Hickman: That helpful?

Aoevanda Goodman: OK. Thank you, sir.

Peter Hickman: You're welcome.

Geanelle Herring: Thank you. We would like to thank everyone for joining us today, particularly our subject matter experts for their participation in the question and answer portion of the call. The audio file and transcript will be available at the Web site in which you downloaded the presentation. If you were unable to ask a question on the MSPB's measure of the CMS subject matter experts

gathered here today, please feel free to contact the e-mail address referenced during the presentation.

To ensure that the National Provider Call Program continues to be responsive to your needs, we are providing an opportunity for you to evaluate your experience with us today. Evaluations are anonymous and strictly voluntary. To complete the evaluation, visit <http://npc.blhtech.com/> and select the title for today's call from the menu. All registrants will receive a reminder e-mail within two business days of today's call. Please disregard this e-mail if you have already completed the evaluation. We really appreciate your feedback and thanks for participating.

Holley: Thank you for participating in today's call. You may now disconnect. Thank you.

**END**