Hospital Inpatient Quality Reporting (IQR) Program

Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

Overview of FY 2025 Hospital-Acquired Condition (HAC) Reduction Program and Hospital Readmissions Reduction Program (HRRP) Question and Answer Summary Document

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The following document provides actual questions from audience participants. Webinar attendees submitted the questions and subject-matter experts provided the responses during the live webinar. The questions and answers have been edited for grammar.

Question 1: **What is the difference between a hospital's measure results and measure scores?**

Measure results are the output of a measure's calculations and the first step of the scoring methodology. The HAC Reduction Program uses measure results from six total measures. Each of the five Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) healthcare-association infection (HAI) measures reports a standardized infection ratio (SIR). The SIRs are calculated as the ratio of a hospital's observed HAIs to its predicted HAIs. The CMS Patient Safety Indicator (PSI) 90 measure reports a composite value, which is a weighted average of the risk- and reliability-adjusted rates of 10 component PSI measures.

Measure scores, or Winsorized z-scores, are used to calculate the Total HAC Score. The HAC Reduction Program completes Winsorization to limit the impact of outlier measure results. Then, it calculates Winsorized z-scores. The z-scores indicate how different a hospital's measure result is from the average measure result across all hospitals in the HAC Reduction Program. The weighted sum of a hospital's measure scores is then used to calculate the Total HAC Score. More information about the HAC Reduction Program's methodology can be found on the QualityNet website.

Question 2: **How does CMS calculate SIRs?**

CMS uses HAI measure results from CDC's NHSN. For each measure, CDC evaluates hospital performance using a SIR, which is calculated as the ratio of a hospital's observed HAIs to its predicted HAIs. CDC determines predicted HAIs for each measure based on hospital information submitted to CDC's NHSN for the calendar year (CY) 2015 NHSN baseline period, using the following risk adjustment processes: Central line-associated bloodstream infections and catheter-associated urinary tract infections are risk adjusted at the hospital and the patient-care-unit levels. Surgical Site Infection (SSI) is risk adjusted at the procedure level. The SSI measure is a pooled measure based on the number of SSIs following abdominal hysterectomy and colon procedures. *Methicillin-resistant Staphylococcus aureus* bacteremia and *Clostridium difficile* infection are risk adjusted at the hospital level.

Question 3: **Which hospitals are in each HRRP peer group?**

CMS publicly reports hospital-level peer group assignments and dual proportions for a given fiscal year (FY) in the Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment

System (LTCH PPS) Final Rule HRRP Supplemental Data File on the IPPS/LTCH PPS Final Rule page on CMS.gov following the Review and Correction period. The HRRP Supplemental Data File can be filtered to show only hospitals in a specific peer group.

For HRRP, a peer group is a group of hospitals with similar patient populations based on the hospitals' dual proportions. The dual proportion is the proportion of Medicare fee-for-service (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.

Question 4: **Do admissions to LTCHs, rehabilitation facilities, and hospice facilities count as a readmission?**

Under HRRP, only stays in subsection (d) hospitals (general short-term acute care hospitals) can be considered as index admissions, and only inpatient readmissions to short-term acute care hospitals can be considered as readmissions. Admissions to facilities other than short-term acute care hospitals, such as inpatient rehabilitation facilities, LTCHs, and hospice facilities, are not considered readmissions in HRRP. If a patient has an index stay for one of the readmission measures and then is admitted to an inpatient rehabilitation facility, LTCH, or hospice facility within 30 days of discharge from the index stay, this is not considered a readmission.

However, if a patient has an index stay for one of the readmission measures; is admitted to an inpatient rehabilitation facility, LTCH, or hospice facility, and later has an unplanned readmission to a short-term acute care hospital, all within 30 days of discharge from the index stay, the readmission to the short-term acute care hospital would be captured in the readmission outcome, regardless of the inpatient rehabilitation facility, LTCH, or hospice admission between the two acute care admissions.

Question 5: **If a patient's primary payer is not Medicare, but their secondary payer is Medicare, will a PSI-90 be captured/counted?**

Patients that are enrolled in Medicare FFS as either primary or secondary payer and meet the other measures criteria are included in the CMS PSI-90 measure. Medicare Advantage patients are not included in the measure. Additional details on the measure criteria are available on the QualityNet website.

Question 6: **When will hospitals get the 2025 HAC Reduction Program data report?**

CMS released the FY 2025 HAC Reduction Program Hospital-Specific Reports (HSRs) on Friday August 2, 2024, via the Hospital Quality Reporting System. Instructions to download your hospital's report are available on the HAC Reduction Program's Reports page on the QualityNet website. The link to this page is available on slide 42.

Question 7: **Can you explain the diagnosis-related group (DRG) ratio calculation?**

Under HRRP, the DRG payment ratio is the proportion of a hospital's base operating DRG payments for each HRRP condition or procedure during the performance period. The numerator includes base operating DRG payments for stays included in the HRRP measure cohort. The denominator includes all Medicare FFS base operating DRG payments. The DRG payment ratio is the weight applied to a measure's contribution in the payment reduction calculation. The DRG payment ratio is referred to as the ratio of DRG payments per measure to total payments in a hospital's HSR.

Question 8: **Are managed Medicare patients included in readmission penalties?**

CMS includes Medicare managed care stays when calculating the dual proportion for HRRP. A hospital's dual proportion is the proportion of Medicare FFS and managed care stays where the patient was dually eligible for Medicare and full Medicaid benefits. Hospitals are sorted into one of five peer groups (quintiles) based on the dual proportion, and CMS assesses hospital performance relative to the performance of hospitals within the same peer group.

CMS does not include Medicare Advantage patients when calculating excess readmission ratios (ERRs) for the six measures in HRRP. ERRs only measure 30-day risk-standardized unplanned readmissions among FFS patients.

CMS applies a hospital's payment adjustment factor to all Medicare FFS base operating DRG payments. Payments for Medicare Advantage patients are not reduced as part of the program.

Question 9: **What is an example of data that can be corrected if we cannot correct claims data during the Review and Correction period?**

During the HAC Reduction Program Scoring Calculations Review and Correction period, hospitals can submit questions about the calculation of their measure results, measure scores, Total HAC Score, and payment reduction status. During the HRRP Review and Correction period, hospitals can submit questions about the calculation of their payment reduction percentage and component results. While claims cannot be corrected, this period provides hospitals with an opportunity to review CMS calculations.

Question 10: **Is there a timeline for HRRP to include hybrid readmission measures?**

CMS does not currently include hybrid readmission measures in HRRP. CMS only includes the following claims-based condition- or procedure-specific 30-day risk-standardized unplanned readmission measures in HRRP: acute myocardial infarction (AMI); chronic obstructive pulmonary disease (COPD); heart failure (HF); pneumonia; coronary artery bypass graft (CABG) surgery; and elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA).

CMS can make changes to the measures included in HRRP through rulemaking. CMS publishes changes annually with the IPPS/LTCH PPS final rule following a public comment period.

Additional information on the measure endorsement process and how CMS makes changes to HRRP are in the HRRP Frequently Asked Question document on QualityNet: https://qualitynet.cms.gov/inpatient/hrrp/resources

Question 11: **If a claim is rebilled, does the rebilled underlying claims information go into these programs?**

CMS takes an annual snapshot of the claims data to perform measure calculations for claims-based measures for quality reporting programs, including the HAC Reduction Program and HRRP. Most recently, CMS took a snapshot of the data on October 13, 2023, to calculate results for the FY 2025 HAC Reduction Program and HRRP. Medicare Administrative Contractors must process all corrections to underlying Medicare FFS claims data by the claims snapshot date (October 13, 2023) to be included in FY 2025 HAC Reduction Program and HRRP calculations.

The next claims snapshot for the claims-based measures is on the last business day of September 2024 to calculate results for FY 2026.

Question 12: **Can hospitals see the other hospitals that are included in the "better than" and "worse than" categories?**

CMS will publicly report FY 2025 HAC Reduction Program data for each hospital on the data catalog on Data.cms.gov in early 2025. The dataset will include each hospital's measure results (the CMS PSI 90 composite value for the CMS PSI 90 measure and SIRs for the HAI measures); measure scores (Winsorized z-scores) for the CMS PSI 90 and HAI measures; Total HAC Score; and payment reduction indicator. (Hospitals that rank in the worst-performing quartile will be subject to a 1-percent payment reduction.)

Question 13: **How does CMS account for hospitals with a small N size where one fallout will cause a high rate?**

CMS accounts for case size in the HAC Reduction Program and HRRP in the following ways so that hospitals will not receive disproportionate penalties due to small case size. Under the HAC Reduction Program, a hospital will not receive a CMS PSI 90 measure result (composite value) if (1) the hospital has fewer than 12 months of data during the CMS PSI 90 performance period or (2) the hospital does not meet both of the following criteria: one or more component PSI measures with at least 25 eligible discharges and seven or more component PSI measures with at least three eligible discharges each. A hospital will not receive an HAI measure result (a SIR) if a hospital's predicted number of infections is fewer than 1 during the performance period for a given measure. CDC will not calculate a SIR for that measure.

Under HRRP, a readmission measure contributes to the payment reduction if, among other criteria, the hospital has 25 or more eligible discharges for that measure. Hospitals with fewer than 25 eligible discharges for that measure are not eligible to be penalized for that measure. Therefore, hospitals will not be disproportionally penalized due to small case size. Additionally, CMS uses multiple years of to allow the program to include more hospitals by increasing the number of discharges for a given hospital during the performance period.

Question 14: **Are readmissions for Medicare A patients but not Medicare Advantage patients?**

Patients enrolled in Medicare Advantage are not included in the readmission measures in HRRP. Patients are included in the readmission measures in HRRP if they meet, at a minimum, the following criteria:

- Are age 65 and older
- Have been hospitalized for one of the following conditions or procedures included in HRRP during the performance period: AMI, COPD, HF, pneumonia, CABG surgery, or THA/TKA
- Are enrolled in Medicare FFS Part A and B for the full 12 months before the index stay (the initial admission), as well as enrolled in Part A during the index stay