Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Overview of the FY 2020 HAC Reduction Program and HRRP

Questions and Answers

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

Question 1: **Who do I contact with questions about the Centers for Disease Control (CDC) National Healthcare Safety Network (NHSN) healthcare associated infection (HAI) measures?**

You can contact the NHSN help desk at nhsn@cdc.gov.

Question 2: **When is the next snapshot date for claims-based data?**

The next claims snapshot for the claims-based measures, except for the Medicare Spending Per Beneficiary measure (MSPB), will be September 27, 2019 for fiscal year (FY) 2021. Hospitals need to correct their claims data before the snapshot date for CMS to have accurate data for calculations. The Hospital-Specific Report (HSR) will not reflect any claim edits processed after this date. CMS cannot regenerate HSRs to reflect corrected claims.

Question 3: **If a hospital does not submit data for a HAI measure and did not have a HAI measure exception, what Winsorized z-score will it receive?**

Hospitals that do not submit data for a HAI measure will receive the maximum Winsorized z-score for the measure if none of the following four circumstances apply:

1. The hospital is classified as a HAI new hospital.
2. The hospital submitted a HAI exception (central line-associated bloodstream infection [CLABSI], catheter-associated urinary tract infection [CAUTI], and/or surgical site infection [SSI]) for the entire two-year reporting period.
3. The hospital did not indicate in NHSN that it had any active intensive care unit (ICU) locations, medical wards, surgical wards, and medical-surgical wards for at least one quarter during the reporting period (i.e., no mapped locations [NML] for CLABSI and CAUTI).
4. The hospital is classified as an outlier for the measure (for Clostridium difficile infections [CDI] only).

Question 4: **What is the 75th percentile threshold or cutoff for receiving a payment reduction for the HAC Reduction Program this year?**

For FY 2020, the 75th percentile threshold is 0.3306. Any hospital that is subject to the FY 2019 HAC Reduction Program with a Total HAC Score greater than 0.3306 will receive a 1 percent payment reduction.

Question 5: **Regarding the HAC Reduction Program, is there a Windows version of the 9.0 CMS Patient Safety Indicator (PSI) software available?**

Yes. A SAS and Windows version of the CMS PSI software is available by request from hacrp@lantanagroup.com.

Question 6: **When will I receive my hospital's FY 2020 HRRP HSRs?**

CMS distributes the HRRP HSRs via *QualityNet Secure Portal* accounts at the start of the 30-day review and corrections period. For FY 2020, the 30-day review and corrections period extends from August 9 through September 9, 2019.

Question 7: **How can I tell if my hospital will receive a payment reduction for HRRP and how can I tell how much it will be as a percentage?**

Hospitals can calculate their payment reduction percentage using their payment adjustment factor. The payment adjustment factors can be found in the sixth column of Table 1: Payment Adjustment in the HRRP HSR. To determine the payment reduction percentage, hospitals must subtract the payment adjustment factor from 1 and multiply the result by 100.

For example, say your hospital has a payment adjustment factor of 0.975. To determine the payment reduction percentage, subtract 0.975 from 1 and multiply by 100. This equals a 2.5 percent payment reduction.

Question 8: **How do the HRRP readmission measure results differ from the readmission measure results on the *Hospital Compare* main pages?**

Prior to July 2019, the *Hospital Compare* Public Reporting HSR readmission measure results were reported as part of the Hospital Inpatient Quality Reporting (IQR) Program on the main pages of *Hospital Compare*. For FY 2020, the "Unplanned Hospital Visits" tab of the "Hospital Profile" on *Hospital Compare* reflects the distribution of hospitals by performance category in your state and the national results for the readmission measures. The *Hospital Compare* Public Reporting HSR reports the Risk-Standardized Readmission Rate (RSRR) for each measure as well as performance categories assessing if the hospital is better, worse, or no different than the national average.

The HRRP HSR results on Data.Medicare.gov and the *Hospital Compare* Public Reporting HSR results on the *Hospital Compare* main pages use the same readmission measure methodology and hospital discharge period in a given reporting cycle; however, each includes a different set of hospitals. The selection of eligible admissions and readmissions for HRRP calculations differ from those used in the *Hospital Compare* Public Reporting calculations.

The Excess Readmission Ratio (ERR) equals your hospital's predicted readmission rate divided by its expected readmission rate. For a given measure, multiplying your ERR by the national observed readmission rate for that condition will produce a number similar to the *Hospital Compare* Public Reporting RSRR for that condition in the same reporting year. The difference in hospitals included in the readmission measure calculations for *Hospital Compare* Public Reporting and HRRP may cause some variation.

Question 9: **How do we request the CMS PSI 9.0 calculation software?**

You can request a copy of CMS PSI software at hacrp@lantanagroup.com.

Question 10: **The language in the final rule stated equal weights would start with January 1, 2020 events. Would this equate to the FY 2021 or FY 2022 HAC Reduction Program? Please clarify. Thank you.**

CMS finalized the adoption of the Equal Measure Weights approach beginning with the FY 2020 HAC Reduction Program in the FY 2019 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule. You can refer to the Final Rule for more information. (83 FR 41486–41489) (August 17, 2018).

Question 11: **Please repeat where we can find the CMS PSI 90 CMS code or measure specifications.**

You can find the CMS PSI 90 measure specifications at the CMS PSI Resources Page on *QualityNet* at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228695355425.

The HAC Reduction Program Measures page contains more information on the CMS PSI 90 measure for the program: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228774294977.

Question 12: **Does the claims-based CMS PSI 90 measure come strictly from CMS claims? Do the NHSN measures come from all patients?**

That is correct. CMS PSI 90 includes fee-for-service claims data.

Question 13: **Slide 27. Can you tell us where in the Medicare Claims Processing Manual we can find the time limits for correction or edits of claims?**

The HAC Reduction Program measure scores will only reflect edits that comply with the time limits and reopening, and revision requirements outlined in Chapter 1 - General Billing Requirements and Chapter 34 - Reopening and Revision of Claim Determinations and Decisions of the Medicare Claims Processing Manual. Links are below:

- Chapter 1 – General Billing Requirements: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf
- Chapter 34 – Reopening and Revision of Claim Determinations and Decisions: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c34.pdf.

Question 14: **If there is a NO on the Subject to Payment Reduction (Yes/No) [i] on Table 1 of our FY 2020 HAC Reduction Program HSR, do we meet the 75% requirement? Are we OK?**

Yes. If your HSR says NO, then your hospital is not in the worst-performing quartile and will not be subject to a payment reduction for FY 2020.

Question 15: **Is Medicare Advantage included?**

Yes. Both Medicare and Medicare Advantage (i.e., managed care) patients will be included in the denominator and the numerator in the calculation of dual proportion. A hospital's dual proportion is the proportion of Medicare fee for service (FFS) and managed care stays where the patient was dually eligible for Medicare and full-benefit Medicaid.

Question 16: **Can you describe the exclusions for HRRP related to "planned" readmissions?**

CMS uses an algorithm to identify admissions that are typically planned and may occur within 30 days of discharge from the hospital. A planned readmission is defined as a nonacute readmission for a scheduled

procedure. Some types of care are always considered planned. These are limited to obstetric delivery, transplant surgery, maintenance chemotherapy/immunotherapy, and rehabilitation. Admissions for acute illness or complications of care are never planned.

Question 17: When will the FY 2020 HRRP reports be available?

The FY 2020 HRRP HSRs will go out in early August 2019. Providers will receive a *QualityNet* notification when the HRRP HSRs are released to the Secure File Transfer inbox in their *QualityNet* account.

Question 18: Are these the National Observed Readmission Rates for 2020 FY?

No. Data included in these slides are mock data.

Question 19: How can we determine the percentile ranking associated with each Winsorized z-Score or Total HAC Score?

The HAC Reduction Program does not report Winsorized z-score or Total HAC Score percentiles for each hospital. However, a hospital can discern its approximate Total HAC Score percentile using the currently available FY 2019 HAC Reduction Program results on *Hospital Compare* by downloading the results, sorting by Winsorized z-scores or Total HAC Score, and seeing what percentage of hospitals have scores greater or less than the hospital. You can calculate FY 2020 percentiles after the FY 2020 HAC Reduction Program data are publicly reported on *Hospital Compare* in January 2020.

Question 20: As mentioned, the HAC Reduction Program results will be out in January 2020. How about HRRP?

The readmission measures data results will also refresh on *Hospital Compare* in January 2020.

Question 21: What does it mean if your raw measure results are the same as the Winsorized measure results?

Hospitals with a measure result between the 5th and 95th percentile will receive a Winsorized measure result equal to their raw measure result (i.e., their measure result is not impacted by Winsorization).

Question 22: **How far back prior to the initial admission does CMS look for Hierarchical Condition Categories (HCCs) and other risk factors that are on claims prior to admission?**

In order 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. For each patient, risk-adjustment variables are obtained from inpatient, outpatient, and physician Medicare administrative claims data extending 12 months prior to the index admission and all claims data for the index admission itself.

Question 23: **Where can we find information regarding what PSI components are included in the modified PSI 90 score? CMS PSI 90 includes the following ten CMS PSIs:**

- PSI 03 Pressure Ulcer Rate
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In-Hospital Fall with Hip Fracture Rate
- PSI 09 Perioperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate

You can find more information in the FY 2020 HAC Reduction Program HSR User Guide on *QualityNet*: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228774298662

Subject-matter experts researched and answered the following questions after the live webinar. The questions may have been edited for grammar.

Question 24: **Is hospital-acquired pressure injury (HAPI) still a CMS PSI 90 component measure?**

Yes. PSI 03 (Pressure Ulcer Rate) is included in the CMS PSI 90 measure for the FY 2020 HAC Reduction Program. For more information on the measures, visit the HAC Reduction Program measures page on *QualityNet*.

Question 25: **What is a smoothed rate?**

The smoothed rate reflects the fact that the results for hospitals with small sample sizes are less reliable than results for hospitals with a much larger sample size. The smoothed rate adjusts for small numbers of discharges and offers a more accurate prediction of a hospital's expected performance with a large number of patients than the hospital's risk-adjusted rate.

Smoothed rates are calculated by taking a weighted average of a hospital's risk-adjusted rate and the Medicare fee-for-service national risk-adjusted rate. The weight used for the hospital's risk-adjusted rate is an estimate of its reliability. Sometimes, a hospital's risk adjusted rate may be "0" as a result of having '"0" numerator counts. When this occurs and there are fewer cases with which to estimate performance, the weight given to the risk-adjusted rate tends to be smaller, while the weight given to the national risk-adjusted rate tends to be larger because of data reliability. Therefore, it is not uncommon that hospitals with small sample size and "0" numerator counts may have smoothed rates closer to the national risk-adjusted rate, rather than their own risk-adjusted rate.

Please refer to the "Understanding Your Hospital's CMS PSI 90 Results" section on Page 16 of the FY 2020 Hospital-Specific Report User Guide for instructions on reproducing your hospital's CMS PSI 90 results.

Question 26: **How do you replicate the CMS PSI 90 measure from individual component PSI's?**

The HAC Reduction Program HSR User Guide contains detailed instructions for replicating a hospital's measure result for CMS PSI 90; Winsorized z-scores for CMS PSI 90, CLABSI, CAUTI, SSI, MRSA bacteremia, and CDI; and Total HAC Score.

An Excel file combining the steps and listing formulas is also available upon request by contacting the HAC Reduction Program Support Team at hacrp@lantanagroup.com with "Request for HAC Reduction Program Replication Example" in the subject line.

You may request the SAS or Windows version of the CMS PSI software used to calculate the CMS PSI 90 by contacting the HAC Reduction Program Support Team at hacrp@lantanagroup.com.

Please refer to the FY 2020 Replication Instruction document on [the CMS PSI Resources page on *QualityNet*] for instructions on how to use the CMS PSI software to replicate your results.

Question 27: **What if a case was coded incorrectly? Can that be changed?**

CMS takes an annual "snapshot" of the claims data to perform measure calculations for quality reporting programs. CMS received a snapshot of the data on September 28, 2018 to perform calculations for FY 2020.

Hospital results will only reflect edits that comply with the time limits and reopening and revision requirements outlined in Chapter 1 - General Billing Requirements and Chapter 34 -Reopening and Revision of Claim Determinations and Decisions in the Medicare Claims Processing Manual.

Medicare Administrative Contractors must have processed all corrections to underlying Medicare FFS claims data by the snapshot date. The HSR will not reflect any claim edits processed after this date. CMS cannot regenerate HSRs to reflect corrected claims.

The next claims snapshot for the claims-based measures, except for the MSPB measure, will be September 27, 2019 for FY 2021. Hospitals need to correct their claims data before the snapshot date for CMS to have accurate data for calculations.

Under the Hospital IQR Program, hospitals can submit, review, and correct the CDC NHSN HAI chart-abstracted or laboratory-identified data for the full 4.5 months following the end of the reporting quarter. The CDC creates a data file for CMS to use in quality reporting and pay-for-performance programs immediately following the submission deadline. This data file is a snapshot of the data at the time of the submission deadline.

CMS understands hospitals can update data in the NHSN system after the deadline. However, CMS does not receive or use data entered after the submission deadline. CMS expects hospitals to review and correct their data prior to the HAI submission deadline.

Question 28: **Is there a date when Critical Access Hospitals (CAHs) will be part of this payment impact for readmissions?**

At this time, CMS does not plan to include CAHs in calculations for the HRRP.

Question 29: **What Agency for Healthcare Research & Quality (AHRQ) PSI 90 version equates with version 9.0?**

Version 2018 Technical Specification applies to the CMS v9.0 PSI software. You can find this on the CMS PSI Resources page on *QualityNet*.

Question 30: **We recently had a HAC case in our HAC Reduction Program HSR that was a fractured rib due to chest compressions and NOT present on admission (POA). How do we correctly code this?**

Rib fractures due to CPR are considered part of the HAC 05 Falls and Trauma measure. HAC 05 Falls and Trauma includes other trauma not only caused by falls (e.g., fracture, dislocation, intracranial injury, crushing injury, burn, other injuries). You can refer to the FY 2016, FY 2017, and FY 2018 ICD-10 HAC Lists for the complete list of Falls and Trauma codes at the following link: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html. Below is the coding clinical advance (for ICD-9 and ICD-10 codes) regarding rib fractures caused by cardiopulmonary resuscitation (CPR):

A rib fracture that occurs during CPR and is not present on admission would be reported with a POA indicator of “N”. Assign the appropriate rib fracture diagnosis code and the appropriate external cause of injury code. Fractures of the rib occurring secondary to CPR efforts are not uncommon and a known risk; therefore, this would not be classified as a complication. Although the fracture is not considered a complication, the external cause of injury code is assigned to provide information about how the fracture occurred. If a hospital feels a condition is not a true HAC, it can appeal the assignment within 60 days. Please see the language regarding review of diagnostic-related group (DRG) assignment from the Code of Federal Regulations below.

Subpart D—Basic Methodology for Determining Prospective Payment Federal Rates for Inpatient Operating Costs

§ 412.60 DRG classification and weighting factors.

(d) Review of DRG assignment. (1) A hospital has 60 days after the date of the notice of the initial assignment of a discharge to a DRG to request a review of that assignment. The hospital may submit additional information as a part of its request. (2) The intermediary reviews the hospital’s request and any additional information and decides whether a change in the DRG assignment is appropriate. If the intermediary decides that a higher-weighted DRG should be assigned, the case will be reviewed by the appropriate Quality Improvement Organization (QIO) as specified in §466.71(c)(2) of this chapter. (3) Following the 60-day period described in paragraph (d)(1) of this section, the hospital may

not submit additional information with respect to the DRG assignment or otherwise revise its claim.

If you have further general clinical coding questions about HACs, please contact the American Hospital Association via http://www.codingclinicadvisor.com/.

Question 31: **Which measures will be removed from the IQR readmissions program and will this mean only the HRRP readmissions data will be displayed on *Hospital Compare*? Will the HRRP readmissions data be used to calculate the Star Rating? Is this similar to how IQR data are used?**

The following readmission measures will only be under HRRP starting in FY 2020: acute myocardial infarction (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), elective primary total hip and total knee arthroplasty (THA/TKA), and coronary artery bypass graft surgery (CABG). For applicable hospitals with at least 25 discharges or more, CMS will still report the following data elements for each of the six condition/procedure 30-day risk-standardized unplanned readmission measures on *Hospital Compare* annually:

- Number of eligible discharges
- Number of readmissions for hospitals with 11 or more readmissions
- Predicted readmissions (i.e., adjusted actual readmissions)
- Expected readmissions
- ERR

The Hospital Overall Quality Star Rating considers all measures publicly reported on *Hospital Compare* for inclusion prior to each Star Rating refresh. If a measure has been finalized for removal from one program (e.g., Hospital IQR Program) but remains and is publicly reported in another (e.g., HRRP), it will be considered for inclusion in the Star Rating. The readmission measures included in the Overall Hospital Quality Star Rating differ from the HRRP measures in several ways.

HRRP includes 30-day risk standardized readmission measures for the following six conditions/procedures: AMI, COPD, HF, pneumonia, CABG, and THA/TKA. The Star Ratings Program uses excess days in acute care (EDAC) measures for AMI, HF, and pneumonia. Results between EDAC measures and 30-day readmission measures are not comparable.

Although HRRP and Overall Star Ratings both include 30-day readmission measures for COPD, CABG, and THA/TKA, these measures are not comparable for several reasons.

As noted, the Overall Star Rating includes readmission measures reported on *Hospital Compare*. Different hospitals are eligible for the *Hospital Compare*

Public Reporting main pages and HRRP readmission measure results. HRRP only identifies admissions and readmissions at applicable hospitals (including subsection (d) and Maryland hospitals) in the measure calculation. Hospitalizations that occur at non-subsection (d) hospitals are not included as eligible index admissions or considered readmissions under HRRP. By contrast, *Hospital Compare* Public Reporting main pages display readmission measure results including a larger group of hospitals, such as CAHs and hospitals in the U.S. territories that are not subsection (d) hospitals.