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Using Data to Understand the Medicare Spending Per Beneficiary Measure

Mary Wheatley, AAMC
Jacqueline Matthews, Cleveland Clinic
Keely Macmillan, Partners Healthcare

December 17, 2013

Association of
American Medical Colleges

Webinar Details

- The link for this slide deck can be found here: www.aamc.org/hospitalpaymentandquality
- This webinar is being recorded and will be posted on this page following the conclusion of today's presentation

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Objectives

- To better understand the Medicare Spending per Beneficiary (MSPB) measure
- Why performance on MSPB is important
- How to use supplemental data files to understand performance
  - The Cleveland Clinic experience
  - Partners Healthcare experience

Efficiency Measures

- The Affordable Care Act requires CMS to include efficiency measures in the Hospital Value-based Purchasing (VBP) Program
  - Include measures of 'Medicare spending per beneficiary'
  - Adjusted for factors such as age, sex, race, severity of illness
- MSPB reported on Hospital Compare starting April 2012
  - Second year of MSPB data reported in December 2013
- MSPB will be included in VBP starting FY 2015

What is MSPB?

Medicare Spending Per Beneficiary

- Hospital measure, reported as a ratio
- Total Parts A and B spending for 3 days prior to hospital admission to 30 days post discharge
- Prices standardized and risk adjusted for patient population
- Exclusions: Medicare Advantage, transfers, deaths, statistical outliers

MPSB Ratios calculated based on a hospitals' average spending compared to the national median

- 1 = Spending is about the same as the national median
- >1 = Spending is MORE than the national median
- < 1 = Spending is LESS than the national median

Additional information on the MSPB measure:

https://www.aamc.org/download/323010/data/mspbcallsummary.pdf

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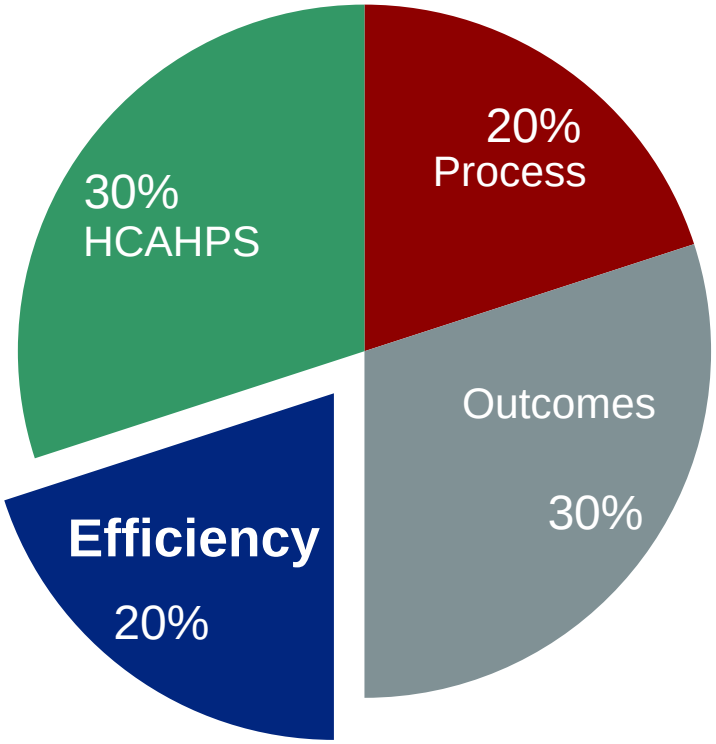
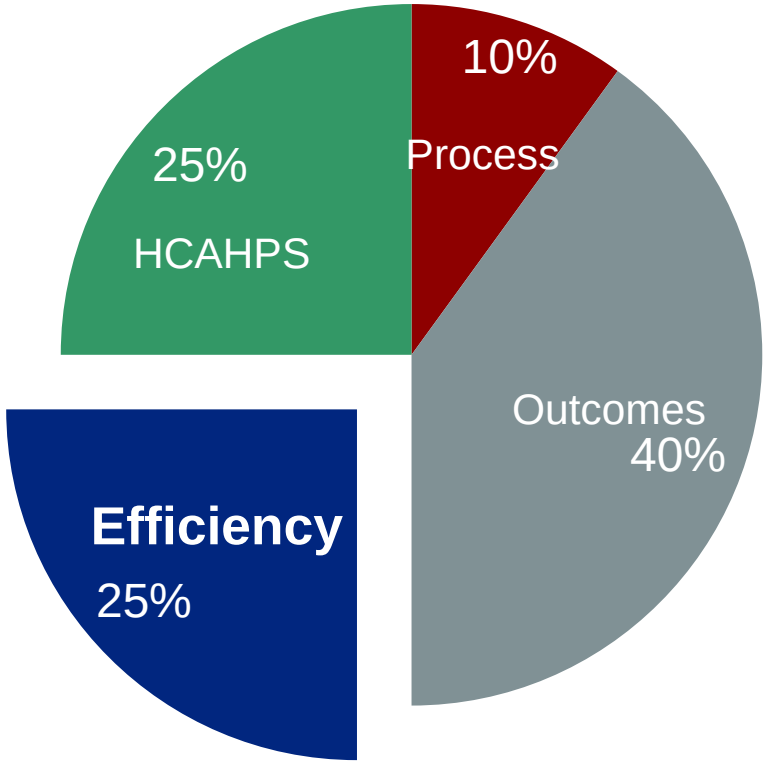
Why is MSPB Important?

VBP Domains FY 2015
1.5% of Base DRG



VBP Domains FY 2016
1.75% of Base DRG



- **MSPB is the only measure in the Efficiency Domain.**
- **Performance on this measure will account for one-quarter of FY 2016 VBP Score**

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MSPB Baseline and Performance Periods (Efficiency Domain)

Threshold	Benchmark
Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period *National MSPB hospital percentile distribution is displayed in your hospital-specific report.*	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the performance period

Baseline Period	Performance Period
FY 2015: (8-months) May 1, 2011 – December 31, 2011 **FY 2016: (12-months)** January 1, 2012 – December 31, 2012	**FY 2015: (8-months)** May 1, 2013 – December 31, 2013 **FY 2016: (12-months)** January 1, 2014 – December 31, 2014

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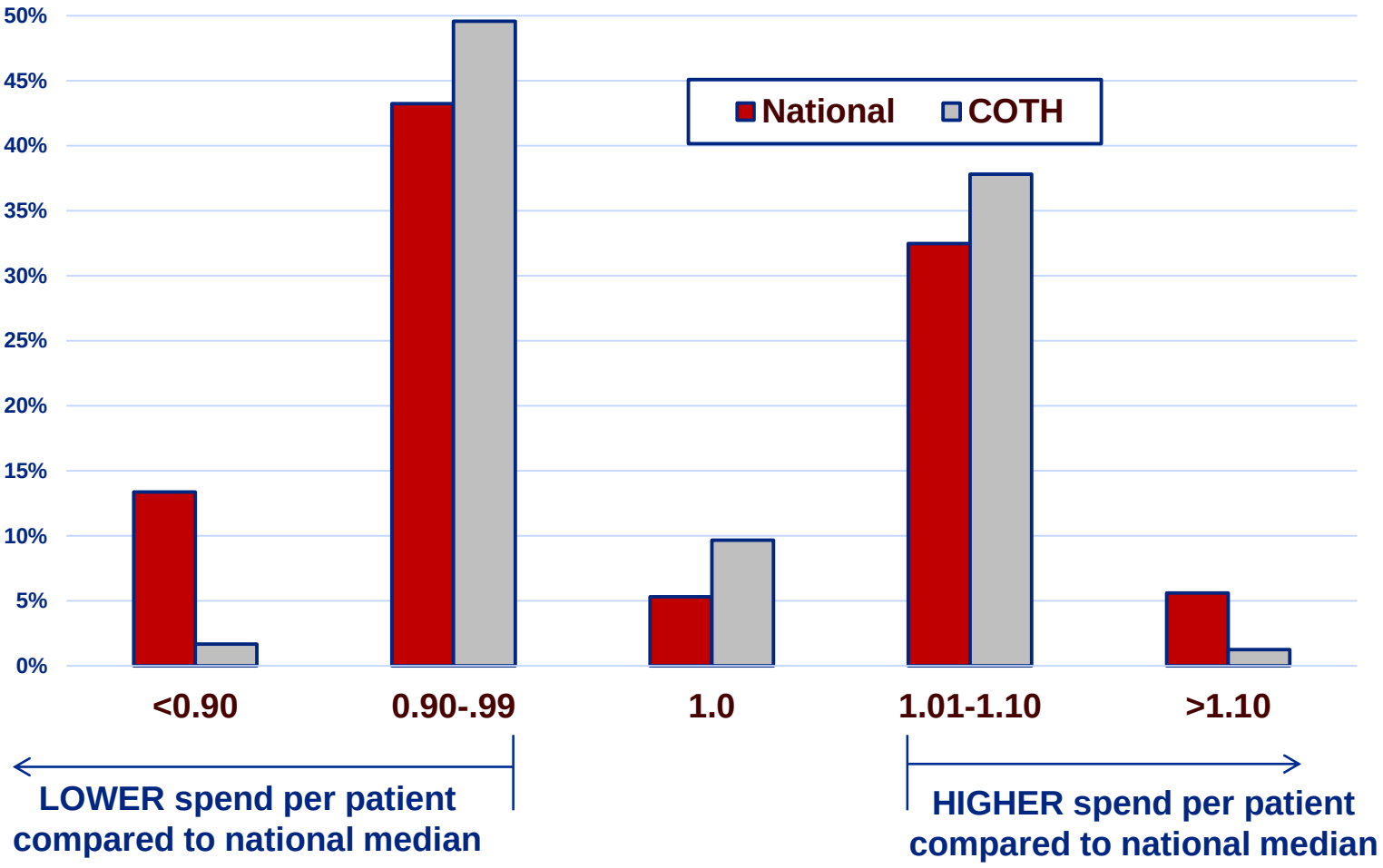
Distribution of MSPB Scores



Note: N = 3,261 hospitals. Performance period is Jan – Dec 2012.
Source: AAMC analysis of Hospital Compare and AAMC member data – December 2013.

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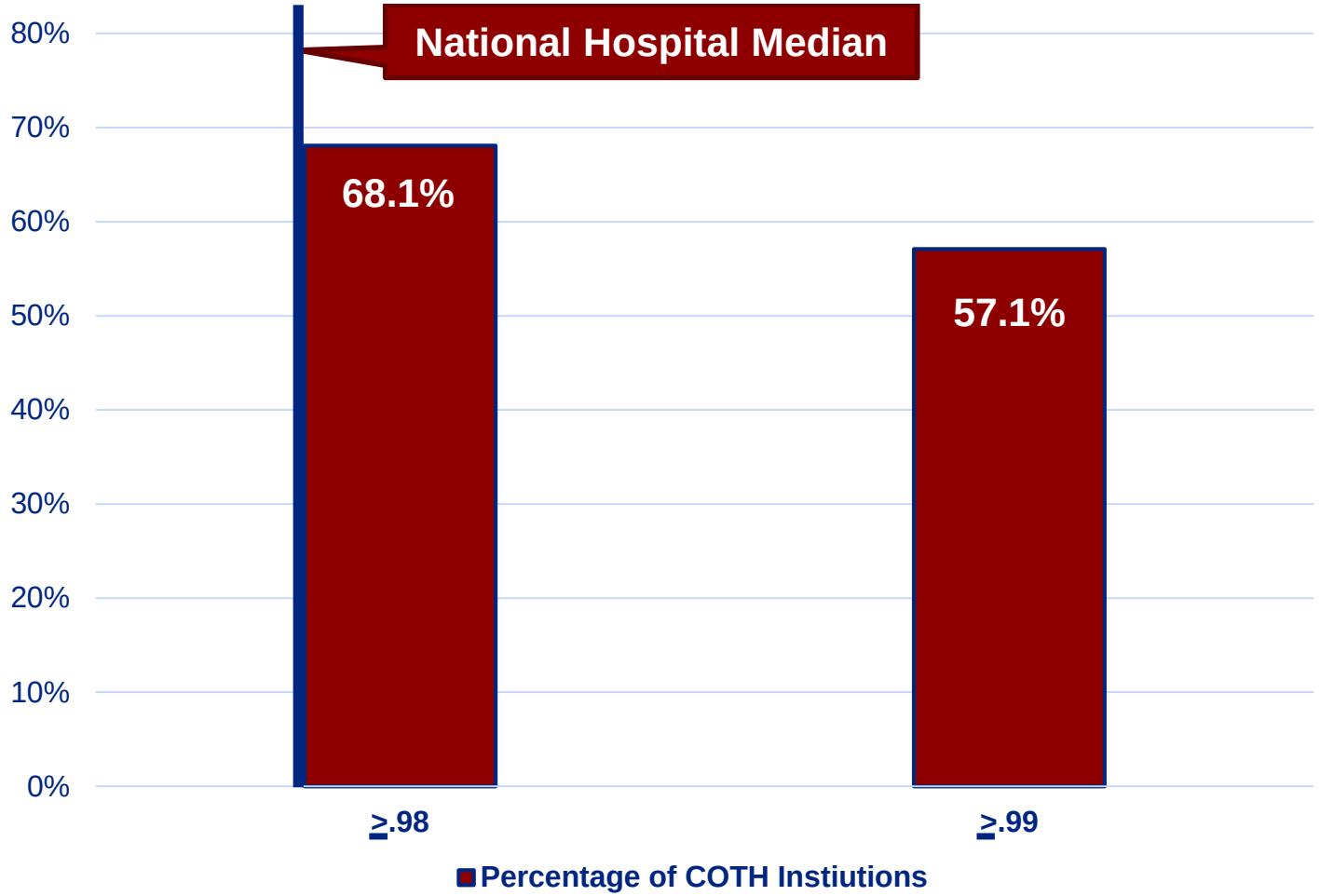
COTH Institutions Higher than the MSPB National Median (No Achievement Points)



Source: AAMC analysis of Hospital Compare and AAMC member data – December 2013.

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MSPB Supplemental Data files

- National data files (data.medicare.gov)
- Hospital Specific Report (Accessed via qualitynet.org)
- Hospital specific files (Accessed via Qualitynet.org)

MSPB National Data files

Downloadable Data available Via Data.Medicare.gov
Summary data for all hospitals by time period and claim type

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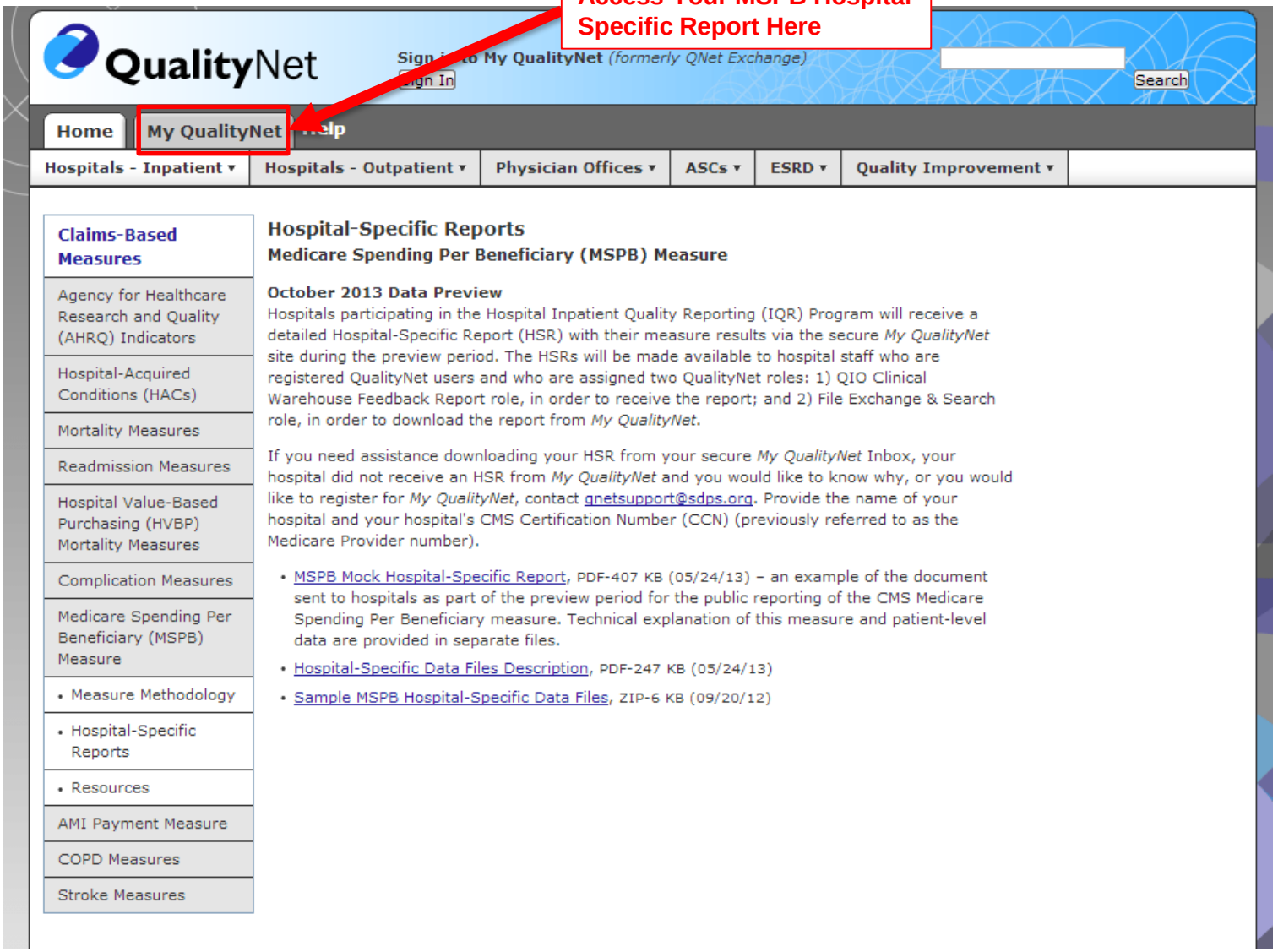
MSPB Hospital Specific Reports Available on Qualitynet.org



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Sample Data from Hospital-Specific Reports

Hospital-Specific Report

[Month] 20XX

Medicare Spending Per Beneficiary Measure

HEARTCARE REGIONAL MEDICAL CENTER
Provider ID: 999999
[State]

Table 3: Detailed MSPB Statistics*
HEARTCARE REGIONAL MEDICAL CENTER

	Your Hospital	State	U.S.
Number of Eligible Admissions	21	64,000	4,482,704
Average Spending per Episode	16,215.81	15,502.55	18,736.44
MSPB Amount (Avg. Risk-Adjusted Spending)	19,546.53	18,900.02	17,683.47
U.S. National Median MSPB Amount	18,017.19	18,017.19	18,017.19
Average MSPB Measure	1.08	1.05	0.98

*Only the bottom row ("Average MSPB Measure") will be posted on *Hospital Compare* for hospitals with 25 or more eligible admissions.

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Hospital Specific Data Files

Supplemental data files on qualitynet.org

- "Index Admissions" file
  - Key data regarding admission: episode id, patient id, admit date, discharge date, los, diagnoses, payment amount, reason for inclusion/exclusion
- "Beneficiary Risk Score" file
  - Patient ID, episode ID, payment amounts, risk adjustment diagnostic information
- "Episodes" file
  - Date ranges, payments and IDs for providers with highest payments for inpatient, outpatient, physicians, SNF, DME, home health, and hospice - over 80 fields in the file

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Contact Information

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Cleveland Clinic

Medicare Spend Per Beneficiary: Walking Through the Data

Jacqueline Matthews, RN, MS
Senior Director, Quality Reporting & Reform
Quality and Patient Safety Institute
December 18, 2013

Cleveland Clinic At a Glance

VITAL STATISTICS:

2012 ANNUAL REPORT DATA, INCLUDING COMMUNITY HOSPITALS

PEOPLE:

3,000+	PHYSICIANS AND SCIENTISTS
11,400	NURSES
43,890	EMPLOYEES

PATIENT CARE:

5.1 million	TOTAL VISITS
157,470	ADMISSIONS
200,800	SURGICAL CASES
1,450	BEDS ON MAIN CAMPUS
4,450	BEDS SYSTEM-WIDE

RESEARCH & EDUCATION:

169 million	TOTAL GRANT AND CONTRACT REVENUE
109 million	TOTAL FEDERAL REVENUE
1,785	RESIDENTS & FELLOWS-IN-TRAINING
67	ACCREDITED TRAINING PROGRAMS

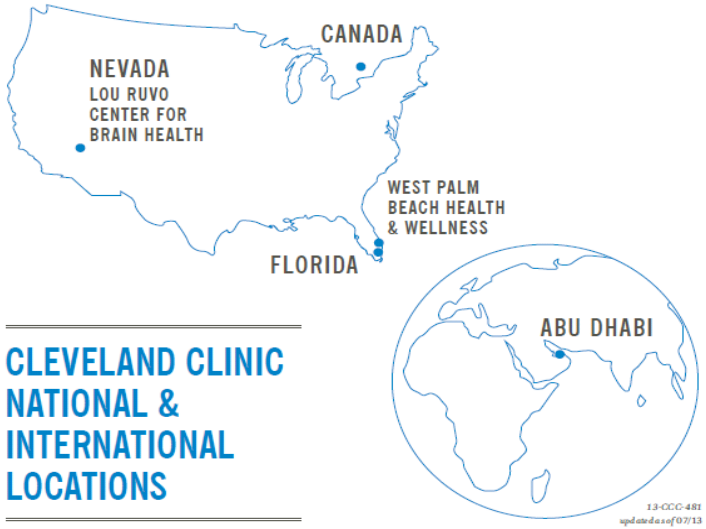
MORE THAN 75 NORTHERN OHIO OUTPATIENT LOCATIONS,

INCLUDING 16 FULL-SERVICE FAMILY HEALTH CENTERS

8 COMMUNITY HOSPITALS

- Euclid Hospital
- Fairview Hospital
- Hillcrest Hospital
- Lakewood Hospital
- Lutheran Hospital
- Marymount Hospital
- Medina Hospital
- South Pointe Hospital

AFFILIATE HOSPITAL Ashtabula County Medical Center



CLEVELAND CLINIC NATIONAL & INTERNATIONAL LOCATIONS

13-CCC-481
updated as of 07/13

Cleveland Clinic

Hospital Specific Report

- Annual Report providing:
  - Hospital results
  - National Distribution
  - Claim Type Breakdowns
  - Major Diagnostic Categories (MDC) Breakdowns

Hospital-Specific Report

May 2013

Medicare Spending Per Beneficiary Measure

CLEVELAND CLINIC
Provider ID: 360180
OH

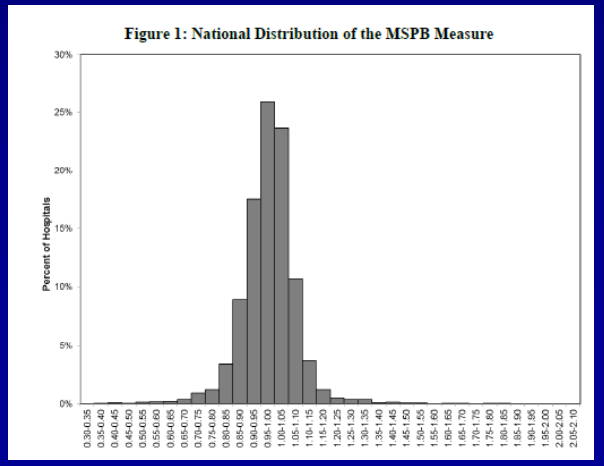
Detailed Statistics

- MSPB Amount is the average spending after controlling patients' health status and regional variation in Medicare payments.
- Average MSPB Measure, calculated in the fifth row, is the MSPB Amount divided by the U.S. National Median MSPB Amount in the fourth row.
- National distribution of the MSPB Measure across all hospitals in the Nation

Table 3: Detailed MSPB Statistics*
CLEVELAND CLINIC

	Your Hospital	State	U.S.
Number of Eligible Admissions	7,293	225,708	5,675,808
Average Spending per Episode	24,116.80	18,883.05	18,703.88
MSPB Amount (Avg. Risk-Adjusted Spending)	18,591.58	18,899.09	18,340.91
U.S. National Median MSPB Amount	18,708.18	18,708.18	18,708.18
Average MSPB Measure	0.99	1.01	0.98

*Only the bottom row ("Average MSPB Measure") will be posted on *Hospital Compare* for hospitals with 25 or more eligible admissions. For hospitals with less than 25 eligible admissions, only the state and national values from the bottom row will be posted on *Hospital Compare*.



Spend by Claim Types

3 Days Prior

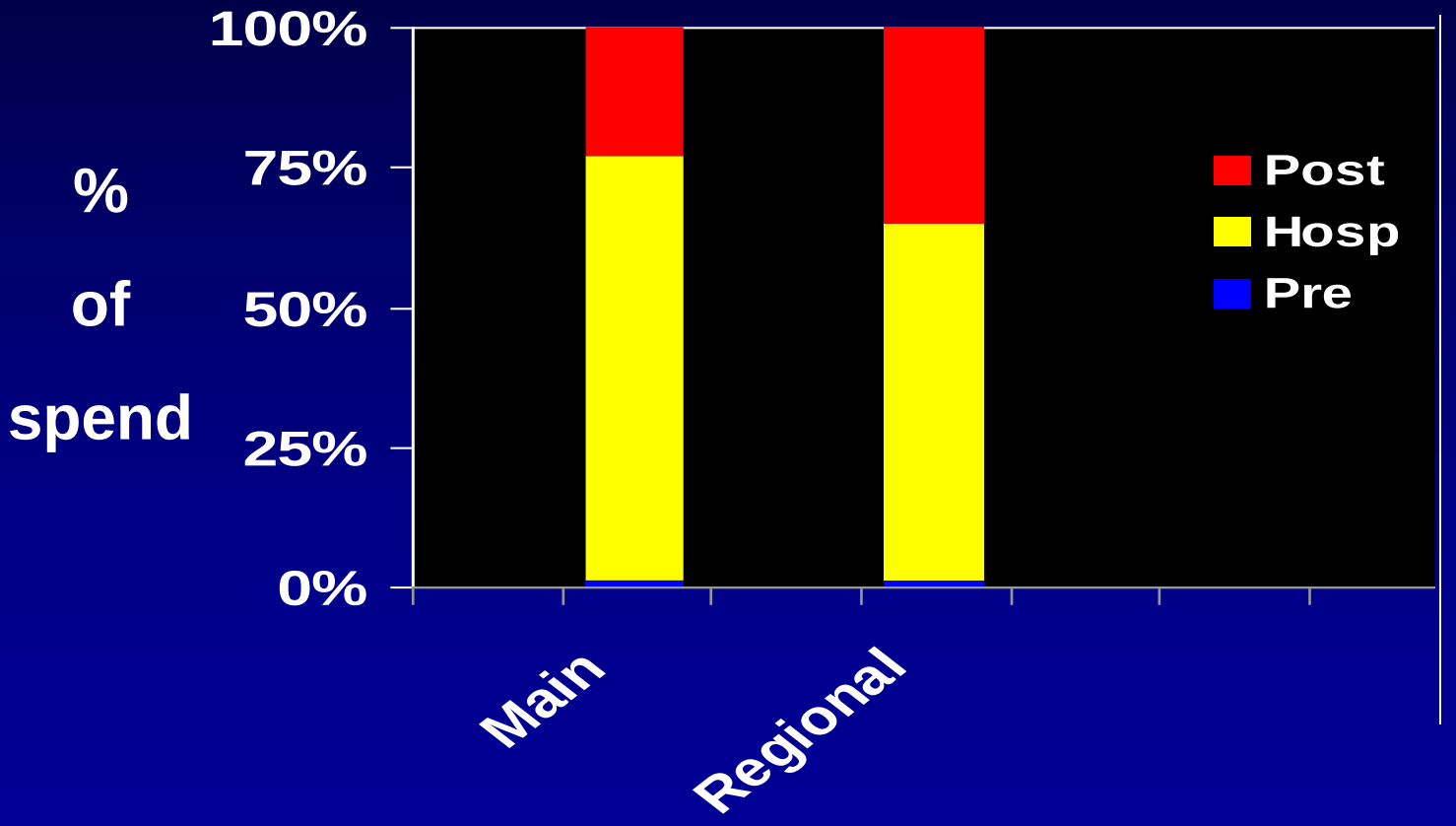
During Index Admission

30 Days After Hospital Discharge

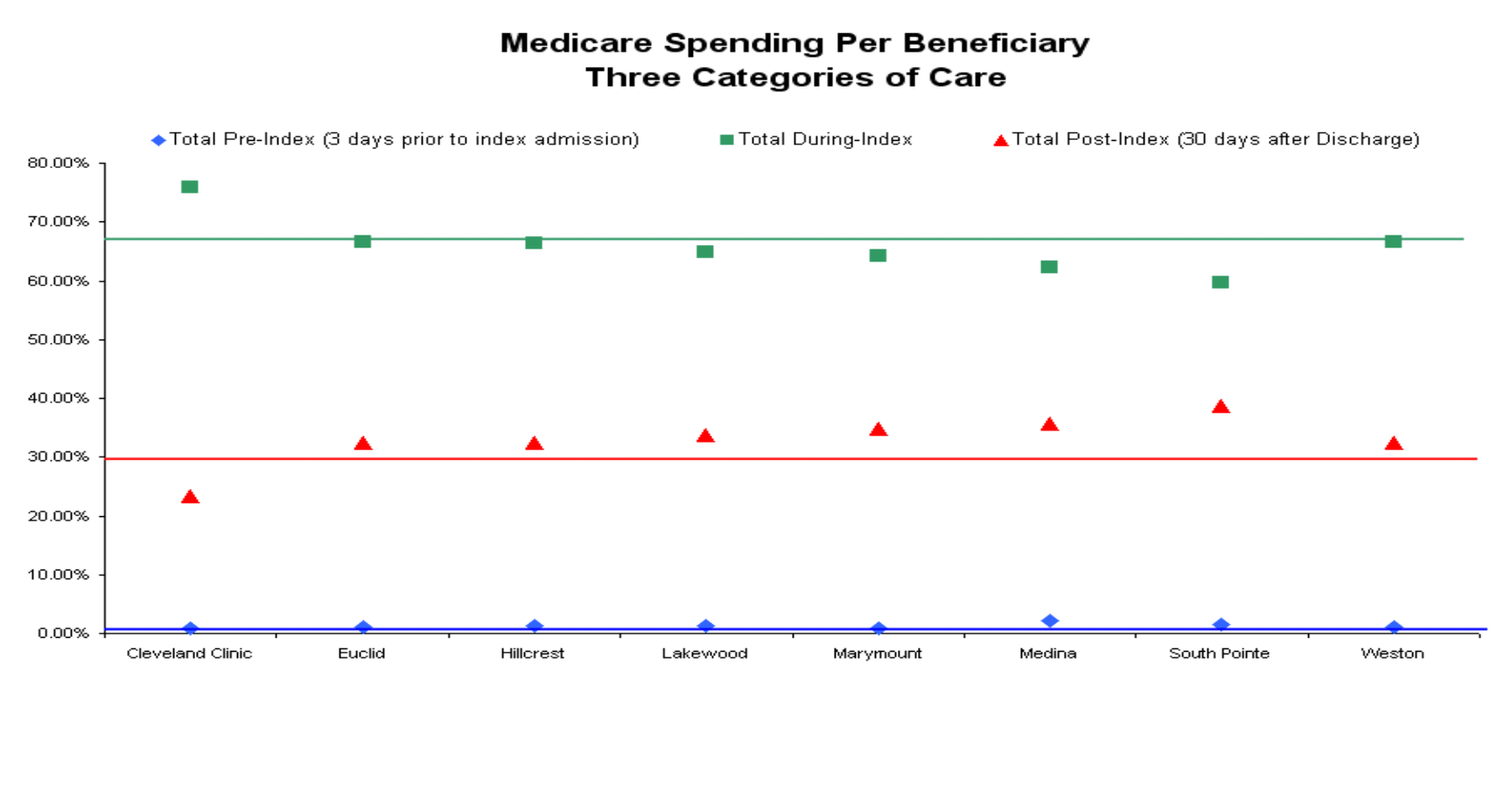
Home Health
Hospice
Outpatient
Inpatient
Skilled Nursing Facility
Durable Medical
Carrier

Percent of "Spend" for 3 Phases

Comparison Main and Regional



Percent of "Spend" for 3 Phases
Comparison all Hospitals



Average Spending by MDC

- MSPB utilizes a risk adjustment model adopted from the Medicare Advantage programs to control for differences.

- Average Expected Spending per Episode: predicted values from the risk adjustment model that measures the relationship between episode spending and beneficiary age, severity of illness, and the MS-DRG of the index admission.

Breakdowns by MDS

- Examine the highest spend by MDC
- Drill down to the patient level using the Episode File

		A	B	C	D	E	F
		Your Hospital		State		National	
MDC	Description	Average Spending per Episode	Average Expected Spending per Episode	Average Spending per Episode	Average Expected Spending per Episode	Average Spending per Episode	Average Expected Spending per Episode
5	Circulatory System	31,363	33,004	18,201	18,263	17,887	18,058
6	Digestive System	20,025	20,169	16,115	15,871	15,561	15,686
7	Hepatobiliary System and Pancreas	20,589	21,082	16,920	16,681	16,601	16,868
8	Musculoskeletal System and Connective Tissue	24,666	24,116	25,242	24,650	25,218	24,785

MDC	Number of Patients	Hospital Average Spending per Episode	Hospital Average Expected Spending per Episode	National Average Spending per Episode	National Average Expected Spending per Episode	Hospital Higher Then Expected Spending*
Digestive System	835	20,025	20,169	15,561	15,686	4,483

*Hospital average expected spending – National Expected Spending

Utilizing the MSPB Data Files

- Files provided beneficiary specific information
- Provide the HIC number, admission date and DOB for identifier
- Must match this data set with internal administrative data to identify the patient.

Episode File

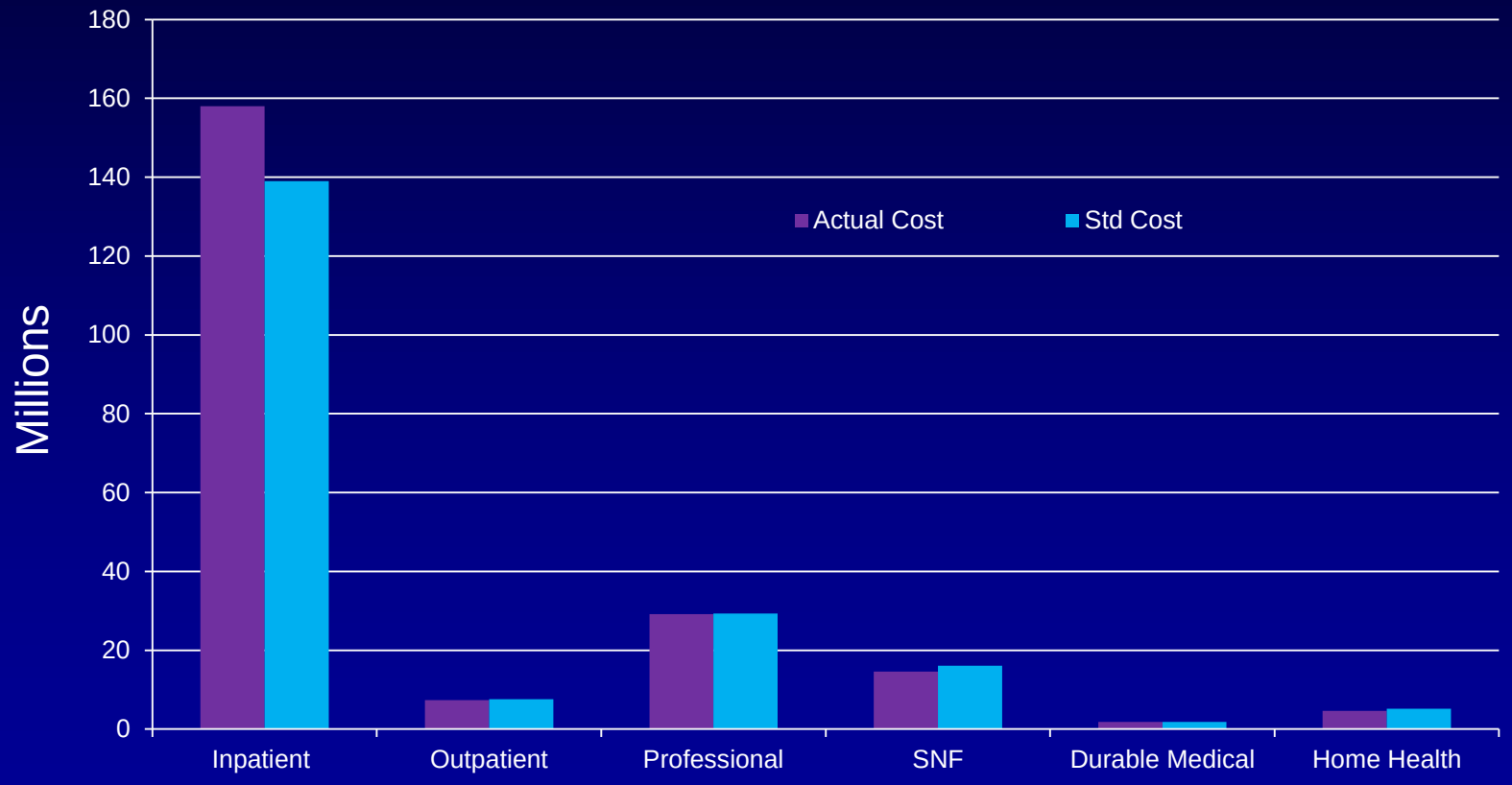
- Identify specific episodes of care
- Types of care provided
- Care provided in other provider settings

Drilling Down on the Episode File

- **Utilize the Episode Database to analysis specific drill down information**

1	HSP_Name	Admsn_Dt	DschrgDt	Len_S	PDGNS	MDC	Episode_Start	Episode_End	PMT_ALL_CL	Std_Pmt_Al	Pred_Amt_Rer	IP_StartDate	IP_EndDate
2	CLEVELAND CLINIC	7/20/2012	7/21/2012	1	59	6	7/17/2012	8/20/2012	5858.66	5268.39	7791.4992	7/20/2012	7/21/20
3	CLEVELAND CLINIC	10/7/2012	10/13/2012	6	88	6	10/4/2012	11/12/2012	6414.58	5790.12	6932.739025	10/7/2012	10/13/20
4	CLEVELAND CLINIC	12/30/2011	1/3/2012	4	88	6	12/27/2011	2/2/2012	7530.78	6859.93	10062.91936	12/30/2011	1/3/20
5	CLEVELAND CLINIC	10/14/2012	10/19/2012	5	88	6	10/11/2012	11/18/2012	46846.53	45785.26	17900.07539	10/14/2012	11/14/20
6	CLEVELAND CLINIC	2/1/2012	2/3/2012	2	88	6	1/29/2012	3/4/2012	5756.69	5082.98	19226.52387	2/1/2012	2/3/20

Total Payments by Phase



Actual vs. Standard

- Actual Payments:
  - Payments by CMS
- Standard Payments:
  - Removes variation not directly related to care
    - Regional price differences
    - Eliminates IME & DSH

Provider Levels

- Files list up to 5 providers for each phase
  - Providers ordered by actual payments during MSPB episode
- Cleveland Clinic:
  - Provider 1 = 96%
  - Provider 2 = 33%
  - Provider 3 = 19%
  - Payments can not be split by providers during a phase.

NPI Spending

- File provides NPI of the providers
- Ability to drill down to specific physician and cases
- Examine readmissions and utilization for cases

Beneficiary Risk Score File

- Identifies case mix
- Adjusts for age and severity of illness
- Utilizes Hierarchical Condition Categories (HCC)
  - Used extensively for Medicare Advantage
  - Derived from beneficiaries claims during the period 90 prior to start of episode
  - Adjusts Medicare capitation payments for MA care plans for the health expenditure risk of the enrollees.

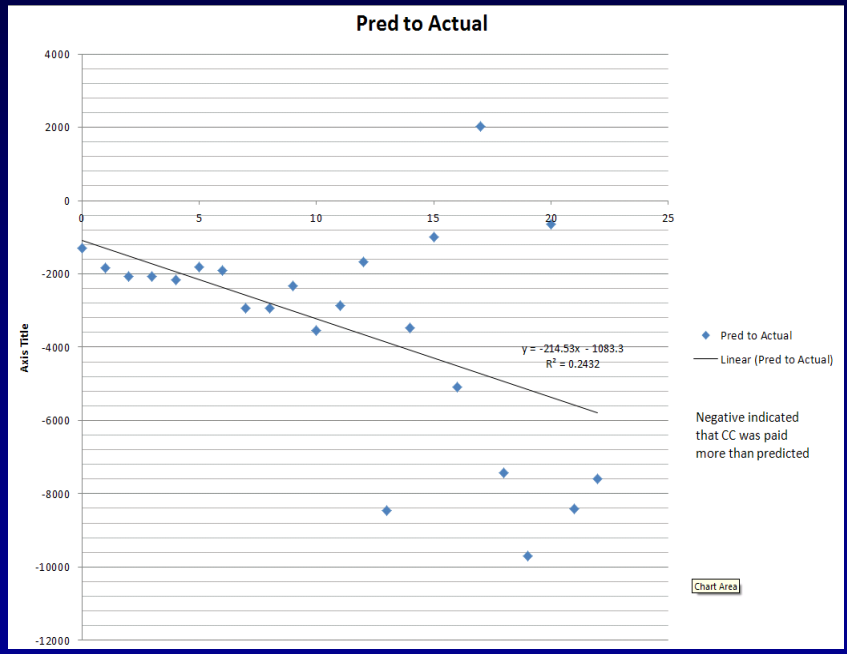
Predictive Payment Amount vs Payment

- Predictive Payment amount
  - Price standardized and risk adjusted payment for all claims

- Payment All Claim amount
  - The sum of the payment amount, coinsurance and deductible amount for all claims

Difference between Predictive Payment and Actual

- There is no correlation between the predictive payment and the actual payment.
- This supports the risk adjustment modeling methodology related to payment
- Extreme outliers are excluded from MSPB



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Cleveland Clinic

Every life deserves world class care.

PARTNERS HEALTHCARE

FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL
AND MASSACHUSETTS GENERAL HOSPITAL

Maximizing the Value of Medicare Spend Per Beneficiary (MSPB) Data

Partners HealthCare System

AAMC Webinar
December 17th, 2013

Keely Macmillan, MSPH
Team Lead, Government Payment Policy
Partners HealthCare System; Boston, MA

Medicare Spend Per Beneficiary (MSPB) data can be used to identify ways to improve efficiency

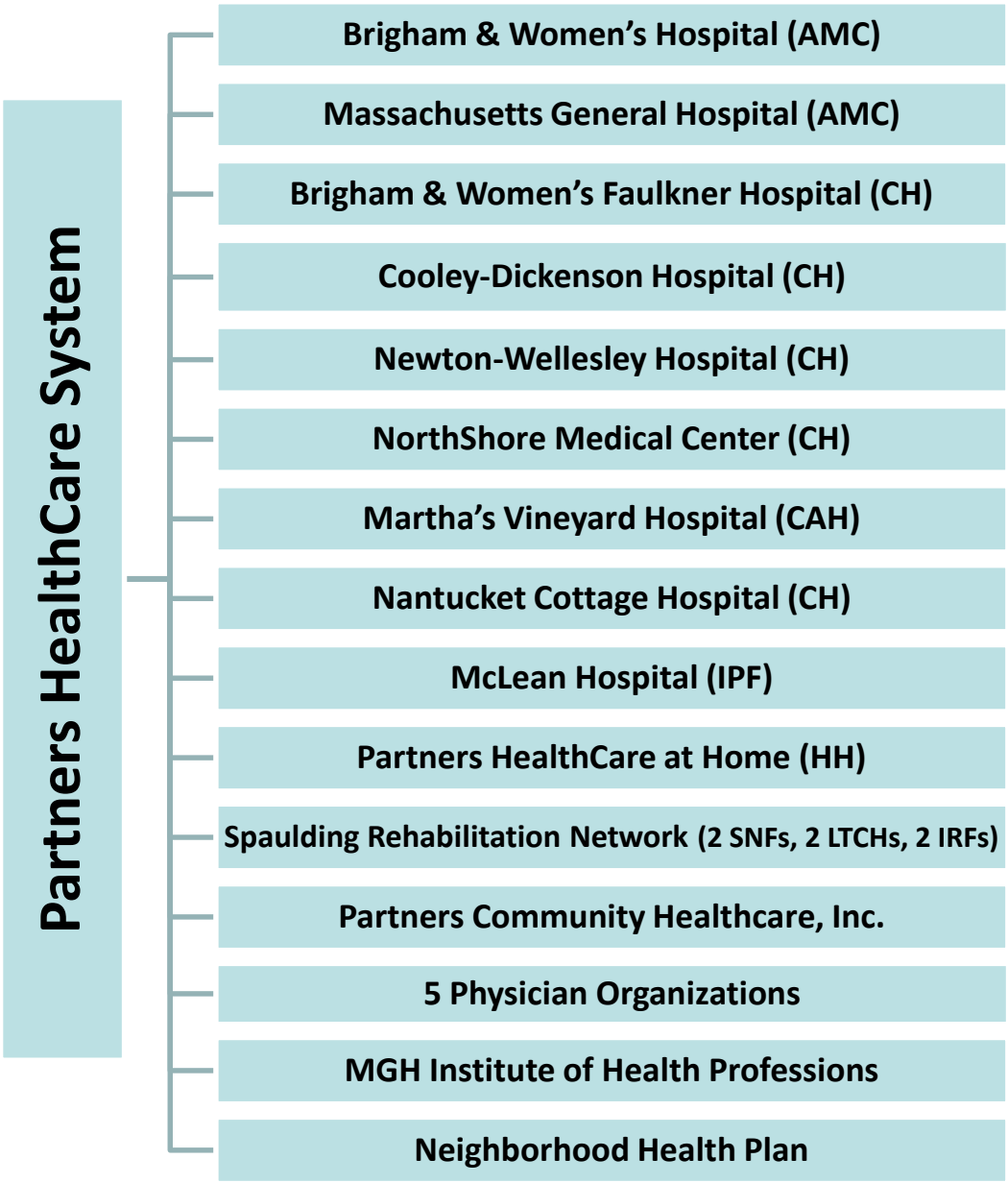
Outline

- Overview of Partners HealthCare System
- Show value of national MSPB data (downloadable from Hospital Compare)
- Show value of hospital specific MSPB (as provided via QNET)

Where applicable: Limitations of dataset
- [Example]
- [Example]

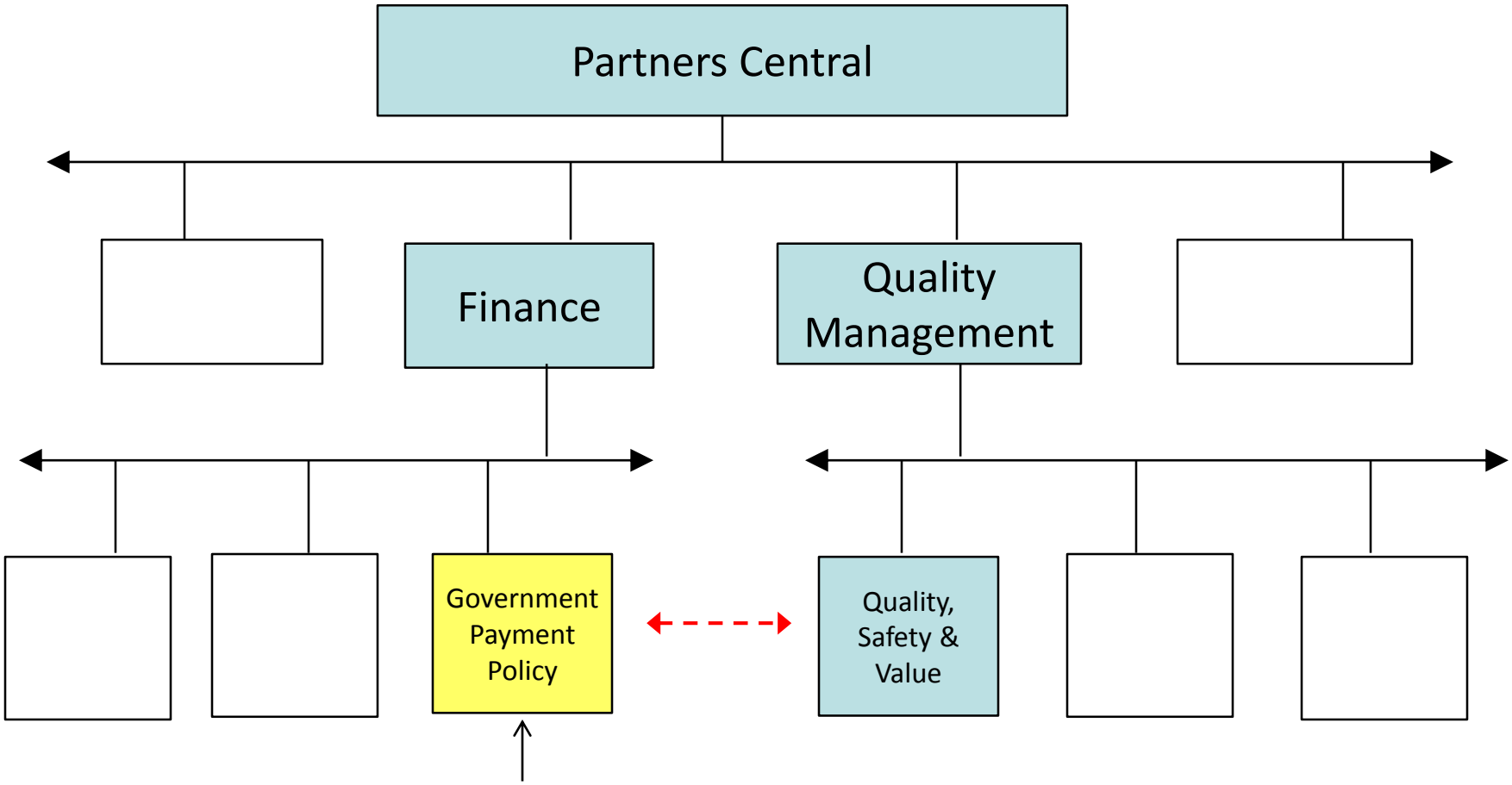
Keely Macmillan, MSPH
Team Lead, Government Payment Policy

Partners HealthCare System *Boston, MA*



- **AMC:** Academic Medical Center
- **CH**: Community Hospital
- **CAH:** Critical Access Hospital
- **IPF:** Inpatient Psychiatric Facility
- **HH**: Home Health services
- **SNF**: Skilled Nursery Facility
- **LTCH**: Long Term Care Hospital
- **IRF**: Inpatient Rehabilitation Facility

Partners' Finance and Quality Departments work together on quality incentive programs



Department models revenue impact from government payment reform

MSPB Data Sources & Potential Uses

[MSPB Dataset]	• *[Potential Uses]*
National MSPB Data (Hospital Compare)	•Comparison to state and national providers •Comparison of price standardized spend per episode by claim •Intra-system comparisons
Hospital-Specific MSPB Data (QNET)	• Post-acute care patterns and variation in spending, e.g. SNF • All cause readmissions • Variations in spending by condition • Higher than expected spending by MDC

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National MSPB Data can be used to benchmark MSPB 'performance' to state and national providers

- How does your hospital compare with regional & national providers?
- Can you identify drivers of disparity in MSPB ratio?
- If your hospital is part of a system, how do system hospitals compare to each other? Can 'best-practices' be shared?

Data shortcomings:
•More significant digits for correlation analysis

Hospital	City, State	MSPB Ratio	MSPB Percentile	CMI	DSH
↑	↑	↑			
[Hospital]	[City, State]	0.94			
[Hospital]	[City, State]	0.95			
[Hospital]	[City, State]	0.96			
[Hospital]	[City, State]	0.97			
[Your hospital]	[City, State]	0.98			
[Hospital]	[City, State]	0.99			
[Hospital]	[City, State]	1.00			
[Hospital]	[City, State]	1.01			
[Hospital]	[City, State]	1.02			
↓	↓	↓			
	Average:				

Tip: Populate using Hospital Compare data and Final Rule Impact File

National MSPB Data can be used to compare price-standardized spending by claim type to local and national providers (and other intra-system hospitals if applicable): What are drivers of variation? Can best practices be leveraged?

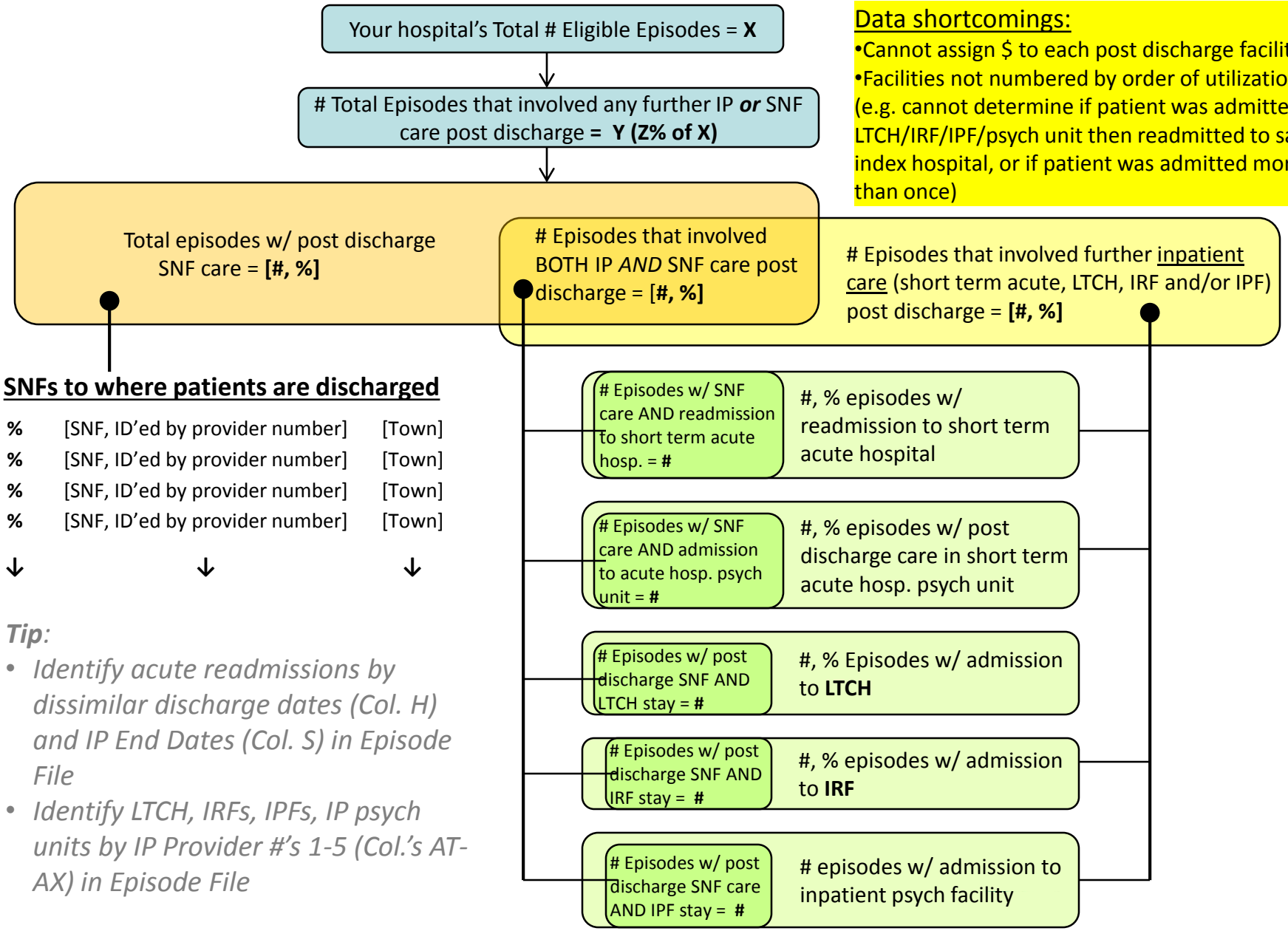
		Hospital A		Hospital B		etc		National	
CMI		x		x		x		1.46	
MSPB Ratio		x		x		x		0.98	
CLAIM TYPE		$	%	$	%	$	%	%	%
3 Days Prior to Admission	**I: Total Pre**	**$**	**%**	**$**	**%**	**$**	**%**	**252**	**1.4%**
	H.H. Agency	$	%	$	%	$	%	14	0.1%
	Hospice	$	%	$	%	$	%	1	0.0%
	Inpatient	$	%	$	%	$	%	5	0.0%
	Outpatient	$	%	$	%	$	%	68	0.4%
	SNF	$	%	$	%	$	%	3	0.0%
	DME	$	%	$	%	$	%	9	0.1%
	Physician	$	%	$	%	$	%	152	0.8%
During Index Admission	**II: Total During Index**	**$**	**%**	**$**	**%**	**$**	**%**	**10,122**	**55.1%**
	Inpatient	$	%	$	%	$	%	8,294	45.2%
	DME	$	%	$	%	$	%	24	0.1%
	Physician	$	%	$	%	$	%	1,804	9.8%
30 Days After Hospital Discharge	**III: Total Post Index**	**$**	**%**	**$**	**%**	**$**	**%**	**7,984**	**43.5%**
	H.H Agency	$	%	$	%	$	%	696	3.8%
	Hospice	$	%	$	%	$	%	110	0.6%
	Inpatient	$	%	$	%	$	%	2,493	13.6%
	Outpatient	$	%	$	%	$	%	602	3.3%
	SNF	$	%	$	%	$	%	3,012	16.4%
	DME	$	%	$	%	$	%	108	0.6%
	Physician	$	%	$	%	$	%	963	5.3%
I + II + III = Total Avg. Spend/ Episode		**x**		**x**		**x**		**18,358**	

- **Data limitation**: While MSPB ratios are risk adjusted, episode spending by claim as posted in the Hospital Compare database is ***not risk-adjusted***

MSPB Data Sources & Potential Uses

[MSPB Dataset]	• *[Potential Uses]*
National MSPB Data (Hospital Compare)	•Comparison to state and national providers •Comparison of price standardized spend per episode by claim •Intra-system comparisons
Hospital-Specific MSPB Data (QNET)	• Post-acute care patterns and variation in spending, e.g. SNF • All cause readmissions • Variations in spending by condition • Higher than expected spending by MDC

Hospital specific data (QNET) can be used to evaluate post discharge site of care distribution and spending (p. 1 of 2)



Data shortcomings:

- Cannot assign $ to each post discharge facility
- Facilities not numbered by order of utilization (e.g. cannot determine if patient was admitted to LTCH/IRF/IPF/psych unit then readmitted to same index hospital, or if patient was admitted more than once)

Tip:

- *Identify acute readmissions by dissimilar discharge dates (Col. H) and IP End Dates (Col. S) in Episode File*
- *Identify LTCH, IRFs, IPFs, IP psych units by IP Provider #'s 1-5 (Col.'s AT-AX) in Episode File*

Hospital specific data (QNET) can be used to evaluate post discharge spending and relationship to total average spend (p. 2 of 2)

- Is there as disparity in average spend per episode between patients who utilize SNF, LTCH, and/or IRF post acute services? Can the discharge process be improved? (Care coordination, warm handoffs, etc)

Data shortcomings:
- Cannot assign $ to each post discharge facility
- Not risk adjusted
- Facilities not numbered by order of utilization (e.g. cannot determine if patient was admitted to LTCH/ IRF/IPF/psych unit then readmitted to same index hospital, or if patient was readmitted more than once)

Post-Discharge Destination Status	# Discharges	Average Spending Per Episode	% Compared to Total Average
Total Eligible Episodes	**X**	**$**	
Readmissions to short term acute hospital	X	$	+/- %
Admissions to SNF	X	$	+/- %
Admissions to LTCH Facility	X	$	+/- %
Admissions to inpatient rehab facility	X	$	+/- %
Admissions to inpatient psych facility	X	$	+/- %
Etc ↓	↓	↓	↓

Tip:
- *Identify acute readmissions by dissimilar discharge dates (Col. H) and IP End Dates (Col. S) in Episode File*
- *Identify LTCH, IRFs, IPFs, IP psych units by IP Provider #'s 1-5 (Col.'s AT-AX) in Episode File*

Hospital specific MSPB Data (QNET) can be used to analyze variance in post-discharge spending and LOS between SNFs

- What is the variance in average spending and average length of stay between SNFs? Can it be used to improve 'efficiency'?
- What % were sent to affiliated SNFs and how does spending/LOS compare to others? Can this information be used for population management?
- What are the drivers of variation? Is there a relationship between SN facility and/or spend and readmission rate?

Data shortcomings:
•Price standardized but not risk-adjusted

Post Discharge SNF	Average Price-Standardized Spend per Day	Spend relative to average	Average Length of Stay	Count (Volume sent to SNF)	Distribution (% sent to SNF)
↑	↑	↑	↑	↑	↑
[SNF]	$	%	#	#	%
[SNF]	$	%	#	#	%
Average	$	%	#	#	%
[SNF]	$	%	#	#	%
[SNF]	$	%	#	#	%
↓	↓	↓	↓	↓	↓

Hospital-specific data (QNET) can be used to evaluate all-cause readmissions and relationship to MSPB

- For systems: what are drivers of variation in all-cause readmission rates? Can best practices be shared? Is there an opportunity to better streamline clinical practice?

Data limitations:
- Reason for readmission
- >1 readmissions

Comparison Factor	Hospital A		Hospital B		etc	
MSPB Ratio	#		#		#	
Readmissions to acute hospital	#	%	#	%	#	%
Readmissions to acute hospital psych unit	#	%	#	%	#	%
Readmissions to index hospital	#	%	#	%	#	%
Post Index Admission to SNF	#	%	#	%	#	%
Post Index Admission to LTCH	#	%	#	%	#	%
Post Index Admission to inpatient rehab facility	#	%	#	%	#	%
Post Index Admission to inpatient psych facility	#	%	#	%	#	%
Etc	↓	↓	↓	↓	↓	↓

Tip:
- *Identify acute readmissions by dissimilar discharge dates (Col. H) and IP End Dates (Col. S) in Episode File*
- *Identify LTCH, IRFs, IPFs, IP psych units by IP Provider #'s 1-5 (Col.'s AT-AX) in Episode File*

Hospital specific data (QNET) can be used to analyze spending by procedure/condition

- MSPB data analysis can aid in bundling efforts
- For systems: *what is driving variation in IP spending, post acute spending, readmission rates, post discharge site of care, etc? Can best practices be shared?*
- Analysis of outliers can further aid care management efforts

Data shortcomings:

- Not risk adjusted
- Data/Hospital specific report does not provide expected-level of spending beyond MDC (can't benchmark against national average or identify areas of opportunity)

Proxy Knee Replacement "Bundle" Average Medicare Spend per Episode	Hospital A	Hospital B	etc.	Comparison
Count	#	#	#	%
Average Total Spend per Episode	$	$	$	%
Average Age	#	#	#	%
Average LOS	#	#	#	%
Average IP Costs (Includes acute, IRF, LTCH, readmissions)	$	$	$	%
Average spend for episodes w/ acute readmission	$	$	$	%
% of episodes w/ readmission to acute hospital	%	%	%	%
Average spend for episodes with IRF services	#	#	#	%
% of episodes with IRF services	*%*	*%*	*%*	%
Average SNF Costs	$	$	$	%
% of Episodes w/SNF services	*%*	*%*	*%*	%
Etc	↓	↓	↓	↓

***Tip**:*

- *Example of proxy knee replacement bundle: DRG 470 **and** Primary Diagnosis Code 71536 (link Episode File with Beneficiary Risk Score File by "HIC_EQ" field)*

CY12 hospital specific data can be compared to CY11 data to evaluate changes in spending

		Hospital A		Hospital B		Etc.		National	
Time Period		**May – Dec'11**	**CY12**	**May – Dec'11**	**CY12**	**May – Dec'11**	**CY12**	**May – Dec'11**	**CY12**
Unadjusted Avg. MSPB	**A**	$	$	$	$	$	$	18,358	18,704
Risk Adjusted Avg. MSPB	**B**	$	$	$	$	$	$	17,994	18,341
Risk Adjusted Episode Spend Yoy % change		**%**		**%**		**%**		**1.93%**	
National Median	**C**	18,307	18,708	18,307	18,708	18,307	18,708	18,307	18,708
PHS MSPB Ratio (B/C = D)	**D**	#	#	#	#	#	#	0.9830	0.9804
MSPB Ratio Yoy % change		**%**		**%**		**%**		**(0.26%)**	
Rounded *(D rounded per Hosp. Compare)*	**E**	**#**	**#**	**#**	**#**	**#**	**#**	**0.98**	**0.98**

- *[It is important to consider external forces on spending that are not captured in data]*

MSPB Data: Take-aways

- National MSPB data (Hospital Compare database) can be used for comparisons to state and national providers
- Hospital-specific, patient-level preview data (QNET) can be used to evaluate potential levers for better-managing Medicare-spending, such as post discharge care patterns, variation in spending between SNFs, all-cause readmissions, and variations in spending by condition
- More-detailed data from CMS (e.g. spending by post-discharge site of care, reasons for readmission, risk-adjusted spending by claim type, expected spending by condition, etc) **is necessary for hospitals to effectively develop and implement cost reduction initiatives**
- Despite limitations, MSPB data has significant potential to aid in cost reduction efforts

Questions?

AAMC