Hospital Value-Based Purchasing (VBP) Program

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

Reviewing Your FY 2023 Hospital VBP Program and January 2023 Public Reporting MSPB HSR Question and Answer Summary Document

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Subject-matter experts researched and answered the following questions after the live webinar. The questions may have been edited for grammar.

Question 1: **Why are beneficiaries required to be continuously enrolled in Part A/B for the 90 days prior to the episode start date?**

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.

Question 2: **Can you explain risk adjustment?**

Risk adjustment predicts the expected costs of an Medicare Spending by Beneficiary (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 represents the mean difference in episode spending when the health condition is present.

For example, if we observe that patients with End-Stage Renal Disease (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 ESRD patients. This adjustment prevents disadvantaging episodes that serve riskier patients.

Question 3: **Do we want a higher or lower value for the MSPB measure?**

An MSPB measure of greater than 1 indicates that your hospital's MSPB amount is more expensive than the US national median MSPB amount. An MSPB measure of less than 1 indicates that your hospital's MSPB amount is less expensive than the US national median MSPB amount. Lowering of a 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.

Question 4: **Has the MSPB measure calculation changed?**

No, there have been no changes to the MSPB Hospital calculation methodology.

Question 5: **What is a subsection (d) hospital?**

A Medicare subsection (d) hospital is a general, acute care, short-term hospital paid under the inpatient prospective payment system (IPPS).

Question 6: **Are there any adjustments by region?**

The measure uses standardized allowed amounts. This standardization process removes differences in payment by region that are not related to differences in resource use. This is summarized in slide 38. The full detailed methodology of price standardization is available here: https://resdac.org/articles/cms-price-payment-standardization-overview

Question 7: **If MSPB is risk-adjusted and patient's data are not correctly logged, would this impact the risk adjustment? For example, a patient from a nursing home might be more likely to have a poorer outcome when compared to a healthy, independent patient.**

The covariate to identify patients that are long-term institutionalized in nursing homes is determined using the nursing facility assessment data, Minimum Data Set (MDS). This assessment data are required to be reported regularly. In general, yes, the measure's accuracy is subject to the accuracy of the data reporting inputs. MDS data are processed by CMS and believed to have high accuracy.

Question 8: **Where can you find the national episode-weighted median MSPB amount?**

The U.S. National Median MSPB Amount is on Table 3, Row 4. An example of this table is presented on slide 54.

Question 9: **In Table 5 of the Hospital-Specific Report (HSR), what is included in the claim type of Carrier?**

Carrier claims are Part B Physician and Supplier claims.

Question 10: **Slide 62. If a beneficiary did not seek care in the 90 days before an episode, would they have no documented co-morbid conditions? What if they document a past medical history on admission?**

If no Part B, outpatient, nor inpatient claims occur within the 90 days prior to the episode start, no co-morbid conditions will be identified. The episode will still include the Medicare Severity Diagnosis Related Group (MS-DRG) of the admitting triggering inpatient stay. This includes some level of coding for severity, where patients with Major Complication or Comorbidities are identified with MS-DRGs of higher reimbursement weights.

Question 11: **What is the achievement threshold and benchmark for MSPB in fiscal year (FY) 2023?**

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.