



Hospital Value-Based Purchasing (VBP) Program

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

Reviewing Your FY 2025 Hospital VBP Program Medicare Spending per Beneficiary Hospital-Specific Report Presentation Transcript

Speaker

Maria Gugliuzza, MBA

Hospital VBP Program, Lead

Inpatient VIQR Outreach and Education Support Contractor

Sarah Sabbagh

Policy Associate

Acumen, LLC, Measure Development Contractor

Mike Miller

Hospital Quality Reporting Analytics Team

Moderator

Brandi Bryant

Hospital VBP Program, Inpatient VIQR Outreach and Education Support Contractor

June 5, 2024

2:00 p.m. Eastern Time

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Brandi Bryant: Hello. Welcome to today's webinar, titled *Reviewing Your FY 2025 Hospital VBP Program MSPB Hospital-Specific Report*. I am Brandi Bryant from 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, or VBP, Program Lead for the Inpatient VIQR Outreach and Education Support Contract. Also joining us is Sarah Sabbagh, who holds the position of Associate Research Manager at Acumen, LLC. Lastly, we are honored to have Mike Miller 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, along with instructions on accessing the MSPB HSRs through the *Hospital Quality Reporting Secure Portal*.

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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 the key acronyms that will be referenced throughout this webinar.

Now, I would like to turn it over to our first speaker. Maria, the floor is yours.

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 Medicare Spending per Beneficiary Hospital-Specific Reports to hospitals was completed by May 30, 2024. 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 2025 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 FY 2025 Hospital VBP Program Baseline Measures Report.

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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 FY 2025 Baseline Measures Report.

By following these instructions, you will be able to successfully download and access your FY 2025 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 May 30, 2024. A notification was sent via email to individuals who are registered to receive updates regarding the Hospital IQR and Hospital Inpatient VBP Program 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 they had the necessary information to access and utilize the reports effectively.

In this slide, we will discuss the steps to download the FY 2025 MSPB HSR from the Hospital Quality Reporting system. Please follow these instructions to access your HSR.

In my 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.

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The review and correction period concludes on July 1, 2024. 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 [question and answer 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 over the presentation to Sarah. Sara, the floor is yours.

Sarah Sabbagh:

Thank you. Hi, my name is Sarah Sabbagh. I'm a Policy Associate at Acumen, LLC, the measure development contractor for the MSPB Hospital measure. Today, I'll be going over the methodology and calculation of the measure.

The MSPB Hospital measure evaluates hospitals' efficiency relative to the national median hospital. Specifically, the MSPB Hospital 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 Parts A and B claims during the periods immediately prior to, during, and after a patient's hospital stay.

The MSPB Hospital measure is the sole efficiency measure in the Hospital Value-Based Purchasing, or VBP, Program. The measure was included starting in fiscal year 2015, and the measure was required for inclusion by the Social Security Act. More measure details are included in the fiscal year 2012 and 2013 IPPS final rules. The links are included on this slide.

The MSPB Hospital measure was comprehensively re-evaluated in 2020 and re-endorsed in 2021 as part of the measure maintenance process.

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This re-evaluated measure was adopted in the Hospital Inpatient Quality Reporting, or IQR, Program starting in the fiscal year 2024, and it has been finalized for adoption in the Hospital VBP Program starting in the fiscal year 2028 payment year and subsequent years. Per statutory requirements, measures in the Hospital VBP Program must be publicly reporting for at least one year prior to the beginning of the performance period. The re-evaluated measure is set to be removed from the Hospital IQR Program once it's adopted in the Hospital VBP Program as a way to reduce the burden that would arise from duplicative reporting of the measure in a quality reporting program and value-based program.

The re-evaluated MSPB Hospital measure currently in the Hospital IQR Program differs in three ways from the MSPB Hospital measure currently in the Hospital VBP Program, the measure we're discussing today. The table on this slide provides a summary of these differences as well as the rationale and benefit of each refinement that you can reference. At a high-level, the first difference is that the re-evaluated measure allows acute care hospital readmissions to trigger an MSPB Hospital episode. Second, the re-evaluated measure includes an indicator variable in the risk adjustment model to account for the differences in expected costs for episodes that are triggered by readmission to ensure that hospitals are not unfairly penalized. Third, the re-evaluated measure has a slight change in the measure score calculation.

By measuring costs of care through the MSPB Hospital measure, CMS hopes to increase the transparency of care for consumers and recognize hospitals that are involved in the provision of high-quality care at lower cost to Medicare. Under the Hospital IQR Program, CMS collects data from hospitals paid under IPPS, with the goal of driving quality and cost improvement through measurement and transparency by publicly displaying data. The Hospital VBP Program is intended to assess hospital efficiency and resource use and encourage hospitals and clinicians to improve the quality of inpatient care and adjusts Medicare payments to reward hospitals based on the care they deliver.

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That concludes a high-level overview of how the two versions of the MSPB Hospital measure differ in each program. Now, we want to focus back on the MSPB Hospital measure in the Hospital VBP Program. In conjunction with the Hospital VBP Program quality measures, the MSPB Hospital measure aims to promote more efficient care for beneficiaries by financially incentivizing hospitals to coordinate care, reduce system fragmentation, and improve efficiency. All subsequent slides are going to describe the methodology and calculation of the MSPB Hospital measure in the Hospital VBP Program.

The MSPB Hospital 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 this 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 Hospital measure is based on all MSPB episodes that an 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 discharge emphasizes the importance of coordinating care transitions and mitigating complication 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 hospitals for both the transferring and receiving hospital; episodes where the index admission claim has zero dollars payment; and lastly admissions having a discharge date fewer than 30 days prior to the end of a measure performance period.

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Episodes are used in the MSPB Hospital measure to calculate a hospital's 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. 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 Hospital 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. Better performance on the measure for a hospital would be observed as a lower MSPB measure value. We do want to point out that the MSPB Hospital measure alone does not necessarily reflect the quality of care provided by hospitals. The MSPB Hospital measure is most meaningful when presented in the context of other quality measures, which is why the MSPB Hospital measure is combined with other measures in the Hospital VBP Program to provide a more comprehensive assessment of hospital performance.

Now that I've gone over the definition of key terms and how to interpret the MSPB Hospital measure, this slide will discuss what populations of beneficiaries are included and excluded when calculating a hospital's measure. Beneficiaries included 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.

Over these next several slides, we'll walk through the steps to calculate the hospital's MSPB measure in detail. There are eight calculation steps and one reporting step. 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.

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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 steps are 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. Finally, in Step 9, we report the MSPB measure for the Hospital VBP 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 made 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 several factors. 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 HCCs. The expected spending for each episode is calculated by using a separate model for episodes within a Major Diagnostic Category, or MDC.

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In the regression model in Step 3, many variables are included to capture beneficiary case mix more accurately. 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 MDC, episodes that fall below the 0.5 percentile of the MDC expected cost distribution are identified. Next, the expected spending of those extremely low spending episodes is set to the 0.5 percentile. Then, the expected spending scores are renormalized to ensure that the average expected episode spending level for any MDC 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 steps, 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 is 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, episodes' 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 into dollars.

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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 relative to the national median.

In the last step, the MSPB measure of hospitals that are eligible for the Hospital VBP 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 a residual higher than the 99th percentile; 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. In this example, the MSPB Amount for Hospital A 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 amount is \$9,100. As a result, our example hospital would then have an MSPB measure of 0.93.

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Since our example hospital here has 29 episodes, which exceeds the reporting case minimum of 25 episodes, its MSPB measure will be reported and used in the Hospital VBP Program. I'll now hand the presentation over to Mike Miller to describe the Hospital-Specific Reports and supplemental files.

Mike Miller:

Thank you. My name is Mike Miller, and I am the Delivery Manager for 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, including measure results for the hospital, plus state and national results. The exported zip file also includes three supplemental hospital-specific data files and a PDF user guide, also known as a HUG, with detailed information regarding the HSR and supplemental files. Let's take a look at the tables in the HSR.

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.

Table 3 is the comparison of the hospital's MSPB performance.

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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 FY 2024 episode restriction period is October 1, 2023, through December 1, 2023. The FY 2024 MSPB performance period is July 1, 2023, through December 31, 2023. Please note that the performance period is different from the episode restriction period because the entire 90-day lookback period and the entire 30-day, post-discharge period must fall within the performance period. The next row is the U.S. national median MSPB Amount, which is the same for your hospital, state, and the nation. Finally, 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. Also note that 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. These 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% 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:

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Three days prior to index admission, during 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 percentage of total average spending at a hospital 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 level.

In this example, the hospital spent an average of \$10,296 for inpatient claims during the index admission. This represents 51.3% 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 seen here on this example highlighted as yellow. In this example, the hospital spends 51.3% of episode spending on inpatient services during the index hospital admission. This is higher than the percent of spending in the state, which is 47%, and the nation, which is 47.6%. A higher percentage of spending in an individual hospital for a given time period and claim type indicates that the individual hospital spends more than other hospitals in their state and the nation. Alternatively, a lower 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 less 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.

In this example, we can look at the hospital's average actual and expected spending per episode for the MDC for Nervous System.

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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 \$20,202 per episode, compared to an average spending of \$23,770 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 Nervous System, let's look at Columns G and H and identify the national average actual and expected spending which we see as being about \$27,600 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 \$23,770. Here, we see that this hospital has a lower 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, 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.

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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 believe it is time for the question-and-answer portion of the presentation.

Brandi Bryant: Thank you. 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 or B for the 90 days prior to the episode start date?

Sarah Sabbagh: 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?

Sarah Sabbagh: Risk adjustment predicts the expected costs of an MSPB episode by adjusting for factors outside of the hospital's reasonable influence that can impact spending, such as pre-existing health conditions or age. A linear regression is used to predict the coefficients for each indicator in the model. These coefficients represent the mean difference in episode spending when the health condition is present. For example, if we observe that patients with ESRD are more expensive than 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 ESRD patients. This adjustment prevents disadvantaging episodes that serve riskier patients.

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

Sarah Sabbagh: 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.

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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 Hospital measure is not the only measure by which CMS evaluates hospitals.

Brandi Bryant: Has the MSPB Hospital measure calculation changed in previous years?

Sarah Sabbagh: There have been no changes to the methodology and calculation for the MSPB Hospital measure that is currently adopted 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, and it is set to be adopted in the Hospital VBP Program starting with fiscal year 2028 payment year and subsequent years.

Brandi Bryant: It seems that that's all the time have for questions today.

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 and Answer Tool on QualityNet](#).

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