Hospltal Value-Based Purchasing (VBP) Program

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

Overview of the FY 2024 Hospital Readmissions Reduction Program (HRRP) Presentation Transcript

Speakers

Rebecca Silverman
HRRP Analyst
Division of Value, Incentives, and Quality Reporting Program Support Contractor

Maria Gugliuzza, MBA
Hospital VBP Program, Lead
Inpatient VIQR Outreach and Education Support Contractor

Donna Bullock, MPH, BSN, RN
Hospital IQR Program, Lead
Inpatient VIQR Outreach and Education Support Contractor

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Maria Gugliuzza: Greetings! Thank you for joining us for the Hospital Readmissions Reduction Program webinar, where we will provide you with an in-depth look at the highlights for the fiscal year 2024 program year.

Please remember that the raised-hand feature in the Chat tool during webinars is not operational. However, you can engage with us by using the Chat tool, or you can submit questions relevant to the webinar subject. All questions pertaining to the webinar topics submitted through the Chat tool will be reviewed. A transcript of the Q&A session will be created and made available at a later date. To ensure the transcript effectiveness, we will consolidate the questions received and focus on addressing the most significant and frequently posed ones. Please note that only questions related to the webinar's topic will be addressed in the Chat tool and included in the question-and-answer transcript. For queries that are unrelated to this webinar's content, we recommend utilizing the QualityNet Question and Answer Tool. The link to access the QualityNet Question and Answer Tool can be found on this slide. There, you can search for and ask questions unrelated to the current webinar topic. If your question is not answered there, you can still submit it to us through the question-and-answer tool, using the link provided.

I'm Maria Gugliuzza, serving as the Program Lead at the CMS Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be here to guide you through today's webinar. Let me take a moment to introduce our distinguished speaker. Joining us today is Rebecca Silverman. She holds the role of Hospital Readmissions Reduction Program analyst at CMS's Division of Value, Incentives, and Quality Reporting [Program] Support Contractor. We're delighted to have you here, Rebecca, and we extend our gratitude for sharing your insights with us today.

During this event, we will present a comprehensive look at the fiscal year 2024 Hospital Readmissions Reduction Program. The presentation will cover a range of topics, including program enhancements, the methodology employed, insights from the Hospital-Specific Report, and an outline of the review and correction phase.

By the event's conclusion, attendees will have the opportunity to comprehend the program approach, grasp the outcomes of your hospital's program in your Hospital-Specific Report, pose inquiries regarding your hospital's computation throughout the Hospital Readmissions Reduction Program's review and correction period.

During the current presentation, you'll become acquainted with essential acronyms and abbreviations frequently employed within the HRRP. These terms enhance our communication efficiency and often encapsulate intricate notions. Kindly allocate a moment to familiarize yourself with them.

I will now hand over the presentation to our speaker for today's event. We much appreciate it. Rebecca, the presentation is now yours.

Rebecca Silverman: Thank you, Maria. As Maria stated, my name is Rebecca Silverman. I am an HRRP Analyst for the Division of Value, Incentives, and Quality Reporting Program Support Contractor. Today, I am going to discuss background on the Hospital Readmissions Reduction Program, updates to the program for FY 2024, go through an example that explains the program methodology, and describe how hospitals can review their program results for the FY 2024 program year.

The Hospital Readmissions Reduction Program, or HRRP, is a Medicare value-based purchasing program that was established, beginning October 1, 2012, to reduce payments to hospitals with excess readmissions. HRRP supports CMS' goal of improving health care for Americans by linking payment to quality of hospital care. Under HRRP, hospitals are encouraged to improve communication to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions. Hospitals with excess readmissions may receive payment reductions.

HRRP includes all subsection (d) hospitals with eligible discharges for any of the HRRP readmission measures. Typically, HRRP hospitals are general acute care hospitals.

CMS does not include non-subsection (d) units and hospitals in HRRP, such as critical access hospitals, Veterans Affairs medical centers, and acute care hospitals in US territories. CMS exempts Maryland hospitals from HRRP payment reductions because of an agreement between CMS and the state of Maryland. Although Maryland hospitals are exempt from HRRP payment reductions, CMS publicly reports measure results for Maryland hospitals and includes Maryland hospitals in the calculation of excess readmission ratios, or ERRs.

HRRP includes the following condition or procedure-specific, 30-day, risk-standardized, unplanned readmission measures: AMI, COPD, HF, pneumonia, CABG, and elective primary total hip arthroplasty and/or total knee arthroplasty.

For FY 2024, CMS shortened the HRRP performance period due to the Extraordinary Circumstances Exception granted in response to the COVID-19 public health emergency. CMS is not using claims data representing Quarter 1 and Quarter 2 2020, reflecting services provided January 1, 2020, through June 30, 2020, in its calculations for HRRP. The readmission measures used in HRRP identify readmissions within 30 days of each index stay; therefore, the performance period for HRRP will also not use claims data representing the 30 days before January 1, 2020. The FY 2024 performance period for HRRP is July 1, 2019, to December 1, 2019, and July 1, 2020, to June 30, 2022. In addition, as finalized in the FY 2023 IPPS final rule, CMS resumed use of the pneumonia readmission measure in FY 2024 HRRP payment reduction calculations after pausing use of the measure in FY 2023 payment reduction calculations, due to COVID-19's substantial impact on this measure.

From FY 2013 to FY 2018, CMS used a non-peer grouping methodology to assess hospital performance under HRRP. Under the non-peer grouping methodology, CMS used a threshold of 1.0, or the average ERR, for hospitals that admitted similar patients, to assess hospital performance on each measure.

Beginning in FY 2019, the 21st Century Cures Act directed CMS to use a peer grouping methodology to evaluate a hospital's performance. The peer grouping methodology assesses hospital performance relative to that of other hospitals with a similar proportion of stays for patients who are dually eligible for Medicare and full Medicaid benefits. Dual-eligible status is an indicator of patient social risk, and the approach of grouping hospitals holds all hospitals to a high standard while also making it so that the program does not disproportionality reduce payments for hospitals serving at-risk populations. The 21st Century Cures Act also requires that the peer grouping methodology produce the same amount of Medicare savings generated under the non-peer grouping methodology to maintain budget neutrality. The neutrality modifier in the payment reduction calculation satisfies the Cures Act requirements to maintain budget neutrality between the two methodologies.

The payment reduction is the percentage a hospital's payments will be reduced based on its performance in the program. The payment reduction is a weighted average of a hospital's performance across the HRRP measures during the performance period. In order to administer payment reductions, CMS transforms the payment reduction into the payment adjustment factor, or the PAF, and CMS applies the PAF to all Medicare Fee for Service base operating DRG payments during the fiscal year. The next few slides will walk through the steps involved in calculating the payment reduction in more detail. The slides will show the example calculations for a hospital using mock data.

For Step 1, CMS calculates a dual proportion for each hospital and an ERR for each of the HRRP conditions and procedures. The Excess Readmission Ratio, or ERR, is a measure of a hospital's relative performance used in the payment reduction formula to assess whether a hospital has excess readmissions for each of the conditions or procedures included in HRRP. The ERR is the risk-adjusted ratio of the predicted readmission rate to the expected readmission rate. CMS calculates an ERR for each measure and each hospital included in the program.

For the example hospital, it shows the calculations for taking the predicted readmission rate over the expected readmission rate. For the hip/knee measure, this hospital did not have any eligible discharges, so it did not have an ERR calculated for that measure. The dual proportion is also shown on this slide. It is the proportion of Medicare Fee for Service and managed care stays in a hospital during the performance period in which the patient was dually eligible for Medicare and full Medicaid benefits. For the example hospital, it has 894 stays where the beneficiary was dually eligible for Medicare and full Medicaid benefits and 3,389 total Medicare Fee for Service and managed care stays. For this hospital, the dual proportion equals 894 divided by 3,389 total stays, or 0.2638.

To calculate the payment reduction, CMS sorts hospitals into five approximately equal groups based on their dual proportions. Hospitals are sorted into one of five peer groups, ranging from peer group 1, which has the lowest dual proportions relative to other HRRP hospitals, to peer group 5, which has the highest dual proportions relative to other HRRP hospitals. The example hospital, with a dual proportion of 0.2638, would be assigned to peer group 4 based off the dual proportion ranges for each of the peer groups. CMS then calculates a median ERR for each peer group and each measure. The peer group median ERR is the threshold CMS uses to assess excess readmissions relative to other hospitals within the same peer group. All hospitals in the same peer group will have the same peer group median ERR. The image on this slide shows an example of the peer group median ERRs for each of the peer groups.

For Step 4, CMS determines which ERRs will contribute to the payment reduction. For an ERR to contribute to the payment reduction, it must meet two criteria. First, the ERR must be greater than the peer group median ERR. Second, the hospital must have 25 or more eligible discharges for the measure. The table on this slide shows an example hospital and how measures will contribute to the payment reduction. In this case, the AMI and COPD measures meet both of the criteria and will contribute to the payment reduction calculation.

In Step 5, CMS calculates each measure's contribution to the payment reduction. The slide shows an example of how that is calculated. The DRG ratio included in the calculations is the ratio of base operating DRG payments for the measure cohort to base operating DRG payments for all discharges. Since only AMI and COPD were determined to contribute to the payment reduction based off of Step 4, only these measures are included in the example calculations on this slide.

In Step 6, CMS sums the measure contributions to the payment reduction. If the sum of the measure contributions is greater than 3 percent, CMS will apply a cap because the maximum payment reduction allowed under the program is 3 percent. In this example, the hospital's payment reduction is 0.34 percent.

In Step 7, CMS calculates the payment adjustment factor, which equals 1 minus the payment reduction. The image on this slide shows an example for the hospital.

Then, in Step 8, CMS applies the payment adjustment factor to claims for the fiscal year, payments for Medicare Fee for Service claims submitted starting October 1 each year. In the example, it shows how the payment adjustment factor is applied to the total base operating DRG payment amounts and the resulting dollar amount of payments. In general, the base operating DRG payment amounts are the Medicare Fee for Service base operating DRG payments without any add-on payments, such as Disproportionate Share Hospital payments or Indirect Medical Education payments.

In this section of the presentation, we will review specific aspects of the HRRP Hospital-Specific Report, or the HSR.

The HRRP HSR provides hospitals the necessary information to review their program results. Along with the HSRs, CMS delivers an HSR User Guide, which guides hospitals through the process of reviewing their data.

HSRs are currently available via the Hospital Quality Reporting system. HSRs and the HSR User Guide are accessible to users in your organization

who have a HARP account in the HQR system with access to MFT. An email notification indicating that HSRs are available is sent to Listserve subscribers via the Hospital Inpatient Quality Reporting and Hospital Inpatient Value-Based Purchasing Listserves. The HSR User Guide is also made publicly available on the QualityNet website. Hospitals that are having trouble accessing their HSRs should reach out via the QualityNet Question and Answer Tool.

HSRs are reports that include hospital-level results and discharge-level data that CMS uses to calculate your hospital's payment reduction percentage and component results. The FY 2024 HRRP HSR contains tabs that include the following hospital-specific information: your hospital's payment reduction percentage, payment adjustment factor, measure results and ERRs, the neutrality modifier, information used in the peer grouping methodology, discharge-level information for readmission measures, and contact information for the program. The first tab of the HRRP HSR workbook introduces the user to the HSR, provides links to resources with detailed information on the program and the data in the HSR, as well as information regarding where to direct questions via the QualityNet Question and Answer Tool. The user guide that accompanies the HSR includes more detailed information, including replication instructions to promote transparency into the calculations and data.

The second tab in the HRRP HSR workbook contains Table 1: Payment Adjustment, shown here. This table shows summary information for your hospital. The dual proportion, shown in the third column, is calculated as the number of dually eligible stays, shown in the first column, divided by the total number of stays, shown in the second column on this slide. Your hospital peer group assignment is shown in the fourth column. As noted before, hospitals in peer group 1 have the lowest dual proportions relative to other HRRP hospitals. Hospitals in peer group 5 have the highest dual proportions relative to other HRRP hospitals. The ranges of the dual proportions for each peer group are included in the user guide. The neutrality modifier, shown in the fifth column, is applied in the calculation of the payment reduction to maintain budget neutrality with the non-peer

grouping methodology. The payment reduction percentage, shown in the sixth column, shows the percentage your hospital's payments will be reduced, ranging from 0 percent to 3 percent. The last column in Table 1 shows the hospital's payment adjustment factor. The payment adjustment factor may be between 1.0, which means no reduction, and 0.97, which corresponds with a 3 percent payment reduction, or the maximum payment reduction.

This slide shows the table in the third tab of the HSR, Table 2: Hospital Results. This table shows your hospital's measure-specific results. The sixth column, the ERR, shows the predicted readmission rate, shown in the fourth column, divided by the expected readmission rate, shown in the fifth column, for that measure. If a hospital performs better than an average hospital that admitted similar patients, the ERR will be less than 1.0. If a hospital performs worse than average, the ERR will be greater than 1.0. The penalty indicator, shown in the eighth column on this slide, will indicate if that measure will contribute to the payment reduction. The penalty indicator is Yes for a measure when your hospital has 25 or more eligible discharges and an ERR greater than the peer group median ERR for that measure. The penalty indicator is No for a measure when your hospital has fewer than 25 eligible discharges or the ERR is less than the peer group median ERR for that measure. Each measure with a penalty indicator equal to Yes will contribute to your hospital's payment reduction and increase the size of the payment reduction. When a hospital has no eligible discharges for a measure, a value of NQ will display in the Number of Eligible Discharges column to indicate that there are no qualifying cases for that measure. This will also cause the value of NQ to display in the Excess Readmission Ratio Column for that measure. CMS cannot calculate an ERR without eligible discharges for a measure.

The next six tabs in the HSR show Tables 3 through 8 with discharge-level information for each readmission measure. This slide shows the first eight columns that will appear in each of these tables with example discharge-level data. Each table shows discharge-level data for all Medicare Part A Fee for Service hospitalizations that occurred during the

HRRP performance period where the patient was 65 years or older at the time of admission with a principal discharge diagnosis of either AMI, COPD, heart failure, or pneumonia, or a procedure for CABG surgery, or primary elective total hip/knee. These tables indicate whether a planned or unplanned readmission for any cause followed the discharge within 30 days. HSRs include all discharges that meet the inclusion requirements for each measure. The cohort inclusion/exclusion indicator, shown in the table on this slide, is used to identify discharges that were excluded from the measure. The risk factors for each measure with their corresponding condition category are also included in these tables.

This slide and the next slide show the continuation of the data available in the discharge tabs. The HSR User Guide contains detailed descriptions for each of these columns.

These are more columns that you will see in Tables 3 through 8 of your HSR. The last two columns show your Hospital-Specific Effect and the Average Effect. The Hospital Effect represents the underlying risk of a readmission at your hospital, after accounting for patient risk. The Average Effect represents the underlying risk of a readmission at the average hospital after accounting for patient risk.

This slide shows the table in the last tab of the HSR, Table 9: Dual Stays. This tab shows information for the stays that meet the criteria for the numerator of the dual proportion. As mentioned before, the numerator for the dual proportion includes stays for Medicare Fee for Service and managed care beneficiaries who were also eligible for full Medicaid benefits during the HRRP performance period.

Once hospitals receive their HSRs, the 30-day review and correction period begins. CMS distributes HSRs via the Hospital Quality Reporting system at the beginning of the review and correction period. Hospitals can review the data in their HSRs and replicate their payment reduction percentage and component results.

Hospitals can also submit questions for corrections to their payment reduction percentage and component results and submit questions about their result calculations during the 30-day review and correction period. The HRRP review and correction period for FY 2024 began August 8 and goes through September 7, 2023. HSR review and correction inquiries should be submitted to the QualityNet Question and Answer Tool no later than September 7. A link for this tool is available on this slide.

This slide lists what hospitals can and cannot submit calculation correction requests for during the HRRP review and correction period. Hospitals cannot submit corrections to the underlying claims data or add new claims to the data used for the calculations during this period.

CMS publicly reports hospital HRRP results along with the final rule. This slide shows the data elements that will be released in the IPPS final rule Supplemental Data File following the review and correction period.

In addition to public reporting in the Supplemental Data File, hospitals with at least 25 discharges will have the data elements listed on this slide publicly reported on the CMS-specified website, currently Data.CMS.gov/provider-data, in early 2024.

More information on HRRP, HSRs, and readmission measures is available on QualityNet. The links on this slide can be used to navigate to specific web pages on QualityNet for further information on HRRP, as well as the HSR User Guide and a mock HSR.

Questions about HRRP should be submitted to the QualityNet Question and Answer Tool. The link for the tool is on this slide and can also be found on the QualityNet website. The table on this slide shows the program, topic, and subtopic to select when submitting your question, based on the subject of your question. This brings us to the end of the formal presentation. Thank you for your time. Now back to you, Maria.

Donna Bullock: Thank you, Rebecca. Now, we have time for a few questions that were submitted during the webinar. Our first question is: What is the difference between the HRRP and the Hybrid Hospital-Wide Readmission measure?

Rebecca Silverman: Hi. This is Rebecca Silverman from DPS. I'm happy to answer this question. So, HRRP includes six condition- and procedure-specific claims-based readmission measures. The Hybrid Hospital-Wide Readmission measure merges electronic health record data elements with claims data and includes readmissions after applicable hospital admissions for any condition or procedure. The Hybrid Hospital-Wide Readmission measure is not included in HRRP.

Donna Bullock: Thank you. We had one more question come through the system. How is the predicted rate calculated? Sometimes it is very different from the raw.

Rebecca Silverman: Hi, this is Rebecca again. Thank you for that question. The predicted 30- day readmission rate for an individual hospital is based on its performance for its specific patient case mix. That is the Hospital-Specific Effect in the hospital's discharge-level data in its HSR. For more information, please refer to the Readmission Measures Methodology page on the QualityNet website.

Donna Bullock: Thank you, Rebecca. We're waiting to see if a few more questions will make it through the system.

Currently, we've had no more questions that have made it through this system. We'll give it just another minute to see if any more come through.

We haven't had any more questions come through the system yet. So, if you ask a question, but it wasn't addressed on today's webinar, please use the QualityNet Q&A Tool link that was provided on the preceding slide.

We don't have any more time for any more questions. We extend our gratitude to both the presenter and the participants for being part of today's event. We wish everyone a wonderful day ahead.