Medicare Spending Per Beneficiary (MSPB) Clinician Measure Clinician Group (TIN) Field Test Report

Sample TIN, Maine[1]
Last four digits of your Taxpayer Identification Number (TIN): XXXX
Measurement Period: January 1, 2017 – December 31, 2017

Your TIN's MSPB Clinician Field Test Report Measure Score:

	MSPB Clinician Measure
Your TIN's score	**$16,000**
National Median	**$18,696**
Percentile Rank	**95**

The MSPB clinician measure score above, and the information contained in this report are for field testing ONLY. The information in this report does not affect any scoring or payment adjustments in the Merit-based Incentive Payment System (MIPS). This report has been provided for the October 2018 field testing as part of ongoing measure maintenance and re-evaluation to gather stakeholder feedback.

The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at CMS's discretion, including but not limited to, circumstances in which an error is discovered.

[1] State designation is obtained from the CMS Certification Number (CCN) of the inpatient facility where your MSPB episodes are initiated. If your TIN practices across multiple states, you are assigned the state in which the plurality of your attributed episodes were initiated. The state-level values do not impact your TIN's MSPB clinician measure calculation and are included only to provide meaningful comparisons.

1 RESULTS

Your TIN's MSPB Clinician Measure Score

This section details your TIN's performance on the re-evaluated Medicare Spending Per Beneficiary (MSPB) Clinician measure for field testing only. The MSPB clinician measure assesses your TIN's performance for MSPB clinician episodes (hereafter referred to as "episodes") ending between January 1, 2017 and December 31, 2017, inclusive. Only clinician groups with at least 35 episodes have received a confidential Field Test Report. After reviewing your report, please provide your feedback via the 2018 MACRA Field Testing Feedback Survey.

For more information on the field testing MSPB clinician measure, please see Section 2.

Table 1 displays your TIN MSPB clinician measure score during the measurement period, as well as your TIN's percentile rank nationally. A lower measure score indicates that your episode costs are lower than or similar to the expected for the care provided for the particular patients and episodes included in the calculation, and a higher measure score indicates the opposite. The percentile rank indicates the percentage of TINs that received the same or higher MSPB clinician measure scores than your TIN. Table 1, titled "MSPB Clinician Measure," follows immediately.

Table 1: MSPB Clinician Measure

	MSPB Clinician Measure
Your TIN's score	$**16,000**
National Median	$**18,696**
Percentile Rank	**95**

Detailed MSPB Clinician Measure Statistics

Tables 2-4 below provide detailed breakdowns of your TIN's episode cost to help you understand the factors driving your TIN's score. Table 2 shows how your episode cost by claim type compares to the state and national average, Table 3 breaks down your TIN's episode cost by each Major Diagnostic Category (MDC), and Table 4 shows how different categories of service (e.g., acute inpatient services or post-acute services) contribute to your episode cost.

Table 2 shows your TIN's episode cost within each claim type for three time periods (3 days before the admission, during the admission, and 30 days after discharge) compared to the state and national averages. The first column presents your TIN's average episode cost, and the second column provides this as a percentage of total cost of the average episode. The final two columns provide the percentage of total cost by claim type for the average TIN in your state and nationally. Table 2, titled "MSPB Clinician Cost Breakdown by Claim Type," follows immediately.

Table 2: MSPB Clinician Cost Breakdown by Claim Type†

Time Relative to Index Admission	Claim Type	TIN's Cost per Episode	TIN Percentage of Cost†	State* Percentage of Cost†	National Percentage of Cost†
3 Days Prior	*Total Pre-Index*	$16	0.1%	0.1%	0.1%
3 Days Prior	Carrier	$16	0.1%	0.1%	0.1%
During	*Total During-Index*	$10,912	69.0%	60.1%	61.4%
During	Home Health Agency	$0	0.0%	0.0%	0.0%
During	Inpatient	$8,845	56.0%	49.9%	51.1%
During	Outpatient	$0	0.0%	0.0%	0.0%
During	Skilled Nursing Facility	$0	0.0%	0.0%	0.0%
During	Durable Medical Equipment	$0	0.0%	0.1%	0.1%
During	Carrier	$2,067	13.0%	10.1%	10.2%
30 Days Post Discharge	*Total Post-Index*	$4,880	30.9%	39.8%	38.5%
30 Days Post Discharge	Home Health Agency	$399	2.5%	3.2%	3.4%
30 Days Post Discharge	Inpatient	$1,877	11.9%	12.1%	12.4%
30 Days Post Discharge	Outpatient	$398	2.5%	3.4%	3.2%
30 Days Post Discharge	Skilled Nursing Facility	$1,618	10.2%	16.8%	15.0%
30 Days Post Discharge	Durable Medical Equipment	$3	0.0%	0.3%	0.3%
30 Days Post Discharge	Carrier	$585	3.7%	4.0%	4.3%

† Percentages reported in this table may not add up to 100% due to rounding.

* Your TIN is assigned the state in which the plurality of the attributed episodes were initiated.

Table 3 compares your TIN's episode cost by MDC to the average expected cost calculated by the risk adjustment model. The first column provides your average cost per episode, and the second column, your expected cost, as estimated by the risk adjustment model. The subsequent columns provide the same information at the state and national levels so you can compare the average risk of your patients (as expressed by expected cost) to the state and national average. A higher average expected cost for your TIN compared to the national average indicates that your patients are higher risk than the national average patient. Table 3, titled, "MSPB Clinician Cost Breakdown by MDC," follows immediately.

Table 3: MSPB Clinician Cost Breakdown by MDC

		Your TIN		State*		National	
MDC	MDC Description	Average Episode Cost	Average Expected Episode Cost	Average Episode Cost	Average Expected Episode Cost	Average Episode Cost	Average Expected Episode Cost
00	Pre-MDC**	--	--	$103,803	$97,033	$97,516	$91,014
01	Nervous System	--	--	$20,836	$20,291	$20,503	$20,274
02	Eye	--	--	$10,898	$10,695	$10,380	$10,221
03	Ear, Nose, Mouth, and Throat	--	--	$10,605	$10,250	$10,302	$10,162
04	Respiratory System	$12,253	$14,367	$15,331	$15,179	$14,869	$14,896
05	Circulatory System	$20,309	$21,715	$20,249	$20,500	$20,243	$20,539
06	Digestive System	$10,456	$13,288	$15,588	$15,317	$14,971	$14,975
07	Hepatobiliary System and Pancreas	$16,661	$17,212	$16,283	$16,296	$15,957	$16,173
08	Musculoskeletal System and Connective Tissue	--	--	$24,121	$23,591	$24,047	$23,688
09	Skin, Subcutaneous Tissue, and Breast	$12,121	$14,010	$13,690	$13,601	$13,639	$13,658
10	Endocrine, Nutritional, and Metabolic System	--	--	$14,461	$14,307	$14,130	$14,162
11	Kidney and Urinary Tract	$8,150	$11,840	$15,866	$15,388	$15,467	$15,427
12	Male Reproductive System	--	--	$13,505	$12,981	$13,109	$12,977
13	Female Reproductive System	--	--	$14,724	$14,488	$14,744	$14,759
14	Pregnancy, Childbirth, and Puerperium	--	--	$8,652	$8,797	$9,018	$8,958
15	Newborn and Other Neonates (Perinatal Period)	--	--	--	--	--	--

MDC	MDC Description	Your TIN		State*		National	
		Average Episode Cost	Average Expected Episode Cost	Average Episode Cost	Average Expected Episode Cost	Average Episode Cost	Average Expected Episode Cost
16	Blood and Blood Forming Organs and Immunological Disorders	$20,362	$23,400	$15,979	$16,223	$15,528	$15,905
17	Myeloproliferative DDs (Poorly Differentiated Neoplasms)	--	--	$29,073	$28,502	$28,743	$28,563
18	Infectious and Parasitic DDs	$34,879	$36,538	$21,105	$20,866	$20,414	$20,563
19	Mental Diseases and Disorders	--	--	$14,304	$14,334	$13,969	$14,079
20	Alcohol/Drug Use or Induced Mental Disorders	--	--	$12,709	$11,444	$12,037	$11,871
21	Injuries, Poison, and Toxic Effect of Drugs	$20,474	$23,456	$15,717	$15,623	$15,163	$15,477
22	Burns	--	--	$21,103	$21,729	$28,857	$28,983
23	Factors Influencing Health Status	--	--	$16,992	$16,596	$16,322	$16,414
24	Multiple Significant Trauma	--	--	$38,753	$37,934	$38,570	$37,691
25	Human Immunodeficiency Virus Infection	--	--	$24,569	$24,692	$22,519	$22,967
U	“Ungroupable” episodes that could not be assigned to one of the existing MDCs	--	--	$37,837	$38,058	$37,753	$37,681

* Your TIN is assigned the state in which the plurality of the attributed episodes were initiated.

** MDC 0: Pre-MDC category includes a number of diagnosis and procedure cases, all related to transplants. Pre-MDC DRGs include extracorporeal membrane oxygenation (ECMO), organ transplants, bone marrow transplants, and tracheostomy cases.

Table 4 breaks down per episode cost by service category. The first two columns indicate the number of episodes that contain any costs in the service category as a count and as a percentage of your TIN's total number of episodes. The third column shows the average episode cost for each category of service. The subsequent two columns present the national average for cost per episode and percentage of episodes with costs in the category. The final column indicates how much higher or lower your average episode cost was than the national average for each service category. Table 4, titled "MSPB Clinician Cost Breakdown by Categories of Service," follows immediately.

Table 4: MSPB Clinician Cost Breakdown by Categories of Service

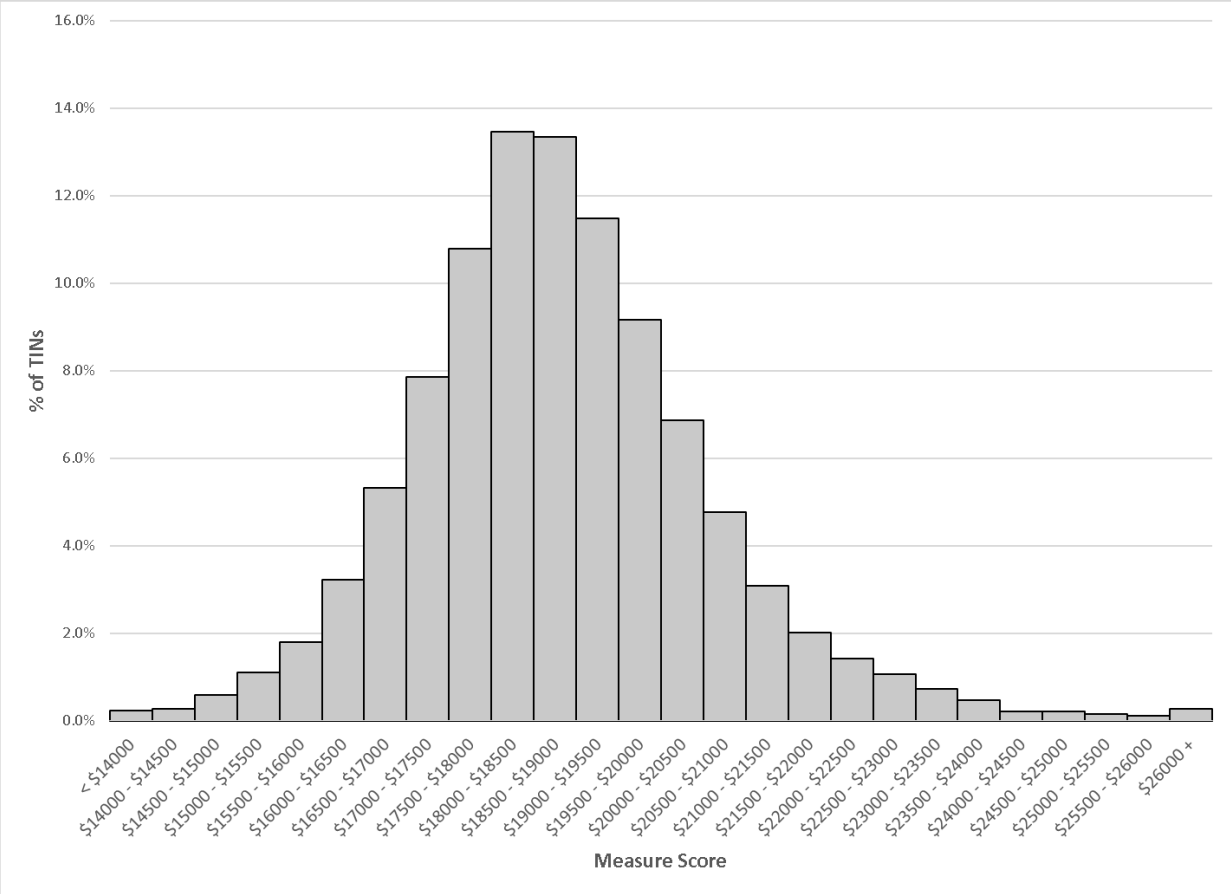
Service Category	Your TIN			National		Percentage Difference Between TIN's Average Cost per Episode and National Average Costs per Episode
	Number of Episodes with Costs in this Category	Percentage of Episodes with Costs in this Category	Average Cost Per Episode	Percentage of Episodes with Costs in This Category	Average Costs per Episode	
ALL SERVICES	45	100.0%	$15,808	100.0%	$18,599	-15.0%
Acute Inpatient Services	45	100.0%	$13,125	100.0%	$13,166	-0.3%
Acute Inpatient Hospital: Index Admission	45	100.0%	$8,933	100.0%	$9,501	-6.0%
Acute Inpatient Hospital: Readmission	11	24.4%	$1,877	14.0%	$1,433	31.0%
Services Billed by Your TIN During Index Hospitalization	45	100.0%	$609	0.0%	$0	--
Services Billed by Other TINs During Index Hospitalization	45	100.0%	$1,449	100.0%	$1,902	-23.8%
Other Physician or Supplier Part B Services Billed During Any Hospitalization	11	24.4%	$257	20.7%	$330	-22.1%
Post-Acute Care	20	44.4%	$1,977	51.6%	$4,311	-54.1%
Home Health	15	33.3%	$379	32.5%	$629	-39.7%
Skilled Nursing Facility	7	15.6%	$1,598	25.4%	$2,801	-42.9%
Inpatient Rehabilitation or Long-Term Care Hospital	--	--	--	4.0%	$881	--
Emergency Services Not Included in a Hospital Admission	6	13.3%	$201	19.6%	$139	44.6%
Emergency Evaluation & Management Services	2	4.4%	$186	16.1%	$118	57.6%

Service Category	Your TIN			National		
	Number of Episodes with Costs in this Category	Percentage of Episodes with Costs in this Category	Average Cost Per Episode	Percentage of Episodes with Costs in This Category	Average Costs per Episode	Percentage Difference Between TIN's Average Cost per Episode and National Average Costs per Episode
Procedures	1	2.2%	$10	6.5%	$15	-33.3%
Laboratory, Pathology, and Other Tests	5	11.1%	$2	5.2%	$1	100.0%
Imaging Services	4	8.9%	$3	9.7%	$5	-40.0%
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	15	33.3%	$184	29.8%	$239	-23.0%
Physical, Occupational, or Speech and Language Pathology Therapy	3	6.7%	$8	6.8%	$32	-75.0%
Evaluation and Management Services	11	24.4%	$37	15.4%	$37	0.0%
Major Procedures	3	6.7%	$52	2.4%	$81	-35.8%
Anesthesia	6	13.3%	$4	2.4%	$4	0.0%
Ambulatory/Minor Procedures	6	13.3%	$83	10.5%	$85	-2.4%
Ancillary Services	21	46.7%	$50	70.7%	$203	-75.4%
Laboratory, Pathology, and Other Tests	14	31.1%	$24	48.7%	$60	-60.0%
Imaging Services	3	6.7%	$16	35.2%	$79	-79.7%
Durable Medical Equipment and Supplies	3	6.7%	$10	21.6%	$64	-84.4%
All Other Services	29	64.4%	$271	77.2%	$541	-49.9%
Ambulance Services	3	6.7%	$70	9.8%	$86	-18.6%
Chemotherapy and Other Part B-Covered Drugs	2	4.4%	$10	9.9%	$114	-91.2%
Dialysis	--	--	--	3.8%	$85	--
All Other Services Not Otherwise Classified	29	73.3%	$191	73.5%	$256	-25.4%

National Distribution of MSPB Clinician Measure Scores

Figure 1, which follows immediately, displays a histogram of the national distribution of MSPB clinician measure scores across all TINs.

Figure 1: National Distribution of MSPB Clinician Measure Scores



2 ABOUT THE MSPB CLINICIAN MEASURE CLINICIAN GROUP (TIN) REPORT

Overview of this report

The MSPB clinician field testing score was calculated with episodes that ended between January 1, 2017 and December 31, 2017, inclusive. Only clinician groups with at least 35 episodes have received a confidential field test report.

This section provides an overview of field testing and the MSPB clinician measure, a description of the supplementary data file that accompanies this report, and links to additional resources.

What is MSPB Clinician?

The re-evaluated MSPB clinician measure assesses the cost to Medicare of services provided to a beneficiary during an episode. The episode window comprises the period immediately prior to, during, and following the beneficiary's hospital admission (also known as the "index admission" for the episode). Medicare Part A and Part B claims concurrent to the episode window are considered for inclusion, with exceptions for unrelated services, as determined through clinical review. The list of services deemed clinically unrelated can be found in the Draft MSPB Clinician Measure Codes List file on the MACRA Feedback Page along with the draft measure methodology.

What is field testing?

Field testing is a voluntary opportunity for clinicians and other stakeholders to provide feedback on the draft measure specifications for the cost measures, the field test report format, and the supplemental documentation. We will be field testing the 13 measures in their current stage of development and re-evaluation to seek clinician and other stakeholder feedback by:

- Posting confidential clinician field test reports for group practices and solo practitioners who meet the minimum number of cases[2] for each measure on the CMS Enterprise Portal.
- Posting mock reports, draft measure specifications, and supplemental documentation on the MACRA Feedback page.[3]

We are collecting stakeholder feedback from **October 3, 2018 to October 31, 2018.** Please provide your feedback on any aspect of field testing via the 2018 MACRA Field Testing Feedback Survey.

Supplemental data file

In addition to this report, your TIN has received an episode-level data file in Comma Separated Value (CSV) format. This data file provides detailed information on every episode used to

[2] A case can be an episode or a beneficiary depending on the measure.
[3] CMS, "Episode-based cost measures," *MACRA Feedback Page,* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html.

calculate your measure score. Your TIN can use the information contained in this file to perform more detailed analysis of how individual episodes are contributing to your measure score.

Additional Resources

For more information on the MSPB clinician measure, please visit the MACRA Feedback Page.[4]

If you have further questions, please call 1-866-288-8292 (TTY 1-877-715-6222), Monday through Friday, 8:00 AM-8:00 PM ET or email QPP@cms.hhs.gov.

[4] CMS, "Episode-based cost measures," MACRA Feedback Page, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html

Appendix A – MSPB Clinician Measure Score Calculation Breakdown

Table 5 provides more information on your TIN's performance. This table allows you to follow the calculation of your TIN's measure score, and to compare your score to state and national averages. Table 5, titled "Statistics of Your TIN's MSPB Clinician Performance," follows immediately.

Table 5: Statistics of Your TIN's MSPB Clinician Performance

Row	Statistic	Your TIN	State*	National
1	Number of Eligible Admissions	45.00	254,017.00	6,369,424.00
2	Average Standardized Episode Cost	$15,808.00	$18,902.67	$18,598.54
3	Average Risk-Adjusted Expected Episode Cost	$18,375.36	$18,691.94	$18,598.54
4	Average Episode Cost Ratio	0.86	1.01	1.00
5	Standardized National Average Cost per Episode	$18,598.54	$18,598.54	$18,598.54
6	MSPB Clinician Measure Score	$16,000.00	$18,831.90	$18,599.85

* Your TIN is assigned the state in which the plurality of the attributed episodes were initiated.

Your TIN's MSPB clinician measure score is calculated as follows:

1. Calculate the standardized observed cost of an MSPB clinician episode by summing all payment-standardized Medicare claims payments during the episode window, excluding a defined list of services.
    - Please see PAYMENT STANDARDIZATION in the Appendix B for more information.
2. Calculate the risk-adjusted expected cost of that MSPB clinician episode using the risk adjustment model.
    - Please see RISK ADJUSTMENT in the Appendix B for more information.
3. Divide the standardized cost obtained in step (1) by the expected cost obtained in step (2) to obtain the episode cost ratio for each episode.
4. Exclude outliers to mitigate the impact of extremely high- or low-cost episodes on the total measure score, and average the episode cost ratio obtained in step (3) across all of your TIN's MSPB clinician episodes (the number of episodes in Table 5, row 1).
    - Your average episode cost ratio can be found in Table 5, row 4.
5. Multiply the average episode cost ratio obtained in step (4) by the standardized national average MSPB clinician episode cost (Table 5, row 5) to obtain your measure score (Table 5, row 6). Due to rounding of the average episode cost ratio, this multiplication might not yield the exact value represented in row 6.
    - We multiply by the national average to convert the average ratio into a figure that is more meaningful from a cost perspective by having the average cost measure score represented as a dollar amount rather than a unit-less ratio.

Appendix B – Glossary

ATTRIBUTION

Attribution is the process of determining which clinician (or clinicians) is responsible for an episode. In the MSPB clinician measure, there are different methods of attribution depending on whether the Medicare Severity Diagnosis-Related Group (MS-DRG) is medical or surgical.

- An episode with a medical MS-DRG is attributed to a:
  - TIN if that TIN billed at least 30 percent of the evaluation and management (E&M) claims billed during the inpatient stay, and to a
  - TIN-NPI if the clinician within an attributed TIN billed at least one E&M claim that was used to determine the episode's attribution to the TIN.
- An episode with a surgical MS-DRG is attributed to a:
  - TIN if that TIN billed the relevant Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) code determined to be related to the surgical MS-DRG, and to a
  - TIN-NPI if the clinician billed the relevant CPT/HCPCS code determined to be related to the surgical MS-DRG.

More details on the attribution process can be found in the MSPB clinician measure methodology documentation on the MACRA Feedback Page.

ELIGIBLE CLINICIAN[5]

MIPS eligible clinicians include:

- Physicians, which includes doctors of medicine, doctors of osteopathy (including osteopathic practitioners), doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors;
- Physician assistants (PAs);
- Nurse practitioners (NPs);
- Clinical nurse specialists;
- Certified registered nurse anesthetists; and
- Any clinician group that includes one of the professionals listed above.

EPISODE WINDOW

The episode window for MSPB clinician is the period from 3 days prior to the hospital admission until 30 days after discharge.

EXPECTED COST

See RISK ADJUSTMENT

[5] Please note that the definition of eligible clinicians may be subject to change through rulemaking. For more information on MIPS eligibility, please see About MIPS Participation on the QPP website: https://qpp.cms.gov/participation-lookup/about

INDEX ADMISSION

The index admission is the period between the beneficiary's admission date and discharge date of their hospital stay, inclusive.

PAYMENT STANDARDIZATION

The MSPB clinician measure is payment standardized to take into account payment factors that are unrelated to the care provided (such as add-on payments for medical education and geographic variation in Medicare payment amounts)[6]. The standardized payment methodology achieves the following:

1. Eliminates adjustments made to national allowed payment amounts to reflect differences in regional labor costs and group expenses (measured by hospital wage indexes and geographic practice cost indexes).
2. Eliminates payments to hospitals for larger program goals, including graduate medical education indirect medical education (IME); serving a disproportionate population of poor and uninsured (i.e., disproportionate share payments (DSH)); and payments associated with incentive payment programs.
3. Substitutes a national amount for services paid on the basis of state fee schedules.
4. Maintains differences in actual payments resulting from the choice of setting in which a service is provided, the choice of who provides the service, and the choice of whether to provide multiple services in the same encounter.

RISK ADJUSTMENT

Risk adjustment is used to estimate expected episode costs in recognition of the different levels of care beneficiaries may require due to comorbidities, disability, age, and other risk factors. A separate risk adjustment model is estimated for episodes within each MDC. This model includes variables from the CMS Hierarchical Condition Category Version 22 (CMS-HCC V22) 2016 Risk Adjustment Model[7] and other standard risk adjustors to capture beneficiary characteristics which are identified using Medicare Parts A and B claims that end in the 90-day lookback period from the episode start date. Further detail about the MSPB clinician risk adjustment model is provided below:

- The MSPB clinician risk adjustment methodology includes 12 age categorical variables.
- Severity of illness is measured using the MS-DRG of the index hospitalization, an indicator for any prior acute hospital admission, and 79 HCC indicators derived from the beneficiary's claims in the 90-day lookback period.

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[6] For more information, please refer to the "CMS Price (Payment) Standardization - Basics" and "CMS Price (Payment) Standardization - Detailed Methods" documents posted on QualityNet: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic/Page/QnetTier4&cid=1228772057350

[7] CMS uses an HCC risk adjustment model to calculate risk scores. The HCC model ranks diagnoses into categories that represent conditions with similar cost patterns. Higher categories represent higher predicted healthcare costs, resulting in higher risk scores. There are over 9,500 ICD-10-CM codes that map to one or more of the 79 HCC codes included in the CMS-HCC V22 model.

- The model includes status indicator variables for whether the beneficiary qualifies for Medicare through disability or age, End-Stage Renal Disease (ESRD), and whether the beneficiary is receiving long-term care.
- In addition, the model accounts for interactions between particular variables. Interaction terms are included because the presence of certain patient characteristics can increase expected cost in a greater way than predicted by the indicators alone.