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 Presentation Transcript

Speakers

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Brandi Bryant: Hello. Welcome to today's webinar, *Reviewing Your FY 2023 Hospital VBP Program and January 2023 Public Reporting MSPB HSR*. My name is Brandi Bryant, and I am with the Centers for Medicare & Medicaid Services' Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be the moderator for today's event. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with a summary of the questions asked today, will be posted to the inpatient website, www.QualityReportingCenter.com, in the upcoming weeks. If you registered for this event, a reminder email and a link to the slides were sent out to your email about two hours ago. If you did not receive that email, you can download the slides at our inpatient website, www.QualityReportingCenter.com.

As a reminder, we do not recognize the raised-hand feature in the Chat tool during webinars. Instead, you can submit any questions, pertinent to the webinar topic, to us via the Chat tool. All questions received via the Chat tool during this webinar that pertain to this webinar topic will be reviewed, and a Q&A transcript will be made available at a later date. To maximize the usefulness of the Q&A transcript, we will consolidate the questions received during this event and focus on the most important and frequently asked questions. These questions will be addressed in a question-and-answer transcript, to be published at a later date. Any questions received that are not related to the topic of the webinar will not be answered in the Chat tool, nor in the question-and-answer transcript for the webinar. To obtain answers to questions that are not specific to the content of this webinar, we recommend that you go to the QualityNet Q&A Tool. You can access the Q&A tool using the link on this slide. There, you can search for questions unrelated to the current webinar topic. If you do not find your question there, you can submit your question to us via the Q&A tool, which, again, you can access at the link on this slide.

I would now like to introduce today's speakers. Maria Gugliuzza is the Hospital Value-Based Purchasing Program Lead for the Inpatient VIQR Outreach and Education Support Contract.

Sam Bounds is the Associate Research Manager for Acumen, LLC. Angelia Drake is with the Hospital Quality Reporting Analytics Team.

Today's event will provide an overview of the Medicare Spending per Beneficiary, or MSPB, measure and Hospital-Specific Report, or HSRs. This includes the goals of the MSPB measure, the measure methodology, and the steps to perform MSPB measure calculations. The event will also provide instructions for submitting a review and correction request and accessing the MSPB HSRs from Managed File Transfer (MFT).

Participants will be able to identify the goals of the MSPB measure, recall the MSPB measure methodology, access and review the HSR, and understand how to submit a review and correction request.

This slide displays a list of acronyms that will be used in this webinar. I would now like to pass the presentation to our first speaker. Maria, the floor is yours.

Maria Gugliuzza: Thank you, Brandi. My name is Maria Gugliuzza, and I'll be covering topics, such as the measurement period associated with the MSPB measure and how to access the HSRs in your new Managed File Transfer inboxes.

The Medicare Spending per Beneficiary, MSPB, Hospital-Specific Reports were delivered to hospitals by May 31, 2022. There is only a single HSR for MSPB, but it serves two purposes. The first is to serve as the mechanism in which hospitals can review the calculations of the measure and request corrections to those calculations as part of the Hospital VBP Program. The second is to serve as part of the preview period prior to the results being reported during the January 2023 public reporting refresh.

In this HSR, only performance period data for the Hospital VBP Program will be included. Baseline results for your hospital are available on your hospital's fiscal year 2023 Hospital VBP Program Baseline Measures Report.

This slide provides directions for downloading your fiscal year 2023 Baseline Measures Report.

I will now be discussing how to access your Hospital-Specific Reports.

The Hospital-Specific Reports were delivered to hospitals on May 31, 2022. A Listserve communication was sent via email to those who are registered to receive notifications regarding the Hospital IQR and Improvement Program and the Hospital VBP Program on QualityNet. This email announced that reports would be available no later than May 28, with instructions for accessing the reports, information regarding the updated measurement periods, how to submit a review and correction request, and where to send questions. When your hospital's HSR was delivered to your Managed File Transfer inbox, an auto route file delivery notification was sent to your email. An example of what that email would look like is on this slide.

I know there may be some of you that previously received the HSRs in the old Secure File Transfer auto route inbox that may not have received an email notice this year. When permissions were transitioned to the HQR System, users that were Security Administrators/Officials for their facilities were granted the appropriate roles to see the reports. However, if you are a basic user, those permissions were not automatically placed in your account. To request access to reports that were being sent via Managed File Transfer for your facility, you'll need to request permissions in your profile in the *HQR Secure Portal*. The steps to complete this action are provided in the announcement linked on this slide.

When you've received the email notification that your reports have been delivered to your Managed File Transfer inbox, please follow the steps to access your report. Please note that you'll need to log in to the Managed File Transfer page specifically. Your Managed File Transfer inbox is not located in the *HQR Secure Portal*. When you log in to the Managed File Transfer application, you'll need to use your HARP ID and password. Reports will be available for just 30 days after the delivery. So, if you are interested in reviewing or saving your report, please download those reports soon.

Okay, so what do you do if you didn't receive an email notification stating the report was delivered to your inbox? First, we recommend logging into Managed File Transfer, using the instructions from the previous slide. If the report is not in your inbox, please review your profile in the *HQR Secure Portal* to ensure that you had the auto route IQR and MFT permissions listed on your account. If you do not, you can request these permissions using the instructions detailed in the notification linked on this slide. However, you would need to request that the reports be resent to you after you have the approved permissions to receive the reports. If your profile did have these permissions prior to the start of the deliveries on May 31, please contact the CCSQ Service Center for assistance.

If you need your HSR resent, please follow the instructions on this slide for requesting the report in the QualityNet Question and Answer Tool.

For my last section, I want to discuss the process you would take if you would like to request a correction to the calculation and who to contact if you have questions about the HSRs.

Hospitals may review and request corrections to the MSPB measure results for 30 days following the release of the HSR. The review and correction period ends on June 30. To submit a request, please follow the instructions on this slide. As with other claims-based measures, hospitals may not submit additional corrections to underlying claims data or request that new claims be added to the calculations.

If you have questions regarding the HSRs, please submit the questions via the question-and-answer tool on QualityNet. So that we may best assist you, please follow the program and topic selection based on your question's topic. If you experience issues accessing your HSR from the MFT, or are reviewing your HARP permissions, please contact the CCSQ Service Center. I would now like to pass the presentation over to Sam Bounds. Sam, the floor is yours.

Sam Bounds: MSPB Methodology and Calculation: 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. It 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.

On screen is our agenda for today's presentation, I will go over the goals of the measure, the measure methodology, the specific calculation steps, and an example calculation. Our colleague from the Healthcare Quality Analytics and Reports Contractor will then take us through a tour of the Hospital-Specific Reports and supplemental files, followed by our question-and-answer session.

Goals of the MSPB Measure: 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 re-admission.

Next, I will provide a description of the measure methodology and define a few key terms.

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 hospital, 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 hospitals for both the transferring and receiving hospital; episodes where the index admission claim has $0 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'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 all the hospital-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 a hospital's performance.

Now that I've gone over the definition of key terms and how to interpret the MSPB Measure, this slide will discuss the populations of beneficiaries that 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 a subsection (d) hospital. 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 spending using linear regression.

In the fourth step, all extreme values produced in step three 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 nine, we report the MSPB Measure for the Hospital Value-Based Purchasing Program for eligible hospitals.

In step one, 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 information on the full methodology that's used in calculating standardized payments, you can refer to documents on the 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 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 that was calculated in step two. 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 admitting 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 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 MS-DRG, of the index hospital stay.

In the regression model in step three, 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 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 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 Major Diagnostic Category and the average Winsorized expected spending level within each Major Diagnostic Category.

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 two, and the Winsorized expected episode spending, which was calculated in step four. 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, episode spending that is much lower than predicted is identified when the residual falls below the first percentile. After excluding outliers, an episode's 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.

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 are reported and used for payment purposes. Hospitals with 24 or fewer episodes will not have the MSPB Measure used for payment purposes, nor publicly reported. CMS anticipates refreshing the measure data on Care Compare during January of 2023.

Now that we've gone over how to calculate the MSPB Measure, the 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 one through four 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 amount is $9,100. As a result, our example hospital would then have an MSPB Measure of 0.93. 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 Value-Based Purchasing Program.

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

Angelia Drake: Thank you, Sam. My name is Angelia Drake, and I am the Hospital VBP Project Lead at the Healthcare Quality Analytics and Reports Contractor. 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 US 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, 2021, through December 31, 2021.

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 2023 episode restriction period is October 1, 2021, through December 1, 2021. The fiscal year 2023 MSPB performance period is July 1, 2021, through December 31, 2021.

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 US 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 US 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 US 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. Next slide, please.

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 0.5 and 1.5, representing 99.7 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 the index admission, during 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 by 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 level.

In this example, the hospital spent an average of $16,208 for inpatient claims during the index admission. This represents 65.3 percent of total episode spending for the hospital.

Table 5 also allows us to compare the percentage 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 65.3 percent of episode spending on inpatient services. This is higher than the percent of spending in the state, which is 60.8 percent, and the nation, which is 54.7 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 hospitals in their state and the nation. On the other hand, 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 $16,513 per episode compared to an average expected spending of $15,624 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 about $16,000 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 $15,624. 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 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, 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 for the Q&A portion of the presentation.

Brandi Bryant: Thank you, Angelia. We will now answer some questions submitted during the webinar. If you would like to submit additional questions at this time, please include the slide number associated with your question. The first question: Why are beneficiaries required to be continuously enrolled in Part A or B for the 90 days prior to the episode start date?

Sam Bounds: The 90 days prior to an episode defines a beneficiary's characteristics to predict expected spending during risk adjustment. Since the measure is based on Part A and B claims, enrollment during this period is required so

the beneficiary's risk factors are 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 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 that non-ESRD patients, when 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?

Sam Bounds: 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.

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

Sam Bounds: No, there were no changes to the MSPB hospital calculation methodology.

Brandi Bryant It looks like that is all the time we have for questions today. If your question wasn't answered and you still have questions regarding measures, HSRs, and the Hospital VBP Program, please submit your questions through the Q&A tool on QualityNet. Thank you again for joining. We hope you have a great day.