Hospital Readmissions Reduction Program (HRRP)

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

Overview of the FY 2024 Hospital Readmissions Reduction Program (HRRP) 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: **What is the difference between the HRRP and the Hybrid Hospital-Wide Readmission (HWR) measure?**

HRRP includes six condition- and procedure-specific, claims-based readmission measures.

The HWR measure merges electronic health record data elements with claims data and includes readmissions after applicable hospital admissions for any condition or procedure.

The Hybrid HWR measure is not included in the HRRP or the HRRP Hospital-Specific Report (HSR).

Question 2: **How is the predicted rate calculated? Sometimes it is very different from the raw.**

The predicted 30-day readmission rate for an individual hospital is based on that hospital's performance for its specific patient case mix (the hospital-specific effect on readmissions).

For more information, please refer to the Readmission Measures Methodology page of the CMS QualityNet website: https://qualitynet.cms.gov/inpatient/measures/readmission/methodology

Question 3: **What is the difference between the HRRP and the conditions and procedure readmission rates that are publicly reported on Care Compare?**

The HRRP readmission measure results and the consumer-oriented readmission measures use the same readmission measure methodology and hospital discharge period in a given reporting year, but each includes a different set of hospitals. HRRP includes subsection (d) hospitals, as well as hospitals in Maryland. By contrast, the measure results on Care Compare are calculated among a larger hospital population, including subsection (d) hospitals, Maryland hospitals, and non-subsection (d) hospitals, such as critical access hospitals and hospitals in U.S. territories. Thus, the selection of eligible admissions and readmissions for the HRRP readmission measures will differ from those used in the consumer-oriented readmission measures. Therefore, the results may differ.

The HRRP readmission measure results are publicly reported in the HRRP dataset on the CMS-specified website and are equivalent to results found in the HRRP HSR.

The consumer-orientated readmission measures are publicly reported on the Medicare Care Compare website and are equivalent to results found in the Public Reporting HSR.

Additionally, the Medicare Care Compare website reports the rate of readmission after discharge, whereas the HRRP reports the excess readmission ratio (ERR). The rate of readmission is a risk-standardized readmission rate and is equal to the ERR multiplied by the national observed readmission rate. The ERR is equal to a hospital's predicted readmission rate divided by its expected readmission rate.

More information on how the HRRP readmission measures differ from the consumer-oriented readmission measures is available in Question 54 in the HRRP Frequently Asked Questions document, available on QualityNet at https://qualitynet.cms.gov/inpatient/hrrp/resources.

Question 4: **What's the difference between the predicted rate and the expected rate?**

The predicted readmission rate is the predicted 30-day readmission rate for a hospital based on *that hospital's* performance for its specific patient case mix. (This is its hospital-specific effect on readmissions, reported in its discharge-level data in the HSR.) The expected readmission rate is the expected 30-day readmission rate for a hospital based on readmission rates at *an average hospital* with a patient case mix similar to that hospital's case mix. (The expected readmission rate is if patients with the same characteristics had been treated at an average hospital rather than at that individual hospital.)

Question 5: **Does the payment reduction apply to all Medicare admissions?**

Under HRRP, CMS applies hospital's payment adjustment factors to all Medicare Fee for Service (FFS) base operating diagnosis-related group (DRG) payments. CMS does not apply the payment adjustment factors calculated under HRRP to Medicare Advantage patients.

Question 6: **If a patient has multiple encounters in the same 30-day period, can they only "index" one time?**

For all readmission measures, except the procedure-specific coronary artery bypass graft (CABG) surgery readmission measure, each eligible admission is included as an index admission if it does not occur within 30 days of discharge from another index admission for that measure.

Admissions that occur within 30 days of discharge (within the outcome time frame) from an index admission may be counted as a readmission.

For the CABG readmission measure, if a patient has multiple qualifying CABG surgeries during the measurement period, only the first qualifying CABG admission is included in the measure. This is because CABG procedures are expected to last for several years without the need for revision or repeat revascularization. A repeat CABG procedure during the measurement period likely represents a complication of the original CABG procedure and is a clinically more complex and higher risk surgery.

Lastly, it is important to note that the cohorts for the condition- and procedure-specific readmission measures are determined independently of each other. As a result, a hospitalization that occurs within 30 days of an index admission for one measure may qualify as an index admission for a different measure. The subsequent hospitalization may also be considered a readmission to the preceding admission if it meets the applicable inclusion/exclusion criteria.

For more information, please refer to the Readmission Measures Methodology page on the CMS QualityNet website: https://qualitynet.cms.gov/inpatient/measures/readmission/methodology

Question 7: **What factors go into the hospital's unique case mix when calculating the predicted readmission rate?**

To account for differences in case mix among hospitals, the measures include an adjustment for factors such as age, comorbid diseases, and indicators of patient frailty, which are clinically relevant and have relationships with the outcome of interest. For each patient, risk-adjustment variables are obtained from inpatient, outpatient, and physician Medicare administrative claims data extending up to 12 months prior to the index admission, and all claims data for the index admission itself.

For additional information on how the readmission measures adjust for case mix, please refer to the Readmission Measures Methodology page on the CMS QualityNet website: https://qualitynet.cms.gov/inpatient/measures/readmission/methodology

Question 8: **If a measure is excluded from penalty, how is calculation adjusted?**

The payment reduction is a weighted average of a hospital's performance across the condition- and procedure-specific readmission measures.

If a hospital receives a payment reduction in fiscal year (FY) 2024, one to six readmission measures could be contributing to the payment reduction.

The amount a readmission measure contributes to the payment reduction depends on the readmission measure's ERR, the peer group median ERR, and the readmission measure's DRG payment ratio (the ratio of base operating DRG payments per measure to total base operating DRG payments). A readmission measure contributes to the payment reduction if the ERR is greater than the peer group median ERR and the hospital has 25 or more eligible discharges for the readmission measure. The contribution of the readmission measure to the payment reduction is calculated by first finding the difference between the ERR and the peer group median ERR. That difference is then multiplied by the neutrality modifier and the DRG payment ratio for the condition or procedure.

Question 9: **Do you have advice on how to calculate the predicted readmissions rate over the expected readmission rate?**

The ERR is the risk-adjusted ratio of the predicted readmission rate to the expected readmission rate. The predicted readmission rate is the predicted 30-day readmission rate for your hospital, based on your hospital's performance for your specific patient case mix (your hospital-specific effect on readmissions provided in your hospital's discharge-level data). The expected readmission rate is the expected 30-day readmission rate for your hospital based on readmission rates at an average hospital with a patient case mix similar to your hospital (if patients with the same characteristics had been treated at an average hospital rather than at your hospital).

To calculate the ERR, use the information provided in Table 2, Hospital Results, of your HRRP HSR to divide the predicted readmission rate by the expected readmission rate for each measure.

Replication instructions for calculating the payment reduction percentage and component results are available in the FY 2024 HRRP HSR User Guide on the Reports page on the QualityNet website: https://qualitynet.cms.gov/inpatient/hrrp/reports#tab2

Question 10: **Hospitals in non-Medicaid expansion states are at a disadvantage in the peer groups since the uninsured patients in these states are not eligible for Medicaid and are not included in dual proportion. For safety net hospitals with up to 30 percent of uninsured patients, this is a significant impact and results in increasing health inequity by reducing payments to the hospitals that are the most strained. Has CMS looked into an adjustment for safety net hospitals in non-expansion states?**

CMS is continuing to evaluate and consider how social risk factors affect health outcomes and how its payment programs can address these issues and achieve its goal of health equity for all patients. Any changes to these programs would be adopted through notice and comment rulemaking.

Additional information on the CMS framework for health equity is available on the CMS website: https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/cms-framework-for-health-equity

Question 11: **Can you clarify if the data collection is from all Medicare and dual eligible patients? Also, is that the same population of patients affected by the reimbursement?**

CMS includes Medicare FFS stays only in all components of the payment reduction calculations under HRRP. Patients enrolled in Medicare Advantage are not included in the readmission measures. Similarly, CMS only applies hospital's payment adjustment factors to all Medicare FFS base operating DRG payments.

However, CMS includes both Medicare FFS and Medicare managed care stays in the calculation of the dual proportion (the proportion of Medicare FFS and managed care stays for which the beneficiary was dually eligible for Medicare and full Medicaid benefits).

Question 12: **Were there changes to the pneumonia cohort this year? It was excluded last year.**

CMS resumed use of the pneumonia readmission measure in FY 2024 HRRP payment reduction calculations. CMS paused use of the measure in FY 2023 payment reduction calculations due to COVID-19's substantial impact on this measure (86 FR 45254–45256).

Question 13: **If a patient leaves and comes back the same day, is this considered a readmission if the accounts are combined?**

None of the readmission measures consider patients "readmitted" if the readmission was to the same hospital for the same condition or procedure and on the same calendar day. CMS rules already require prospective payment system (PPS) hospitals to combine same-day, same-condition readmissions into one claim.

However, the readmission measures do consider patients "readmitted" if they had an eligible readmission to the same hospital on the same day, but for a different condition or procedure.

Question 14: **Has CMS considered the effect of the pandemic on Hierarchical Condition Category (HCC) data used for risk adjustment in the HRRP since many primary care offices were closed and patients avoided healthcare? There is the potential for patients with prior HCC history to have no data for the 12 months prior to a readmission.**

CMS updated the specifications for the readmission measures used by the HRRP to exclude Medicare beneficiaries with a principal or secondary diagnosis of COVID-19 coded as Present on Admission (POA) from the measure cohort and outcome. Additionally, each measure was updated to risk-adjust for patients with a clinical history of COVID-19 in the 12 months prior to the index stay.

CMS continues to conduct yearly reevaluation efforts to assess whether to make potential modifications in the measure cohorts, risk models, or outcomes.

Question 15: **How are the peer groups calculated?**

CMS divides hospitals into five similarly sized groups based on their dual proportion (the proportion of Medicare FFS and managed care stays in a hospital during the performance period in which the beneficiary was dually eligible for Medicare and full Medicaid benefits). Hospitals are sorted into one of five peer groups, ranging from peer group assignment 1, which has the lowest dual proportions relative to other HRRP hospitals, to peer group assignment 5, which has the highest dual proportions relative to other HRRP hospitals.