Hospital Inpatient Quality Reporting (IQR) Program

Inpatient and Outpatient Healthcare Quality Systems Development and Program Support

Overview of the Fiscal Year (FY) 2025 Hospital-Acquired Condition (HAC) Reduction Program and Hospital Readmissions Reduction Program (HRRP) Presentation Transcript

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August 20, 2024
2 p.m. Eastern Time

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Maria Gugliuzza: Greetings and thank you for joining us for the Hospital-Acquired Condition Reduction Program and Hospital Readmissions Reduction Program, where we will provide you with an in-depth look at the highlights for the fiscal year 2025 program year. I'm Maria Gugliuzza from the Inpatient and Outpatient Healthcare Quality Systems Development and Program Support. I'm here to guide you through today's webinar. Let me take a moment to introduce our distinguished speakers. Joining us today is Juliana Conway. She holds the role of HAC Reduction Program Manager. Rebecca Silverman holds the role of HRRP Program Manager. We're delighted to have you both here today, and we'd like to extend our gratitude for sharing your insights with us today.

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 Question and Answer Tool. You can access the QualityNet Question and Answer 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, then you can submit your question to us via the question and answer tool, which you can access at the link on this slide.

Please review the following list of acronyms that will be used in today's presentation.

During this event, we will present a comprehensive look at the fiscal year 2025 HAC Reduction Program and HRRP Program.

The presentation will cover a range of topics, including program enhancements, the methodology employed, insights from Hospital-Specific Reports, 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, and pose inquiries regarding your hospital's computations throughout the HAC Reduction and HRRP Review and Correction Period.

I will now hand over the presentation to our first speaker for today's event. Juliana, the presentation is yours!

Juliana Conway: Thank you, Maria. My name is Juliana Conway, and I am the HAC Reduction Program Manager for the Division of Value, Incentives, and Quality Reporting Program Support Contract. Today, I am going to discuss background on the HAC Reduction Program and updates to the program for fiscal year 2025, provide an overview of the scoring methodology for the program, and describe how hospitals can review their program results for the fiscal year 2025 program year through Hospital-Specific Reports during the Scoring Calculations Review and Correction Period.

The HAC Reduction Program is a Medicare value-based purchasing program that reduces payments to hospitals based on their performance on measures of hospital-acquired conditions. The program reduces the overall Medicare payment by 1 percent for the worst-performing 25 percent of hospitals on hospital-acquired condition quality measures. The program encourages hospitals to implement best practices to reduce their rates of healthcare-associated infections and improve patient safety.

CMS evaluates overall hospital performance under the HAC Reduction Program by calculating a Total HAC Score for each hospital, which is the equally weighted average of their scores across measures included in the program.

Hospitals with a Total HAC Score greater than the 75th percentile, that is the worst-performing quartile, of all Total HAC Scores will be subject to a 1-percent payment reduction.

The HAC Reduction Program includes all subsection (d) hospitals, which are broadly defined as general acute care hospitals paid under the Inpatient Prospective Payment System. A complete list of the hospital types not included in the HAC Reduction Program, such as critical access hospitals, can be found in the Frequently Asked Questions document, available on the Resources page of the QualityNet website. Maryland hospitals are exempt from payment reductions under the HAC Reduction Program due to an agreement between CMS and Maryland. More information on the Maryland Total Cost of Care Model can be found on the CMS website.

The fiscal year 2025 HAC Reduction Program includes six measures: one claims-based composite measure of patient safety, CMS PSI 90, and five chart-abstracted or laboratory-identified healthcare-associated infection surveillance measures based on data that hospitals submit to the Centers for Disease Control and Prevention's, CDC's, National Healthcare Safety Network, NHSN.

Next, I'll cover the updates to the program for the fiscal year 2025 program year.

CMS did not change the scoring or measure methodology for the fiscal year 2025 HAC Reduction Program. For the fiscal year 2025 program year, CMS used Version 14.0 PSI software to calculate the CMS PSI 90 measure. The CMS PSI 90 measure includes all Medicare fee-for-service patient discharges from January 1, 2022, through June 30, 2023. The five CDC NHSN HAI measures include all patient discharges from January 1, 2022, through December 31, 2023.

For the fiscal year 2025 program year, CMS adopted a validation reconsideration policy to allow hospitals that fail to meet the validation requirement to request a reconsideration of this validation decision and made non-substantive changes to the CMS PSI 90 component measure,

CMS PSI 08 In-Hospital Fall-Associated Fracture Rate, to include all hospital fall-associated fractures, rather than only hospital fall-associated hip fractures

Next, I will review the scoring methodology for the program.

The HAC Reduction Program scoring methodology consists of four high-level steps. These steps include 1) calculating the measure results, 2) transforming the measure results into measure scores, 3) calculating the Total HAC Score, and 4) determining the worst performing quartile and payment reduction.

The first step in the scoring methodology is to determine measure results for each of the measures included in the program. For the CMS PSI 90 measure, the measure result is the CMS PSI 90 composite value. For the HAI measures, the measure result is the standardized infection ratio, or SIR, which is calculated by the CDC.

Once measure results have been calculated, the next step in the scoring methodology is to calculate measure scores. CMS calculates a hospital's measure score as the Winsorized *z*-score using measure results for the given measure. This involves two steps, Winsorizing measure results and calculating *z*-scores.

The first step in transforming measure results into measure scores is to Winsorize the measure results. Winsorization is a process that reduces the impact of extreme or outlying measure results while preserving the hospital's relative results.

The second step in transforming measure results into measure scores is to calculate the Winsorized *z*-score. Hospitals that perform worse than the mean will earn a positive Winsorized *z*-score, while hospitals that perform better than the mean will earn a negative Winsorized *z*-score.

Once measure scores have been calculated, the measure scores are used to calculate a hospital's Total HAC Scores.

CMS calculates each hospital's Total HAC Score as the equally weighted average of their measure scores. The Total HAC Score calculation includes only the measures for which a hospital receives a measure score. Higher Total HAC Scores indicate worse overall performance, while lower Total HAC Scores indicate better overall performance.

Once Total HAC Scores are calculated, CMS can use those scores to determine the worst-performing quartile. Hospitals whose Total HAC Score is greater than the 75th percentile Total HAC Score are in the worst performing quartile.

This slide shows the scoring calculation for how raw measure results get Winsorized and Total HAC Score gets calculated for a hypothetical hospital under the HAC Reduction Program. The values in this example are hypothetical and not actual values for the fiscal year 2025 HAC Reduction Program. Because the example hospital's Total HAC Score of -0.0782 is less than the hypothetical 75th percentile Total HAC Score of 0.3306, the hospital will not be subject to the payment reduction.

For hospitals that are subject to the 1-percent payment reduction, the payment reduction is applied to the overall Medicare payment amount for all Medicare fee-for-service discharges during fiscal year 2025; that is from October 1, 2024, to September 30, 2025.

Next, I am going to discuss how hospitals receive their results via the Hospital-Specific Reports, or HSRs, and how they can review those results and request corrections to their scoring, if appropriate.

Each year, CMS provides hospitals with 30 days to review their program data, submit questions about calculations, and request corrections to their scoring, if appropriate. This is known as the Scoring Calculations Review and Correction period. The HAC Reduction Program HSR provides hospitals the necessary information to review their program results. Along with the HSRs, CMS delivers an HSR User Guide, which can guide 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 Managed File Transfer, or MFT. An email notification indicating that HSRs are available is sent to listserv subscribers via the Hospital Inpatient Quality Reporting and Hospital Inpatient Value-Based Purchasing, or HVBP, Listservs. 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.

The HAC Reduction Program HSR contains the following information: a hospital's payment reduction status for fiscal year 2025, their Total HAC Score, measures scores, measure results, discharge-level information for the claims-based CMS PSI 90, and hospital-level information for the HAI measures.

This is an example of Table 1 in the fiscal year 2025 HAC Reduction Program HSR. Table 1 contains the contribution of each measure to the Total HAC Score, the hospital's Total HAC Score, the 75th percentile Total HAC Score, and the hospital's payment reduction status. Because the example hospital's Total HAC Score is less than the 75th percentile threshold, this example hospital will not be subject to a payment reduction.

This is an example of Table 2 in the fiscal year 2025 HAC Reduction Program HSR. Table 2 contains measure results for each of the measures along with the necessary information to calculate Winsorized z-scores. In this example, the hospital's measure results all fall between the 5th percentile and 95th percentile of measure results, or the hospital has insufficient data for the measure result. Winsorized z-scores for each of the measures are equal to the Winsorized measure result minus the mean Winsorized measure result, divided by the standard deviation of Winsorized measure results. This example hospital performs better than the mean on the CMS PSI 90, CLABSI, CAUTI, and CDI measures.

Because the example hospital receives a measure score for four of the six measures included in the program, they are all weighted at one quarter. The contribution of each measure's Winsorized z-score to the Total HAC Score equals the values in Table 1 of the HSR.

This is an example of Table 3 in the fiscal year 2025 HAC Reduction Program HSR. Table 3 in the HSR shows users the necessary information to reproduce their measure result for the CMS PSI 90 measure, the CMS PSI 90 composite value. The CMS PSI 90 is a composite measure that combines results from 10 component patient safety indicator measures. Each component patient safety indicator measure's smoothed rate is weighted to form the composite value.

This is an example of Table 4 in the fiscal year 2025 HAC Reduction Program HSR. Table 4 shows discharge-level information for the CMS PSI 90 measure. If you are referring to information from this table when submitting review and correction requests, it is important that you do not share the personally identifiable information that it contains. Please use the ID number, shown in Column A, when submitting the request.

This is an example of Table 5 in the fiscal year 2025 HAC Reduction Program HSR. Table 5 shows hospital-level information for the five HAI measures. This includes the reported and predicted number of HAIs. The standardized infection ratio, shown in Row 4 of the table, is equal to the reported number of infections divided by the predicted number of infections.

The Scoring Calculations Review and Correction Period for the fiscal year 2025 HAC Reduction Program began on August 5, 2024, and ends on September 3, 2024. Hospitals have this 30-day period to review their data, submit questions about the calculation of their results, and request corrections to calculation errors. Hospitals must submit correction requests to the HAC Reduction Program Support Team via the QualityNet Question and Answer Tool no later than the last day of the Scoring Calculations Review and Correction Period, September 3, 2024, to be considered.

During the Scoring Calculations Review and Correction Period, hospitals can request corrections to their measure result for the CMS PSI 90 measure, their measure score for all of the measures in the program based on the measure results presented in the HSR, their Total HAC Score, or their payment reduction status. Hospitals cannot request corrections to the underlying data because hospitals have already had the opportunity to review and correct those data. For the CMS PSI 90 measure, this means the underlying claims data that are used to calculate results. This includes adding new claims to the data extract. For the five HAI measures, this includes the reported number of HAIs, the standardized infection ratios, or the various volume variables for the HAI measures. All of these pieces of information for the HAI measures can be found on Table 5 of the HSR.

As noted, hospitals cannot request corrections to underlying data during the Scoring Calculations Review and Correction Period as hospitals already had the opportunity to review and correct those data. For the CMS PSI 90, CMS takes an annual snapshot of claims data to perform measure calculations for claims-based measures for all of their hospital quality reporting and value-based purchasing programs. The snapshot for the fiscal year 2025 program year occurred on October 13, 2023. All corrections to underlying claims must be processed by the snapshot date, and claim edits after that date are not reflected in program results. The next claims snapshot, for the fiscal year 2026 program year, will occur the last business day of September 2024.

This image demonstrates key milestones related to the use of claims-based data for the CMS PSI 90 measure. As shown, the claims snapshot occurs approximately 90 days after the end of the performance period. Then, these data are used to calculate scores, which hospitals can review during the Scoring Calculations Review and Correction Period before their HAC Reduction Program results are publicly reported on the data catalog on Data.cms.gov the following January.

As noted, hospitals cannot request corrections to underlying data during the Scoring Calculations Review and Correction Period as hospitals already had the opportunity to review and correct those data.

For the HAI measures, hospitals have the opportunity to submit, review, and correct HAI data within the NHSN system for 4.5 months following the end of each reporting quarter. Immediately following this submission deadline, CDC takes a snapshot of the data for CMS to use in program calculations. CMS does not receive or use data entered after the NHSN submission deadline and expects hospitals to review and correct their data prior to the NHSN submission deadline.

As shown in the table, the NHSN submission deadline occurs 4.5 months following the end of each reporting quarter. For CY 2025, for Quarter 1, the NHSN submission deadline is August 15. Likewise, the Quarter 2 submission deadline is November 15. The Quarter 3 deadline is February 17 of the following year, since February 15, 2026, occurs on a Saturday. The Quarter 4 deadline is May 15.

This image demonstrates the flow of the HAI data from submission to the NHSN through use in program scoring calculations and public reporting. Four and a half months from the end of the reporting quarter, CDC creates a snapshot of the data in NHSN to be used in CMS calculations. Hospitals can review their calculations during the Scoring Calculations Review and Correction Period before their HAC Reduction Program results are publicly reported on a CMS-specified website, currently the Provider Data Catalog, the following January.

In early 2025, CMS will release following data elements from the fiscal year 2025 HAC Reduction Program on the data catalog on Data.cms.gov: measure scores or Winsorized *z*-scores for each of the measures included in the program; Total HAC Score; and payment reduction indicator.

More information on the HSRs and Scoring Calculations Review and Correction Period is available on the QualityNet website. This includes the HSR User Guide and a mock version of the HSR.

For more information on results found in the HSRs, you can submit any questions to the HAC Reduction Program Support Team via the QualityNet Question and Answer Tool.

General information on the HAC Reduction Program can be found in the HAC Reduction Program section of the QualityNet website. This includes information on program scoring methodology, the Scoring Calculations Review and Correction Period, and additional resources such as frequently asked questions and program fact sheets.

As noted elsewhere, if you have questions about the HAC Reduction Program, you can submit them directly to the HAC Reduction Program Support Team via the QualityNet Question and Answer Tool. You do not need to register for an account to submit questions via this tool.

Thank you. I'll now pass it to my colleague, Rebecca.

Rebecca Silverman: Thank you, Juliana. As Juliana stated, my name is Rebecca Silverman, and I am the HRRP Program Manager 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 and updates to the program for FY 2025, go through an example that explains the program methodology, and describe how hospitals can review their program results for the FY 2025 program year.

HRRP is a Medicare value-based purchasing program that was established 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, CMS reduces payments to hospitals with higher-than-expected rates of readmission following treatment for select conditions and procedures, encouraging hospitals to provide high-quality care to reduce avoidable returns to the hospital.

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 the excess readmission ratios, or ERRs.

HRRP includes the following condition or procedure-specific 30-day risk-standardized unplanned readmission measures: AMI, COPD, heart failure, pneumonia, CABG surgery; and elective total hip and/or knee replacement.

The FY 2025 performance period for HRRP is July 1, 2020, to June 30, 2023. CMS did not make any substantive changes to HRRP for FY 2025.

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, 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 eligibility for Medicare and full Medicaid benefits is an indicator of a patient's 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 that would have been 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.

Next, I will review the payment reduction methodology for the program.

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 or 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 beneficiary 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 dually-eligible stays divided by 3,389 total stays, or 0.2638.

To calculate the payment reduction, CMS sorts hospitals into five similarly sized peer 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, that is, payments for Medicare fee-for-service claims submitted starting October 1st 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 HSR.

HSRs are reports that include hospital-level results and discharge-level data that CMS use to calculate your hospital's payment reduction percentage and component results. The FY 2025 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, equals 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 the 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 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 be displayed in the number of eligible discharges column to indicate that there are no qualifying cases for the measure. This will also cause the value of NQ to display in the ERR 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’s 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 Medicare fee-for-service and managed care stays during the HRRP performance period in which the beneficiary was dually eligible for Medicare and full Medicaid benefits.

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 also submit requests 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 2025 began August 12 and goes through September 10, 2024. HSR review and correction inquiries should be submitted to the QualityNet Question and Answer Tool no later than September 10. 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/LTCH PPS Final Rule HRRP 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 data catalog on Data.cms.gov in early 2025.

More information on HRRP, HSRs, and readmission measures is available on the QualityNet website. 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.

Maria Gugliuzza: Thank you, Rebecca. We now have some time to answer a few questions. Our first question is: What is the difference between a hospital's measure results and measure scores?

Julia Conway: Thanks. That's a good question. 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 CDC NHSN HAI measures report a standardized infection ratio, or an SIR. The SIRs are calculated as the ratio of a hospital's observed HAIs to its predicted HAIs. The CMS 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 and then 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.

Maria Gugliuzza: Our next question: How are standardized infection ratios calculated?

Julia Conway: Thanks for that question. CMS uses HAI measure results from CDC's NHSN. For each measure, CDC evaluates hospital performance using an 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 or CY, 2015 NHSN baseline period, using the following risk adjustment processes: CLABSI and CAUTI are risk adjusted at the hospital- and the patient-care unit levels. 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. MRSA bacteremia and CDI are risk adjusted at the hospital level.

Maria Gugliuzza; How can I figure out which hospitals are in each HRRP peer group?

Rebecca Silverman: Thanks. That's a great question. CMS publicly reports hospital-level peer group assignments and dual proportions for a given fiscal year in the IPPS/LTCH PPS Final Rule HRRP Supplemental Data File, posted 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 and managed care stays in a hospital during the performance period in which the beneficiary was dually eligible for Medicare and full Medicaid benefits.

Maria Gugliuzza: Thanks. Our next question: Do admissions to Long-Term Care Hospitals, rehabilitation, and hospice facilities count as a readmission?

Rebecca Silverman: Thank you**.** Under HRRP, only stays in subsection (d) hospitals, that is, 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 readmissions. Admissions to facilities other than short-term acute care hospitals, such as inpatient rehabilitation facilities, Long-Term Care Hospitals, 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 rehab facility, Long-Term Care Hospital, 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 and then is admitted to an inpatient rehab facility, Long-Term Care Hospital, 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 rehab facility, Long-Term Care Hospital, or hospice admission between the two acute care admissions. Thank you.

Maria Gugliuzza: Our next question: If a patient's primary payer is not Medicare, but their secondary payer is Medicare, will a PSI 90 be captured/counted?

Juliana Conway: Thanks, Maria. Patients that are enrolled in Medicare fee-for-service as either primary or secondary payer and meet the other measure 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.

Maria Gugliuzza: Great. Thank you. Our next question: When will hospitals get the 2025 HAC Reduction Program data report?

Juliana Conway: Thank you. CMS released the fiscal year 2025 HAC Reduction Program Hospital-Specific Reports on Friday, August 2, 2024, via the Hospital Quality Reporting system. Instructions for how 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.

Maria Gugliuzza: Great. Next question. Can you please explain the DRG ratio calculation?

Rebecca Silverman: Sure. 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 fee-for-service 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. Thank you. Next question

Maria Gugliuzza: Long-Term Care Hospitals Are managed Medicare patients included in readmission penalties?

Rebecca Silverman: CMS includes Medicare managed care stays when calculating the dual proportion for HRRP. A hospital's dual proportion is the proportion of Medicare fee-for-service 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, or ERRs, for the six measures in HRRP. The ERRs measure 30-day risk-standardized unplanned readmissions among fee-for-service patients only. CMS applies a hospital's payment adjustment factor to all Medicare fee-for-service base operating DRG payments. Payments for Medicare Advantage patients are not reduced as part of the program.

Maria Gugliuzza: Okay, next question. What is an example of data that can be corrected? Does that mean there was an error when calculations were done? I'm having a hard time understanding the purpose of this correction period, considering claims data is not an option to correct.

Juliana Conway: Thanks, Maria. 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. While claims cannot be corrected, this period provides hospitals with an opportunity to review CMS's calculations.

Maria Gugliuzza: Okay. It looks like that it appears be that our allotted time for questions has been exhausted for today. If your question wasn't addressed, kindly utilize the QualityNet Question and Answer Tool link provided on the proceeding slide.

We'd like to extend our gratitude to both the presenters and participants for being part of today's event. Wishing everyone a wonderful day ahead. Thank you.