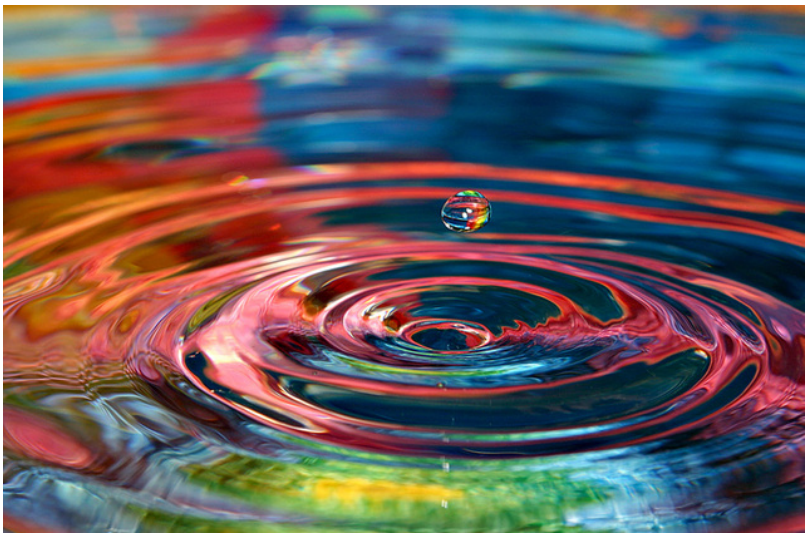
Mastering MSPB: How "Episode" Care Calculations Make or Break Your Revenues

written by Dave Halpert | September 2, 2015



The whole may be greater than the sum of its parts—but how those parts each contribute to the whole is key to a new Medicare calculation of episode costs. If you aren't paying attention to the total cost of an entire "episode" of care for your patients—including that rendered by others—your future revenues may take a hit.

Enter Medicare Spending Per Beneficiary (MSPB), a component of CMS's Value-Based Payment Modifier (VBPM) calculations that is crucial to your bottom line.

MSPB is a measure of charges per episode of care that looks at costs immediately prior to, during and following a hospital stay. (Not to be confused with the measure of per capita costs calculated for all Medicare beneficiaries, which is an entirely different calculation under the VBPM.)

If you don't master MSPB and fail to incorporate episode costs into your tactics for performance measurement and improvement, you are risking more than VBPM penalties. Recent federal Medicare legislation introduced Alternative Payment Models (APMs) that are designed to reimburse providers using non-FFS methods. MSPB aligns with the law's APM requirements, as well as the Bundled Payments for Care Improvement initiative (BPCI) that is already in place.

Why does this matter? According to Medicare's timeline, in 2019, 25 percent of revenue must come through APMs. Over the next eight years, that benchmark will rise to 75 percent. In fact, some APMs are already here. It's critical that you understand MSPB and how it varies from the rest of the VBPM—not only will it affect your revenues in the short-term, but it may play a substantial role in your reimbursements down the road. In fact, some are predicting that Medicare will make a quick switch to permanently install bundled payments for defined care

episodes in the next few years.

The MSPB Measure Numerator

First, a primer on how MSPB figures into your group's VBPM cost composite. For this calculation, Medicare uses these three components:

> MSPB Measure;
> Per Capita Costs For All Beneficiaries;
> Per Capita Costs for Beneficiaries with Specific [Chronic] Conditions (a composite of Diabetes, Coronary Artery Disease, Heart Failure and COPD).

For each component, Medicare will risk-adjust your patients, using their Hierarchical Condition Categories (HCC) model. This estimates how much effort it will take to keep that patient healthy, compared to the rest of the population.

The MSPB measure scores groups according to allowed charges billed before, during and after a hospitalization. An "episode" includes the three days prior to admission through 30 days post-hospital discharge.

Specifically, to calculate your group's MSPB, Medicare follows these five steps:

> Calculation of Medicare payments according to a standardized national fee schedule;
> Estimation of Expected Costs, based on risk factors including age, risk scores, co-morbidities, etc.
> Determination of Risk-Adjusted, TIN-Level MSPB Amounts
> Adjustment for Specialties within the TIN
> Calculation of Final, Specialty Adjusted MSPB

Once calculated, the MSPB will be rolled up with the cost components of the VBPM to create a final Cost Composite.

The MSPB Measure Denominator

MSPB has a unique attribution methodology among all VBPM components, for both cost and quality. This ties to how a patient's "plurality of service" is defined.

Under MSPB, patients are placed in a group's MSPB denominator *according to which group provided the plurality of claims as measured in total allowed charges surrounding a patient's Inpatient Prospective Payment System (IPPS) hospital admission, sometimes referred to as the*

"index admission." In plain English, the calculation is biased toward attributing patients to hospital-based physicians and proceduralists.

In short, you may have patients in your MSPB denominator that are not included elsewhere in your VBPM composite. Seeing a patient in the hospital does not *automatically* make that patient MSPB-eligible. To be included in the measure, in addition to your group having provided the most care (as measured in charges), there are enrollment requirements for the patient.

To wit, the patient must be:

> Enrolled in both Medicare Parts A and B for at least 93 days prior to IPPS hospital admission;
> Enrolled in Medicare Parts A and B for at least 30 days following discharge from a short-term acute care hospital stay (where the stay occurs during the performance period).

Patients will be excluded from the denominator if enrollment requirements are not met, or if the admission is, in fact, a readmission. Readmissions do not count as index admissions, but the costs associated with the readmission may be tied back to the previous index admission, if occurring within the episode's performance period.

How to Succeed Under Episode-Based Care

Remember, every provider will be affected by Medicare's Value-Based Payment Modifier calculations beginning in 2016, even those who are participating in Alternative Payment Models such as a Comprehensive Primary Care Initiative (CPCI) or an ACO. This is new. *If you are in an ACO, your revenues will be affected by the costs calculated for episodes across all providers, so there is even more need to pay attention to what everyone else is doing, too.*

To succeed under any Alternative Payment Method, but especially episode-based care, you need a lot more tools than your EMR technology. Here are some basic requirements you will need to support:

> Aggregation of patient data into episodes that are time-based and embed an attribution model. If your provider systems are disparate, it's essential to plan how you are going to integrate and match patients across multiple platforms.
> Performance measurement in episodes and bundles. You will need special analytics or a sophisticated Registry to accomplish this. Of course, this is just an additional component to a larger performance measurement program, but it requires grouping of services into episodes and identifying the drivers of variation in care.
> VBPM analysis of your group or organization. Reviewing historical costs for your group

and evaluating the patient-specific data provided by CMS will help you understand your risk potential and develop a plan to improve. And, if you're in an ACO, the ACO should be using a similar audit tool for all providers to determine how to best structure performance improvement activities that will meet the goal of shared savings. Bottom line: the CMS goal is to compare quality and costs, and pay providers for delivering better value than others.

Performance improvement. In reducing costs of episodes, you will have an incentive to reach into pre-acute care as well as the acute and post-acute. This makes your performance improvement plan reach more providers and, as a result, become more complex.

Benchmarking. Before you put yourself out there for comparisons, you need to know where you stand. With public reporting of your quality and costs on the very near horizon, you will need to equip yourself with the strategy for improving your performance.

These activities require much more than analytics, or an EMR. You will need to have a full system of performance measurement and improvement that is flexible, patient-centric and consultative. This will command a very sophisticated Registry.

Alternative Payment Methods are on the way, and they will be mandatory. Bundled Payments are among the most prevalent, but certainly not the only APM. To protect your revenues, even if you have chosen not to participate in the bundled care initiative, you should be working with a strong Registry, your colleagues and your facilities to define plans for coordinating care, rather than duplicating it—and track whether you are succeeding.

In addition to improving your cost composite this year for the VBPM, your mastery of the Medicare Spending Per Beneficiary measure will position your organization for a new form of reimbursement, both from Medicare and from other health plans.

Download your free copy of the ICLOPS *Insider's Guide to PQRS 2015 Reporting: How to Succeed in the Value-Based Health Care Environment.*

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