Hospltal Value-Based Purchasing (VBP) Program

Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor

Reviewing Your Fiscal Year 2024 Hospital Value-Based Purchasing Program Medicare Spending per Beneficiary Hospital-Specific Report Presentation Transcript

Speakers

Maria Gugliuzza, MBA
Hospital VBP Program, Lead
Inpatient VIQR Outreach and Education Support Contractor
Sam Bounds
Associate Research Manager, Measure Development Contractor (Acumen, LLC)
Angie Drake
Hospital Quality Reporting Analytics Team

Moderator

Brandi Bryant
Hospital VBP Program, Inpatient VIQR Outreach and Education Support Contractor

July 12, 2023
2:00 p.m. Eastern Time (ET)

Brandi Bryant: Good day. Welcome to today's webinar titled, *Reviewing Your Fiscal Year 2024 Hospital Value-Based-Purchasing Program Medicare Spending per Beneficiary Hospital-Specific Report*. I am Brandi Bryant for the Centers for Medicare & Medicaid Services, representing the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. As the moderator for this session, I will guide you through today's proceedings. Before we commence, I would like to share a few important announcements. Firstly, please note that this webinar is being recorded. In the coming weeks, a transcript of the presentation and a summary of the questions discussed today will be made available on the inpatient website, www.QualityReportingCenter.com. For those who have registered for this event, an email containing a reminder and a link to the slides was sent approximately two hours ago. In case you have not received this email, you can access and download the slides directly from our inpatient website, www.QualityReportingCenter.com.

Now, let me introduce the distinguished speakers for today's session. We are privileged to have Maria Gugliuzza, serving as the Hospital Value-Based Purchasing Program Lead for the Inpatient VIQR Outreach and Education Support Contract. Also joining us is Sam Bounds, who holds the position of Associate Research Manager at Acumen, LLC. Lastly, we are honored to have Angie Drake from the Hospital Quality Reporting Analytics Team. Please join me in welcoming our esteemed speakers.

During today's event, we will delve into the Medicare Spending per Beneficiary, or MSPB, measure and explore Hospital-Specific Reports, or HSRs, in detail. Our discussion will encompass the objectives of the MSPB measure, the methodology employed to calculate the measure, as well as the necessary steps involved in performing MSPB measure calculations. Additionally, we will guide you on how to submit a review and correction request and give instructions on accessing the MSPB HSRs through the *Hospital Quality Reporting Secure Portal*.

During this session, you will gain an understanding of the goals of the MSPB measure, refresh your knowledge of the methodology used for the MSPB measure, learn how to access and review the HSR, and understand the process for submitting a review and correction request.

Before we move forward, let's take a brief moment to acquaint ourselves with key acronyms that we will reference throughout this webinar.

Now, I would like to invite our first speaker, Maria, to take the floor to begin her presentation. Maria, over to you.

Maria Gugliuzza Thank you, Brandi. I am Maria Gugliuzza, and I will be guiding you through important aspects related to the MSPB measure. Specifically, I will discuss the measurement period associated with the MSPB measure and provide instructions on accessing the HSRs through the *Hospital Quality Reporting Secure Portal*.

The delivery of the MSPB HSR to hospitals was completed on June 9, 2023. Although there is only one HSR for MSPB, it serves two important purposes. Firstly, the HSR acts as a means for hospitals to review the calculations of the measure. It allows hospitals to carefully assess the accuracy of the calculations and, if necessary, request corrections to be made as part of the Hospital VBP Program. Secondly, the HSR plays a crucial role in the preview period prior to the results being publicly reported during the January 2024 refresh. It provides hospitals with an opportunity to preview the results and gain insights before they are made available to the public. Overall, the MSPB Hospital-Specific Reports serve as both a tool for hospitals to review and request corrections and as a preview of the upcoming public reporting of results.

The HSR exclusively includes performance period data for the Hospital VBP Program. It provides a comprehensive overview of your hospital's performance during that specific period. For baseline results, you can refer to your hospital's fiscal year 2024 Hospital VBP Program Baseline Measures Report.

This report specifically outlines the baseline measures for your hospital, allowing for a comparison against the performance period data presented in the HSR. Together, these reports provide a comprehensive view of your hospital's performance and progress within the Hospital VBP Program.

On the following two slides, we will guide you through the process of downloading your fiscal year 2024 Baseline Measures Report.

By following these instructions, you will be able to successfully download and access your fiscal year 2024 Baseline Measures Report for comprehensive insights into your hospital's performance.

Now, let's proceed to discuss how you can access your Hospital-Specific Reports.

The Hospital-Specific Reports became available for download on June 9, 2023. A notification was sent via email to individuals who are registered to receive updates regarding the Hospital IQR and Hospital VBP Programs on QualityNet. The email communication informed recipients about the availability of the reports and included instructions on how to access them. It also provided details on the updated measurement periods, guidance on submitting review and correction requests, and information on where to direct any questions or inquiries. By receiving this email, registered individuals were promptly informed about the release of the HSRs, ensuring that they had the necessary information to access and utilize the reports effectively.

In this slide, we will discuss the steps to download the FY 2024 MSPB HSR from the *HQR Secure Portal* system. Please follow these instructions to access your HSR.

In the final segment, I intend to explore the steps involved in requesting a correction to the calculation, as well as the appropriate individuals to approach for inquiries regarding the HSRs.

Following the release of the HSR, hospitals have a 30-day window to review and request corrections to the MSPB measure results. The review and correction period concludes on July 12.

To submit a request, please adhere to the instructions provided on this slide. It is important to note that, similar to other claims-based measures, hospitals are not permitted to submit additional corrections to the underlying claims data or request the inclusion of new claims in the calculations.

If you have any inquiries regarding the HSRs, kindly submit your questions using the questions and answers tool on QualityNet. To ensure optimal assistance, please select the appropriate program and topic based on your question's subject. If you encounter any difficulties accessing your HSR through the *Hospital Quality Reporting Secure Portal* or reviewing your HARP permissions, please reach out to the CCSQ Service Center.

Now, I would like to hand the presentation over to Sam Bounds.

Sam Bounds: Hi. My name is Sam Bounds. I'm an Associate Research Manager at Acumen, LLC, the measure development contractor for the MSPB measure. Today, I'll be going over the methodology and calculation of the measure.

The MSPB measure evaluates hospital efficiency relative to the national median hospital. Specifically, the MSPB measure evaluates the cost to Medicare for services performed by hospitals and other healthcare providers during an MSPB episode. An MSPB episode includes all Medicare Part A and B claims during the periods immediately prior to, during, and after a patient's hospital stay.

The MSPB measure is the sole efficiency measure in the Hospital Value-Based Purchasing Program, also known as the Hospital VBP Program. The measure was included starting in fiscal year 2015, and the measure was required for inclusion by the Social Security Act and is endorsed by the National Quality Forum. More measure details are included in the

fiscal year 2012 and 2013 Inpatient Prospective Payment System final rules. The links are included on this slide.

The MSPB measure was comprehensively re-evaluated in 2020 and re-endorsed in 2021 as part of the measure maintenance process. This re-evaluated MSPB measure was adopted in the Hospital Inpatient Quality Reporting, or IQR, Program in the fiscal year 2023 Inpatient Prospective Payment System final rule. The fiscal year 2024 Inpatient Prospective Payment System proposed rule proposed to adopt this re-evaluated MSPB measure into the Hospital VBP Program under the Efficiency and Cost Reduction domain, beginning with the calendar year 2026 performance period, affecting the payment year or fiscal year 2028. The links are included on this slide.

The re-evaluated MSPB measure, currently in the Hospital IQR Program, differs in three ways from the MSPB measure currently in the Hospital VBP Program, the measure that we're discussing today. First, the re-evaluated measure allows acute care hospital readmissions to trigger an MSPB Hospital episode. Readmissions are defined as an acute care hospitalization occurring within 30 days of another hospital discharge. Second, it includes an indicator variable in the risk adjustment model that accounts for these episodes that are readmissions. Third, the re-evaluated measure has a slight change in the measure score calculation, which imposes equal weighting to each hospital's MSPB Hospital episodes.

This table provides a visual of the differences I just explained between the two versions of the measure. Allowing readmissions to trigger new episodes increases the number of episodes for which a provider can be scored and aligns the incentives of the measure during readmissions. Adding a new indicator variable in the risk adjustment model for readmissions helps account for the differences in expected costs for episodes that are triggered by readmitted stays to ensure that a hospitals are not unfairly penalized. Finally, changing the measure score calculation methodology slightly increases the measure reliability with minimal score changes, imposes equal weights to each hospital's attributed episodes, and minimizes the impact of outlier episodes.

That concludes a high-level overview of how the two versions of the MSPB measure differ in each program.

Now we want to shift our focus back onto the MSPB measure in the Hospital VBP Program. In conjunction with the Hospital Value-Based Purchasing Program quality measures, the MSPB measure aims to promote more efficient care for beneficiaries by financially incentivizing hospitals to coordinate care, reduce system fragmentation, and improve efficiency. For example, hospitals can improve efficiency through actions, such as improving coordination with pre-admission and post-acute providers to reduce the likelihood of a readmission. All subsequent slides describe the methodology and calculation of the MSPB measure in the Hospital VBP Program.

The MSPB measure is a claims-based measure that includes price standardized payments for Part A and Part B services. A hospital admission, indicated by the large, striped triangle on the slide, is also known as the "index hospital admission." An index hospital admission is the signal to initiate and measure an episode of care within the MSPB Hospital measure. As detailed on the present slide, the three days prior to an index hospital admission through 30 days after the hospital discharge constitutes an episode of care and is the duration for which Part A and Part B service cost will be assessed.

The MSPB measure is based on all MSPB episodes that an Inpatient Prospective Payment System, or IPPS, hospital has during a period of performance. As previously noted, an MSPB episode includes all services provided three days before the hospital admission through 30 days post-hospital discharge. The reason why an episode includes three days prior to hospital admission is to include diagnostic or pre-operative services that are related to the index admission. Including services that are 30 days after the discharge emphasizes the importance of coordinating care transitions and mitigating complications of care. The population of hospital admissions that qualify as an MSPB episode excludes the following scenarios to create a more homogenous study group: Admissions that occur within 30 days of discharge of another index admission; transfers

between acute care hospitals for both the transferring and receiving hospital; episodes where the index admission claim has 0 dollars payment; and, lastly, admissions having a discharge date fewer than 30 days prior to the end of a measure performance period.

Episodes are used in the MSPB measure to calculate a Hospital MSPB amount. An MSPB amount is the sum of all standardized and risk-adjusted spending across all of the hospital's eligible episodes divided by the number of episodes. In other words, it's a hospital's average risk-adjusted spending across the hospital's attributed episodes. In later slides detailing the calculation steps, we'll cover how the risk-adjusted spending of an episode is determined. The MSPB Amount is a representation of how efficiency is measured. The MSPB measure is then defined as the hospital's MSPB amount divided by the episode-weighted, median MSPB amount across all hospitals. This transformation step from the MSPB Amount to the MSPB measure normalizes the measure score so that it can be interpreted as a ratio of a hospital's cost efficiency in comparison to the national median.

An MSPB measure that is less than 1 indicates that a given hospital spends less than the national median MSPB amount across all hospitals during a given performance period. Improvement on this measure for a hospital would be observed as a lower MSPB measure value across performance periods. For example, a hospital would have improved in their MSPB measure if they had a measure value of 1.05 in the 2018 baseline period and then that decreased to 1.01 in the 2020 performance period. Now, we do want to take a moment to point out that the MSPB measure alone does not necessarily reflect the quality of care provided by hospitals. The MSPB measure is most meaningful when presented in the context of other quality measures, which is why the MSPB measure is combined with other measures in the Hospital Value-Based Purchasing Program to provide a more comprehensive assessment of hospital performance.

Now that I've gone over the definitions of key terms and how to interpret the MSPB measure, this slide will discuss what populations

of beneficiaries are included and excluded when calculating a hospital's measure.

Beneficiaries are those who are enrolled in Medicare Parts A and B from 90 days prior to the episode through the end of the episode and who are admitted to subsection (d) hospitals. Beneficiaries that are excluded are those enrolled in Medicare Advantage, those who have Medicare as a secondary payer, or those who died during the episode.

The next section of this presentation will go through the steps to calculate the hospital's MSPB measure in detail. There are eight calculation steps and one reporting step that we will walk through over the next several slides. The first step is to standardize claim payments so that spending can be compared across the country. The second step is to calculate the standardized episode spending for all episodes in a hospital. The third step is to estimate the expected episode spending using linear regression and, in the fourth step, all extreme values produced in Step 3 are Winsorized. The fifth and sixth step is to calculate the residuals for each episode so that we can exclude outlier episodes. The seventh step is to calculate the MSPB amount for each hospital. The eighth step is to calculate the MSPB measure for a hospital based on the MSPB amount. Finally, in Step 9, we report the MSPB measure for the Hospital Value-Based Purchasing Program for eligible hospitals.

In Step 1, claims payments are standardized to adjust for geographic differences and payments from special Medicare programs that are not related to resource use, such as hospital graduate medical education funds for training residents. However, payment standardization maintains differences that result from healthcare delivery choices, such as the setting where the service is provided, specialty of the provider, the number of services provided in the same visit, and outlier cases. For more information and the full methodology that's used in calculating standardized payments, you can refer to the documents on this ResDAC website.

In the second step, all standardized Medicare Part A and B claim payments during MSPB episodes are summed. Payments are defined as

Medicare allowed amounts, which includes patient deductibles and co-insurance. A claim is defined as occurring during an episode based on the from date, or the start date variable.

This means if a claim starts during the MSPB episode and extends beyond 30 days after hospital discharge, the entire claim will be included without proration.

The third step is to calculate the expected episode spending amount. In this step, the episode spending amount is adjusted for age, severity of illness, and comorbidities. Specifically, to account for case-mix variation and other factors across hospitals, a linear regression is used to estimate the relationship between a number of risk adjustment variables and the standardized episode cost calculated in Step 2. Risk adjustment variables include factors such as age, severity of illness, and comorbidity interactions. Severity of illness is measured using several indicators, including the Hierarchical Condition Categories, or HCCs; the admission MS-DRG; end stage renal disease; reason for Medicare entitlement through disabilities, and long term care institutionalized patients. The expected spending for each episode is calculated by using a separate risk-adjusted model for episodes within a Major Diagnostic Category, or MDC. The MDC of an episode is determined by the Medicare Severity Diagnosis-Related Group, or the MS DRG, of the index hospital stay.

In the regression model in Step 3, many variables are included to more accurately capture beneficiary case mix. However, a risk of using a large number of variables is that the regression can produce some extreme predicted values due to having only a few outlier episodes in a given cell. In the fourth step, extremely low values for expected episode spending are Winsorized, or bottom coded. That is, for each Major Diagnostic Category, episodes that fall below the 0.5 percentile of the Major Diagnostic Category's expected cost distribution are identified. Next, the expected spending of those extremely low spending episodes are set to the 0.5 percentile. Lastly, the expected spending scores are renormalized to ensure that the average expected episode spending level for any Major Diagnostic Category is the same before and after Winsorizing. This

renormalization is done by multiplying the expected spending by the ratio of the average expected spending level within each MDC and average Winsorized expected spending level within each MDC.

In the fifth and sixth step, we calculate the residual for each episode to exclude outliers. The residual is calculated as the difference between the standardized episode spending, which was calculated in Step 2, and the Winsorized expected episode spending, which was calculated in Step 4. Outlier episodes are identified and then excluded to mitigate the effect of high-spending and low-spending outliers for each hospital's MSPB measure. Spending far above the expected spending as predicted through risk adjustment are identified when the residuals fall above the 99th percentile of the residual distribution across the total episode population. Inversely, episodes spending much lower than predicted are identified when the residual falls below the first percentile. After excluding outliers, the episode expected cost is renormalized again to ensure that the average expected spending is the same as the average standardized spending after outlier exclusions.

In the seventh step, the risk-adjusted MSPB amount is calculated as the ratio of the average standardized episode spending by the average expected episode spending. This ratio is then multiplied by the average spending level across all hospitals, a constant which transforms the metric back into dollars.

In the eighth step, the MSPB measure is calculated as a ratio of the risk-adjusted MSPB amount for a given hospital, as calculated in the previous step, and the national, episode-weighted, median MSPB amount. This final calculation step is a transformation so that the measure can be interpreted respective to the national median.

In the last step, the MSPB measure of hospitals that are eligible for the Hospital Value-Based Purchasing Program and have at least 25 episodes is reported and used for payment purposes. Hospitals with 24 or fewer episodes will not have the MSPB measure used for payment purposes or publicly reported.

Now that we've gone over how to calculate the MSPB measure, these next several slides will walk through the calculation for an example hospital.

In this example, Hospital A has 30 MSPB episodes ranging from $1,000 to $33,000 in standardized episode spending. After applying Steps 1 through 4 of the calculations, each episode will have an observed standardized episode spending and a Winsorized expected episode spending as predicted through risk adjustment. We see that the hospital has one episode with the residual higher than the 99th percentile. The residual is calculated as a difference between the standardized episode spending and the Winsorized expected episode spending. This episode is considered an outlier and excluded. The MSPB amount and the MSPB measure will then be calculated based on the remaining 29 episodes for Hospital A.

The MSPB amount for Hospital A is then calculated as the ratio of the average standardized episode spending across Hospital A's 29 episodes and the average expected episode spending across these same episodes. The ratio is multiplied by the average episode spending across all hospitals. So, for Hospital A the MSPB amount is $8,462.

Next, the MSPB measure for Hospital A is calculated as the ratio of the MSPB amount, which we calculated in the previous slide, divided by the national episode weighted median MSPB amount. So, let's pretend that the national episode weighted median MSPB amount is $9,100. As a result, our example hospital would then have an MSPB measure of 0.93. Since our example hospital has 29 episodes, which exceeds the reporting case minimum of 25 episodes, its MSPB measure will be reported and used in the Hospital Value-Based Purchasing Program.

I'll now hand the presentation over to Angie Drake to discuss the Hospital-Specific Reports and supplemental files.

Angie Drake: Thank you, Sam. My name is Angie Drake, and I am the Delivery Manager on the Healthcare Quality Reporting Analytics team. Today, I am

going to provide an overview of the Medicare Spending Per Beneficiary Hospital-Specific Report and supplemental data files.

During the preview period, hospitals can review their MSPB measure results in their HSR. The MSPB HSR includes six tables and is accompanied by three supplemental hospital-specific data files. Tables include the MSPB measure results of the individual hospital and of other hospitals in the state and nation. In addition to the MSPB measure, the HSR includes the major components used to calculate the MSPB measure: Average Spending per Episode, Average Risk-Adjusted Spending or MSPB Amount, Number of Eligible Admissions, and National Median MSPB Amount for the hospital, state, and the nation. The three supplemental hospital-specific data files contain information on the admissions that were considered for the individual hospital's MSPB measure and data on the Medicare payments to individual hospitals and other providers that were included in the measure. A separate PDF Hospital User Guide, or HUG, will accompany the HSR that includes additional information about the data in the HSR and supplemental files.

Table 1 displays your hospital's MSPB measure. The MSPB Measure is calculated as the ratio of the payment-standardized, risk-adjusted MSPB Amount for the hospital divided by the episode-weighted median MSPB Amount across all hospitals. A MSPB Measure of greater than 1 indicates that the hospital's MSPB Amount is more expensive than the U.S. National Median MSPB Amount. A MSPB Measure of less than 1 indicates that the hospital's MSPB Amount is less expensive than the national median MSPB amount.

Table 2 provides a summary of your hospital's individual MSPB performance. It includes the number of eligible admissions at your hospital and the MSPB Amount for your hospital, the state, and the nation during the performance period from July 1, 2022, through December 31, 2022.

Table 3 is the comparison of the hospital's MSPB performance. This table displays the major components used to calculate an individual hospital's

MSPB measure, including the number of eligible admissions, MSPB amounts, and the national median MSPB amount.

The following data are included in Table 3 for your hospital, state, and the nation: The number of eligible admissions is the number of episode-establishing index admissions. The average spending per episode is the average spending for non-risk-adjusted services provided to a Medicare beneficiary during an episode. The MSPB Amount is the average payment-standardized, risk-adjusted Medicare Part A and Part B payments included in the MSPB measure for episodes that occur during the discharge period. The fiscal year 2024 MSPB performance period is January 1, 2022, through December 31, 2022. The performance period is different from the episode restriction period because the entire 90-day look-back period and the entire 30-day post-discharge period must fall within the performance period. The U.S. national median MSPB amount is the same for your hospital, state, and the nation. The MSPB Measure is the ratio of the MSPB Amount divided by the U.S. national median MSPB Amount. Only the MSPB Measure will be publicly reported. Hospitals with fewer than 25 episodes will not have their MSPB Measure publicly reported. Only state and U.S. national values will be posted in that instance.

Table 4 displays the national distribution of the MSPB measure by percentile across all hospitals in the nation. This data are the same for all hospitals.

The graph on this slide provides a visual representation of the national distribution of the MSPB measure found in the HSR User Guide. The graph includes hospitals with an MSPB Measure between 0.45 and 1.5, representing 99.8 percent of hospitals. Hospitals outside of this range were excluded to ensure the figure is readable.

Table 5 provides a detailed breakdown of the individual hospital's spending by seven claim types and three time periods: three days prior to index admission, during the index admission, and 30 days after hospital discharge. Spending levels are broken down by claim type within each of these time periods. Hospitals can compare the percentage of total average

episode spending by claim type and time period to the percent of total average spending at hospitals in their state and the nation.

The values included in Table 5 represent the average actual standardized episode spending amount. Please note that the spending amounts are not risk-adjusted for hospital case mix because risk adjustments are performed at the Major Diagnostic Category, MDC, level.

In this example, the hospital spent an average of $12,422 dollars for inpatient claims during the index admission. This represents 45.0 percent of total episode spending for the hospital.

Table 5 also allows us to compare the percent of total average spending in an individual hospital to the percent of spending at the state and national levels. The red box highlights the comparison that we can make for the percent of spending on inpatient claims during the index hospital admission. In this example, the hospital spends 45.0 percent of episode spending on inpatient services. This is lower than the percent of spending in the state, which is 47.8 percent, and the nation, which is 48.1 percent. A lower percentage of spending in an individual hospital for a given time period and claim type indicates that the individual hospital spends less than other hospital's in their state and the nation. Alternatively, a higher percent of spending in an individual hospital, when compared to the percent of spending in their state and the nation, indicates that the individual hospital spends more than the other hospitals in the state and the nation.

Table 6 provides a breakdown of average, actual, and expected spending for an MSPB episode by major diagnostic category, or MDC. Hospitals can compare their average, actual, and expected spending to the state and national average, actual, and expected spending.

In this example, we can look at the hospital's average, actual, and expected spending per episode for the Major Diagnostic Category, MDC, for Ear, Nose, Mouth, and Throat. The hospital's average, actual, and expected spending per episode are found in Columns C and D. This

hospital has an average actual spending of $16,592 per episode compared to an average expected spending of $17,087 per episode.

Table 6 also allows us to compare the average, actual, and expected spending of the individual hospital to the spending level in their state and the nation. For episodes included in the MDC for Ear, Nose, Mouth and Throat, let's look at Columns G and H and identify the national average, actual, and expected spending, which we see as being about $16,600 per episode. Hospitals can compare their average expected spending per episode, found in Column D, to the national average expected spending per episode, found in Column H. In this example, the hospital had an average expected spending of $16,662. Here, we see that this hospital has a higher than average expected spending per episode than the nation.

Accompanying your MSPB HSR are three supplemental hospital-specific data files: the Index Admission File, the Beneficiary Risk Score File, and the Episode File. These files contain information on the admissions that were considered for inclusion in the MSPB measure calculation for your hospital. The Index Admission File presents all inpatient admissions for your hospital in which a beneficiary was discharged during the period of performance. This file indicates whether or not an inpatient admission was counted as an index admission and, if not, it provides the reason for exclusion. For each inpatient admission, the file provides dates of admission and discharge, length of stay, diagnosis codes, Major Diagnostic Category (MDC), and actual payment amounts. The Beneficiary Risk Score File identifies beneficiaries and their health status based on the beneficiary's claims history in the 90 days prior to the start of an episode. This file includes the predicted payment amount and the risk adjustors used in the MSPB risk-adjustment regression model. The Episode File identifies the type of care, spending amount, and the top five billing providers in each care setting for each MSPB episode at your hospital, allowing you to identify the type of inpatient provider that is billing the most for the given episode. The information included in the three supplemental hospital-specific data files is not publicly reported. This concludes the MSPB HSR and supplemental file overview. Now,

I'd like to turn it over to Brandi for the question-and-answer portion of the presentation.

Brandi Bryant: Thank you, Angie. We will now address some of the questions that were submitted during the webinar. If you have any additional questions, please include the slide number related to your question. Why are beneficiaries required to be continuously enrolled in Part A/B for the 90 days prior to the episode start date?

Sam Bounds: The 90 days prior to an episode is used to define a beneficiary's characteristics to predict expected spending during risk adjustment. Since the measure is based on Part A and Part B claims, enrollment during this period is required so that the beneficiary's risk factors can be appropriately observed through the claims data used.

Brandi Bryant: Can you explain what is meant by risk adjustment?

Sam Bounds: Risk adjustment predicts the expected costs of an MSPB episode by adjusting for factors outside the hospitals reasonable influence that can impact spending, such as pre-existing health conditions or age. A linear regression is used to predict the coefficient for each indicator in the model. These coefficients represents the mean difference in episode spending when the health condition is present. For example, if we observe that patients with ESRD are more expensive that non-ESRD patients, holding all other covariates constant, then the mean difference in episode spending observed in the population for ESRD patients will be added to the expected cost of an episode for an ESRD patient. This adjustment prevents disadvantaging episodes that serve riskier patients.

Brandi Bryant: Do we want a higher or lower value for the MSPB measure?

Sam Bounds: An MSPB measure of greater than 1 indicates that your hospital's MSPB amount is more expensive than the U.S. national median MSPB amount. An MSPB measure of less than 1 indicates that your hospital's MSPB amount is less expensive than the U.S. national median MSPB amount. Lowering of an MSPB measure score indicates improvement on the measure. The MSPB measure should be viewed in the context of other

measures to evaluate the quality of care. The MSPB measure is not the only measure by which CMS evaluates hospitals.

Brandi Bryant: Has the MSPB Hospital measure calculation changed from last year?

Sam Bounds: There have been no changes to the MSPB Hospital methodology and calculation for the MSPB measure currently in the Hospital VBP Program. The measure was re-evaluated to adopt three changes to its methodology and calculation, but this re-evaluated version of the measure is currently only included in the Hospital IQR Program, proposed to be adopted in the Hospital VBP Program for the fiscal year 2028 payment determination.

Brandi Bryant: What is the achievement threshold and benchmark for MSPB in fiscal year 2024?

Maria Gugliuzza: The benchmark and achievement threshold values are calculated for the MSPB measure using performance period data instead of baseline period data. As a result, these values will be available when the Percentage Payment Summary Report is added to the user interface.

Brandi Bryant: What is a subsection (d) hospital?

Maria Gugliuzza A Medicare subsection (d) hospital is a general, acute care, short-term hospital paid under the Inpatient Prospective Payment System, IPPS.

Brandi Bryant: Will critical access hospital's receive a fiscal year 2024 MSPB HSR?

Maria Gugliuzza The MSPB Measure calculation only includes hospitals subject to the IPPS. As a result, critical access hospitals are excluded from the MSPB calculation and will not receive an MSPB HSR.

Brandi Bryant: If a hospital had less than 25 episodes, will it still be possible to download an MSPB HSR from the *HQR Secure Portal*? If not, how can we determine if we have not met the threshold?

Maria Gugliuzza Certainly! If a hospital had less than 25 episodes and measure results for the abbreviated time period, it would indeed receive an MSPB HSR,

Medicare Spending per Beneficiary Hospital-Specific Report, for the fiscal year 2024.

Brandi Bryant: It seems that we have run out of time to answer further questions.

If your question was not addressed and you still require information regarding measures, HSRs, or the Hospital VBP Program, please submit your questions via the Question & Answer Tool on QualityNet.

Once again, we appreciate your participation and hope you have a wonderful day.