Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Overview of the FY 2020 HAC Reduction Program and HRRP

Presentation Transcript

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July 23, 2019
2 p.m. ET

Bethany Bunch: Hello and welcome to the Overview of the Fiscal Year 2020 Hospital-Acquired Condition Reduction Program and Hospital Readmissions Reduction Program webinar. My name is Bethany Bunch, and I am with the Inpatient VIQR Support Contractor. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation and the questions and answers will be posted to the inpatient web site, *www.QualityReportingCenter.com*. If you registered for this event, a reminder e-mail and the slides were sent out to your e-mail about two hours ago. If you did not receive the e-mail file, you can download the slides at the inpatient web site, *www.QualityReportingCenter.com*. 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 question-and-answer summary will be made available 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 summary 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* Inpatient Q&A tool. I would now like to introduce the speakers for today's presentation. Our speakers for today's event are from the Hospital Quality Reporting Program Support Contractor. April Compingbutra is a Program Lead for the HAC Reduction Program and Laura Blum is a Program Lead for the Hospital Readmissions Reduction Program. Thank you for speaking to us today.

This event will provide an overview of the fiscal year 2020 HAC Reduction Program and HRRP, including program updates, methodology, Hospital-Specific Reports, and the review and corrections process.

At the conclusion of today's event, participants will be able to interpret the methodology used in both programs, understand your hospital's program results in your HSR, submit questions about your hospital's calculations during the HAC Reduction Program Scoring Calculations Review and Corrections Period and the HRRP review and corrections period.

Without further ado, I will now turn over the presentation to April Compingbutra, Program Lead of the HAC Reduction Program from the Hospital Quality Reporting Program Support Contract.

April Compingbutra: Thank you, Bethany. Hello, my name is April Compingbutra, and I am a program lead on the Hospital-Acquired Condition, or HAC, Reduction Program under HQRPS.

To provide a little background on the program, the HAC Reduction Program was established to incentivize hospitals to reduce the number of hospital-acquired conditions, or HACs. HACs include patient safety events, such as falls; and healthcare-associated infections, such as surgical site infections, SSI. The program was established under Section 1886 of the Social Security Act. CMS started applying payment adjustments beginning with the fiscal year 2015 discharges. Hospitals that rank in the worst-performing quartile, or 25 percent, of all subsection (d) hospitals receive a 1-percent payment adjustment.

This page describes what hospitals are subject to the HAC Reduction Program and what hospitals are exempt. As defined under the Social Security Act, all subsection (d) hospitals are subject to the HAC Reduction Program. For a full description of subsection (d) hospitals, refer to the Social Security Act on the Social Security Administration's website.

CMS exempts certain hospitals and hospital units from the HAC Reduction Program. These include:

- Critical access hospitals
- Rehabilitation hospitals and units
- Long-term care hospitals
- Psychiatric hospitals and units
- Children's hospitals
- Prospective Payment System-exempt Cancer Hospitals
- Short-term acute care hospitals located in Guam, the U.S. Virgin Islands, the Northern Mariana Islands, and American Samoa
- Religious nonmedical health care institutions, and

- Maryland hospitals, which are exempt from payment reductions under the HAC Reduction Program. These hospitals currently operate under a waiver agreement between CMS and the state of Maryland.

CMS made the following updates in FY 2020:

- CMS calculated the CMS PSI 90 using the CMS v9.0 PSI software. The CMS v9.0 PSI software, both SAS and Windows versions, is available from hacrp@lantanagroup.com by request.
- This year CMS returned to a 24-month performance period for CMS PSI 90 using ICD-10 data, which includes patient discharges from July 1, 2016 through June 30, 2018.
- The performance period for the CDC NHSN HAI measures includes patient discharges from January 1, 2017 through December 31, 2018.
- CMS removed domain weights from the HAC Reduction Program scoring methodology and adopted the Equal Measure Weights approach. We'll go into that later.

This table shows which measures were included in each fiscal year of the program. Fiscal year 2020 includes the modified CMS PSI (Patient Safety Indicator) measure, Central Line-associated Bloodstream Infection (CLABSI), Catheter-Associated Urinary Tract Infection (CAUTI), Surgical Site Infection (specifically Abdominal Hysterectomy and Colon Procedures), or SSI, Methicillin-Resistant Staphylococcus aureus (MRSA), and Clostridium difficile infection (CDI), and these are the same measures that were included in fiscal year 2019.

This table shows the difference between the performance periods of fiscal year 2020 and 2019. In fiscal year 2020, the two domains are removed. Equal weight is applied to each measure with a measure score. Fiscal year 20 has an updated performance period of July 1, 2016 through June 30, 2018 for the CMS PSI 90 measure. The CDC NHSN HAI measures have an updated performance period of January 1, 2017, through December 31, 2018. For the fiscal year 2020 HAC Reduction Program, the payment

adjustment applies to all Medicare fee for-service discharges between October 1, 2019 and September 30, 2020.

Fiscal year 2020 uses the same Winsorized z-score score methodology that CMS adopted in fiscal year 2018. Hospitals that perform worse than the mean will earn a positive Winsorized z-score, and hospitals that perform better than the mean will earn a negative Winsorized z-score. So, lower z-scores indicate better performance and, for more information on the scoring methodology, you can refer to the resources slide towards the end of this presentation.

In fiscal year 2020, CMS implemented the Equal Measure Weights approach, which was finalized in the fiscal year 2019 IPPS final rule. The Equal Measure Weights approach applies equal weight to each measure for which a hospital has a Winsorized z-score. This removes the two domain weights and addresses concerns about the disproportionate weight applied to Domain 2 measures for low-volume hospitals. All other aspects of the HAC Reduction Program scoring methodology remain the same, including the calculation of measure scores as Winsorized z-scores, the determination of the 75th percentile Total HAC Score, and the determination of the worst-performing quartile.

This table displays the weight applied to each measure with a Winsorized z-score under the Equal Measure Weights approach. For example, if you only have two measures with a Winsorized z-score, CMS would apply a weight of 50 percent to each measure. With four measures, CMS would apply a weight of 25 percent.

The fiscal year 2020 scoring methodology consists of the following steps. First, CMS calculates the Winsorized measure results for each measure and, from that, CMS calculates the Winsorized z-scores for each measure. Then, CMS apples an equal weight for each measure with a Winsorized z-score and multiples the measure score by the weight for each measure. This determines each measure’s contribution to the Total HAC Score. Then, CMS sums the contributions to obtain the Total HAC Score.

Once all of the hospitals' Total HAC Scores are calculated, CMS determines the 75th percentile of Total HAC Scores. Hospitals that have a Total HAC Score greater than the 75th percentile are classified in the worst-performing quartile and subject to a payment reduction.

This is an example of calculating Hospital A's Total HAC Score using mock data to determine if it is in the 75th percentile. Hospital A has six measures with Winsorized measure results and z-scores. So, it has an equal measure weight of 16.7 percent applied to each measure to determine each measure's contribution to the Total HAC Score. Once all the contributions are added up, the Total HAC Score is compared to the 75th percentile of Total HAC Score. In this example the 75th percentile is at .345. As Hospital A's Total HAC Score is negative .0782, it is less than the 75th percentile. Hospital A is not penalized in this example.

CMS begins distributing HSRs a couple of days before the start of the scoring calculations review and corrections period. The HAC Reduction Program scoring calculations review and corrections period began on July 19th. A *QualityNet* notification indicating the reports are available via email were sent to those who registered for notifications. Hospital users with the Hospital Reporting Feedback (Inpatient Role) and the File Exchange and Search Hospital Inpatient Quality Reporting, or IQR, Program Role will have access to the HSRs. The HSRs and the user guide can be located in the *My QualityNet* Secure File Transfer Inbox on the *QualityNet* website. It's also important to note to keep your *QualityNet* account up to date, so that you're able to access your hospital's HSR as soon as it becomes available. If you have questions about your account, you can contact the *QualityNet* Help Desk.

The HAC Reduction Program HSR provides hospitals the following information: contact information and resources for the program, performance on Total HAC Scores and measure scores, measure results and Winsorized z-scores, performance on CMS PSI 90, discharge-level information for CMS PSI 90, as well as performance on CDC NHSN HAI measures. Now, I'm going to give a brief walkthrough of a mock HSR.

Please note, the screenshots of this mock HSR do not include actual values for fiscal year 2020.

This is a screenshot of Table 1, which shows a hospital's Total HAC score performance. This table includes the CMS PSI 90 scores and CDC NHSN HAI measure scores, the contribution of each measure to your hospital's Total HAC score, your Total HAC score, and the last column indicates if your hospital is subject to a 1-percent payment reduction. If a hospital has only one measure score, CMS applies a weight of 100 percent to that measure.

This is a screenshot of Table 2 which shows a hospital's measure results and Winsorized z-score for each measure. In this HSR example, CAUTI has "INS" for insufficient data for the measure result. So, their Total HAC Score will be based on five measures instead of six. For each measure, CMS calculates Winsorized measure results for each hospital based on raw measure results in the fifth and 95th percentile result for all eligible hospitals. So, if a hospital's measure result falls between the minimum and the fifth percentile, CMS sets the hospital's measure result equal to the fifth percentile, and if a hospital's measure result falls between the 95th percentile and maximum, CMS sets the hospital's measure result equal to the 95th percentile.

This hospital's raw measure results fall between the 5th and 95th percentile, so Winsorization does not change their measure result. These hospitals' Winsorized measure results equal their raw measure results in the second column. CMS then subtracts the mean Winsorized measure result for all eligible hospitals from a hospital's Winsorized measure result and divides by a standard deviation of Winsorized measure results for all eligible hospitals. So, this is how CMS calculates the Winsorized z-score, or measure score, for each measure found in the third to last column on the right.

Table 3 provides information on interpreting performance results for CMS PSI 90 and the ten CMS PSI component measures that make up CMS PSI 90. This table summarizes your hospital's number of eligible discharges,

number of outcomes, observed rates, expected rates, risk-adjusted rates, and smoothed rates for each component CMS PSI. This table provides the Medicare fee for service national results for CMS PSI 90 and risk-adjusted rates for each component CMS PSI. This table contains each CMS PSI component measure weight in CMS PSI 90, along with the reliability weight. The HAC Reduction Program HSR user guide contains detailed information for replicating a hospital's measure result for CMS PSI 90, Winsorized z-scores for each measure, 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 the following subject line: "Request for HAC Reduction Program Replication Example." You may request the SAS or Windows version of the CMS PSI software used to calculate the CMS PSI 90 by emailing the same address.

Table 4 includes information on discharges that were included in the numerator of one or more CMS PSIs. Note this table in your HSR includes personally identifiable information. So, if you need to email any questions about a particular discharge, you should use the ID number listed in the first column and leave out any patient identifying information.

Table 5 includes information on interpreting performance results for the CDC NHSN HAI measures (or CLABSI, CAUTI, SSI, MRSA bacteremia, and CDI) and summarizes your hospital's reported number of HAIs. The CDC calculates SIRs by dividing a hospital's reported number of HAIs by the hospital's predicted number of HAIs.

This graphic shows the data flow of claims-based data. The CMS PSI 90 measure is based on Medicare fee for service claims data. Approximately 90 days after the end of the reporting period, which is usually in September, CMS effectively takes a snapshot of the claims data, and then hospitals receive their HSRs and have a 30-day scoring calculations review and corrections period to review their data. Then, the hospital's data are publicly reported which, this year, will be in January.

For CMS PSI 90, hospital results will only reflect edits that comply with the time limits in the Medicare Claims Processing Manual. The snapshot of the data for fiscal year 2020 was September 28, 2018. Only corrected claims processed by September 28, 2018, were included for the HAC Reduction Program. If hospitals submitted a corrected claim after the snapshot date, the hospital's HSR results will not include the corrected claim data.

This graphic depicts the flow of HAI data from when it's generated through to pubic reporting. First, HAI data is generated by events during a patient's hospitalization. Under the Hospital IQR Program, hospitals can submit, review, and correct their HAI data in NHSN for four and a half months following the end of the reporting quarter. Hospitals are strongly encouraged to review and correct their data prior to the HAI submission deadline. Immediately following the submission deadline, the CDC creates a snapshot of the data and sends it to CMS, so CMS does not receive or use data entered into NHSN after the submission deadline. CMS then uses the chart-abstracted data submitted through NHSN to calculate the HAI measure scores, which CMS sends to hospitals in their HSRs at the beginning of the scoring calculations review and corrections period. In January, CMS publicly reports the data on *Hospital Compare*.

CMS calculates the following CDC NHSN HAI measures using chart-abstracted surveillance data reported to NHSN for infections: CLABSI, CAUTI, SSI, MRSA bacteremia, and CDI.

The HAC Reduction Program scoring calculations review and corrections period began on July 19, 2019 and ends on August 16, 2019. As we mentioned, CMS distributes HSRs via the *QualityNet Secure Portal*. Please send any questions about your HSR data or program-related questions to the HAC Reduction Program Support Team via email at hacrp@lantanagroup.com or via the *QualityNet* Question and Answers tool as soon as possible, but no later than 11:59 p.m. Pacific Time on August 16.

This slide shows what is and what is not allowed during the review and corrections period. A common question we receive is hospitals wanting to correct their underlying data included in their HSR. The purpose of the scoring calculations review and corrections period is to allow hospitals an opportunity to submit questions about the calculation of your hospital's results and request corrections of potential calculation errors. It does not allow hospitals to submit additional corrections related to underlying claims or NHSN data.

For more information, the HSR user guide and the mock HSR is posted for the public on the *QualityNet* website. Hospitals can also request a copy of Example Replication Instructions from the HAC Reduction Program Support Team, which includes example calculations and formulas in Excel using the mock HSR. You can also visit the scoring calculations review and corrections web page, and you can request a copy of the CMS v9.0 PSI software from the HAC Reduction Program Support Team. You can refer to the fiscal year 2020 Replication Instructions document, which is on the *QualityNet* CMS PSI resources web page, for instructions on how to use the CMS PSI software.

Hospitals with a Total HAC Score greater than the 75th percentile of all Total HAC Scores, or hospitals in the worst-performing quartile, will be subject to a 1-percent payment reduction. This payment reduction applies to all fee for service Medicare discharges between October 1, 2019 and September 30, 2020 (i.e., fiscal year 2020). The payment reduction occurs when CMS pays hospitals' hospital claims. CMS notifies hospitals whether they will receive a payment reduction in fiscal year 2020 in the HAC Reduction Program HSR.

In January 2020, CMS will release the following fiscal year 2020 HAC Reduction Program information on *Hospital Compare*: the CMS PSI 90, CLABSI, CAUTI, SSI, MRSA bacteremia, and CDI measure scores; Total HAC Score; and Payment Reduction Indicator.

This slide just includes additional resources for the HAC Reduction Program on the *QualityNet* website, as well as contact information for the HAC Reduction Program Support Team for any questions, listed at the bottom.

Now, I will turn it over to Laura to cover HRRP. Thank you.

Laura Blum: Thank you, April. My name is Laura Blum and I am a Program Lead for the Hospital Readmissions Reduction Program, along with Kati Warren, under the HQRPS contract for CMS.

The Hospital Readmissions Reductions Program, also known as HRRP, is a Medicare value-based purchasing program that reduces payments to hospitals with excess readmissions.

Starting in fiscal year 2013, Section 3025 of the 2010 Affordable Care Act added section 1886(q) to the Social Security Act, which required the Secretary of the Department of Health and Human Services to establish HRRP. HRRP supports CMS' national goal of improving healthcare for Americans by linking payment to the quality of hospital care. HRRP encourages hospitals to improve communication and care coordination efforts to better engage patients and caregivers, with respect to post-discharge planning.

All subsection (d) hospitals are subject to HRRP. Due to the Maryland All-Payer Model, which reduces payments to Maryland hospitals under a waiver agreement with CMS, Maryland hospitals are included in HRRP but exempt from receiving payment reductions.

CMS exempts the same hospitals from HRRP as it does from the HAC Reduction Program. Please refer to the eligible hospital slide earlier in this presentation for a list of these exemptions.

HRRP includes 30-day risk-standardized unplanned readmission measures for specific conditions and procedures that significantly affect the lives of large numbers of Medicare patients. HRRP currently has four condition and two procedure measures: acute myocardial infarction, heart failure,

pneumonia, chronic obstructive pulmonary disease, elective primary total hip and/or total knee arthroplasty, and coronary artery bypass graft surgery. The fiscal year 2020 3-year performance period for these measures covered discharges occurring July 1, 2015 through June 30, 2018.

The 21st Century Cures Act requires CMS to assess the hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid. The legislation requires estimated payments under the non-stratified methodology, which corresponds to fiscal years 2013 through 2018, equal payments under the stratified methodology, which corresponds to fiscal year 2019 and subsequent years, to maintain budget neutrality. In the next slides, we will break down each step of the stratified methodology in detail.

This figure shows the steps CMS takes to use hospital claims to generate excess readmission ratios, also known as ERRs, and dual proportions, and then stratify hospitals into five peer groups based on the hospitals' dual proportions. As shown in Step 1, CMS assembles each hospital's Medicare claims and then identifies 30-day risk-standardized, unplanned readmissions for the six measures included in the program. For each measure, CMS uses the hospital's Medicare fee for service, or FFS, claims to calculate an ERR, which is the ratio of a hospital's predicted readmissions to its expected readmissions. CMS uses the hospital's Medicare FFS and managed care claims to calculate its dual proportion, which is the proportion of stays where a patient was dually eligible for Medicare and full-benefit Medicaid. In this figure, the blue and white person icons represent dual-eligible and non-dual eligible patients. As shown in Step 2, CMS stratifies hospitals into one of five peer groups based on the dual proportion. CMS assesses hospital performance on the six measures relative to the performance of hospitals within the same peer group. In this figure, the hospitals with similar dual proportions of blue and white person icons are grouped into peer groups, represented by the colored boxes. The first peer group represents hospitals with the lowest dual proportions, whereas the fifth peer group represents hospitals with the

highest dual proportions. The ranges of the dual proportions for each peer group are included in the fiscal year 2020 HSR user guide.

Although ERRs are calculated among Medicare FFS beneficiaries only, the dual proportion is calculated using all full-benefit, dual-eligible Medicare FFS and managed care stays sourced from State Medicare Modernization Act files. CMS includes managed care inpatient stays due to variation in the size of hospitals' managed care populations. This more accurately reflects the proportion of dual-eligible patients for all hospitals.

The ERR is a measure of a hospital's relative performance and is used in the payment adjustment factor to assess hospitals' excess readmissions for each of the conditions/procedures included in HRRP. As shown in Steps 3 and 4, CMS calculates an ERR for each measure and each hospital in the program and uses the peer group median ERR as the threshold to determine excess readmissions.

An ERR greater than the peer group median ERR indicates that a hospital has excess readmissions relative to other hospitals in its peer group. If a hospital's ERR is greater than the peer group median and the hospital has 25 or more eligible discharges, the ERR will enter the payment adjustment factor formula and the hospital may be subject to a payment reduction.

If a hospital has fewer than 25 eligible discharges for a measure, CMS will not use the ERR for that measure in the payment adjustment factor formula calculation. This ensures CMS has enough information to reliably determine a hospital's performance on each measure.

As shown in Step 5, CMS calculates the neutrality modifier, which is the multiplicative factor that, when applied to hospital payment reductions, equates total Medicare savings under the non-stratified and stratified methodologies. The non-stratified methodology was the methodology used in HRRP during fiscal years 2013 through 2018. The neutrality modifier is calculated by estimating the total Medicare savings across all hospitals under the non-stratified methodology and the stratified methodology in the

absence of a modifier. The inclusion of the neutrality modifier in the payment adjustment factor ensures budget neutrality.

As shown in Step 6 and 7, hospitals can calculate their payment reduction percentage using the payment adjustment factor formula, which we will go into more detail about on the next slide. As of fiscal year 2015, the minimum payment adjustment factor is 0.97, which corresponds to a maximum 3-percent payment reduction. To determine the payment reduction percentage, hospitals must subtract the payment adjustment factor from one and multiply the result by one hundred. If the payment adjustment factor is equal to one, then the hospital will not receive a payment reduction. Hospitals with higher payment adjustment factors will have lower payment reductions.

The payment adjustment factor formula displayed on this slide represents the size of the payment reduction. *DX* is one of the six measures. *Payments* are Base Operating Diagnosis-Related Group, or DRG, payments. *ERR* is the measure of excess readmissions, and *NM* is the neutrality modifier.

Finally, as shown in Step 8, hospitals can determine the payment amount for Medicare FFS claims by applying the payment adjustment factor to base operating DRG payment amounts. Medicare FFS base operating DRG payments are the base DRG payments without any add-on payments, such as Disproportionate Share Hospital and Indirect Medical Education payments. CMS applies the payment adjustment factor to all Medicare FFS base operating DRG payments for discharges in the applicable fiscal year, regardless of the condition. For fiscal year 2020, the payment reduction will apply to payments for discharges occurring October 1, 2019 through September 30, 2020.

The HRRP Payment Adjustment Factor Methodology infographic that we just went over illustrates how CMS determines the payment adjustment factor. The infographic can be found on the *QualityNet* website under HRRP Resources.

CMS provides hospitals with detailed HRRP data and results in confidential HSRs. Hospitals can use the HRRP HSR to review their measure results and discharge-level data and to replicate their payment adjustment factor calculation and component results. A slide earlier in this presentation details how hospitals can access their HSR.

On the first tab of the HSR is the HRRP Workbook, where hospitals can find information to assist with understanding the data in their HSR and who to contact for questions about the program. The remaining HSR tabs provide hospitals information about the payment adjustment factor, hospital results, discharge data, and dual stays. As always, the HSR user guide provides replication instructions for the payment adjustment factor calculations and component results to promote transparency.

The second HSR tab is Table 1: Payment Adjustment, which provides hospital-level data for the Number of Dual Eligible Stays, Number of Eligible Stays, Dual Proportion, Peer Group Assignment, Neutrality Modifier, and Payment Adjustment Factor. Please note that mock data is displayed in this presentation. The first three columns are your hospital's Number of Dual Eligible Stays (Numerator), Number of Eligible Stays (Denominator), and Dual Proportion. The dual proportion is the ratio of dual eligible stays to eligible stays. Medicare FFS and managed care patients are included in the numerator and the denominator calculations of the dual proportion. The fourth column is your hospital's Peer Group Assignment. Peer Group Assignment 1 represents the hospitals with the lowest dual proportions and Peer Group Assignment 5 represents hospitals with the highest dual proportions. The fifth column is the Neutrality Modifier, which is the same for all hospitals subject to HRRP and is applied in the calculation of the payment adjustment factors to maintain budget neutrality. The sixth and final column is your hospital's payment adjustment factor, which represents the size of your payment reduction. For fiscal year 2020, hospitals subject to HRRP will have payment adjustment factors between 1, which indicates no payment reduction, and 0.97, which is the maximum payment reduction.

The third HSR tab is Table 2: Hospital Results, which provides an overview of hospital-level performance across the six measures. If your hospital performs better than an average hospital that admitted similar patients on a given measure, the ERR for that measure will be less than 1. If your hospital performs worse than average on a given measure, the ERR for that measure will be greater than 1. If your hospital has fewer than 25 eligible discharges for a measure, CMS will not use the ERR for that measure in the payment adjustment factor formula. The peer group median ERR is the threshold that assesses hospital performance on each measure. The Penalty Indicator indicates whether the ERR for each measure will enter the payment adjustment factor formula. If the Penalty Indicator equals "Yes" on a given measure, then your hospital has 25 or more eligible discharges and an ERR greater than the peer group median ERR for that measure. If your hospital has less than 25 eligible discharges or the ERR is less than the peer group median ERR for that measure, the Penalty Indicator equals "No". The ERRs for each measure enter the payment adjustment factor formula additively. Each additional measure with a Penalty Indicator of "Yes" increases the payment adjustment factor Whether your hospital will receive a payment reduction depends on your hospital's number of eligible discharges, ERR, the peer group median ERR for each of these measures, and the neutrality modifier.

If your hospital has no eligible discharges for a given measure, the number of eligible discharges, number of readmissions among eligible discharges, predicted readmission rate, expected readmission rate, ERR, and ratio of DRG payments per measure to total payments will be "NQ" to indicate there are no qualifying cases for the measure. CMS cannot calculate an ERR for a measure without a qualifying case for a measure. So, the Penalty Indicator will have a value of "No".

The next six HSR tabs are Tables 3 through 8: Discharges. HRRP discharges include patients aged 65 and over who are enrolled in Medicare FFS Part A and Part B. A patient must be enrolled in Medicare FFS Part A and Part B for the full 12 months prior to the index admission, as well as enrolled in Part A during the index admission, to be included in the HRRP

measures. These tables include all discharges that meet the inclusion requirements for each measure and use the inclusion/exclusion indicator to identify discharges that were excluded from measure results calculation. The tables also indicate whether an unplanned or planned readmission followed the discharge within 30 days and include the risk factors for each measure with the corresponding condition category.

The next two slides show the continuation of the available data in the discharge tabs. These data are explained in detail in the HSR user guide.

The last HSR tab is Table 9: Dual Stays, which provides Medicare FFS and managed care stays where the patient was dually eligible for Medicare and full-benefit Medicaid during the applicable period. Please note that the table has been modified in this presentation to show only the first few stays.

CMS distributes HSRs via *QualityNet Secure Portal* at the beginning of the review and corrections period. The HRRP fiscal year 2020 review and corrections period extends from August 9, 2019 through September 9, 2019. Hospitals have 30 days during the review and corrections period to review their HSR data and ensure the calculations are correct prior to public reporting. If hospitals identify potential discrepancies in their payment adjustment factor and component results, they can request a review of the calculations by emailing hrrp@lantanagroup.com. Please remember that the HSRs contain personally identifiable information and protected health information and should not be emailed. Hospitals can replicate their results by referring to the instructions in the fiscal year 2020 HRRP HSR user guide on the HRRP HSR page of the *QualityNet* website. Please note that the HSR user guide, mock HSR, and replication instructions will be available on *QualityNet* at the beginning of the review and corrections period.

This slide shows a list of what hospitals can correct during the HRRP review and corrections period. As a reminder, hospitals cannot submit corrections to the underlying claims data or add new claims to the data extract CMS used to calculate the finalized results.

For hospitals with at least 25 discharges, CMS reports the following data elements for each of the 30-day, risk-standardized unplanned readmission measures on *Hospital Compare*: number of eligible discharges, number of readmissions for hospitals with 11 or more readmissions, predicted readmissions, expected readmissions, and ERR.

CMS also releases data elements in the Final Rule Supplemental Data File, including: Hospital Payment Adjustment Factor, Hospital Dual Proportion, Hospital Peer Group Assignment, ERR for each measure, Number of eligible discharges for each measure, Peer Group Median ERR for each measure, Penalty Indicator for each measure, and DRG payment ratio for each measure.

CMS will publicly report fiscal year 2020 HRRP data on *Hospital Compare* in early 2020. As a reminder, while there are no changes to HRRP's public reporting process, the readmission measures removed from the Hospital Inpatient Quality Reporting Program will be solely under HRRP beginning with fiscal year 2020.

This brings us to the end of our fiscal year 2020 HRRP HSR overview. For further information on HRRP, please refer to the additional resources on this slide or email hrrp@lantanagroup.com. Thank you. Back to you, Bethany.

Bethany Bunch: Thank you, Laura. We have time for a few questions for each program. I will start with the HAC Reduction Program. Who do I contact for questions about the CDC NHSN measures?

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

Bethany Bunch: Thank you, April. Next question: When is the next snapshot date for claims data?

April Compingbutra: The next claims snapshot date for the claims-based measures, except for the Medicare Spending Per Beneficiary measure, MSPB, will be September 27, 2019 for fiscal year 2021. Hospitals need to correct their claims data before the snapshot date, so CMS has accurate data for

calculations. The HSR will not reflect any claim edits processed after this date. CMS cannot regenerate HSRs to reflect corrected claims.

Bethany Bunch: Thank you. 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?

April Compingbutra: 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 (CLABSI, CAUTI, and/or SSI) for the entire two-year reporting period.
3. The hospital did not indicate in NHSN that it had any active ICU locations, medical wards, surgical wards, and medical-surgical wards for at least one quarter during the reporting period (i.e. no mapped locations for CLABSI and CAUTI).
4. The hospital is classified as an outlier for the measure (for CDI only).

Bethany Bunch: Thank you. Next question: What is the 75th percentile threshold or cutoff for receiving a payment reduction for the HAC Reduction Program this year?

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

Bethany Bunch: Thank you and one more question for the HAC Reduction Program. Regarding the HAC Reduction Program, is there a Windows version of the 9.0 CMS PSI software available?

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

Bethany Bunch: Thank you, April. Shifting gears to the Hospital Readmissions Reduction Program. First question: When will I receive my hospital's fiscal year 2020 HRRP HSR?

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

Bethany Bunch: Thank you. Next question: How can I tell if my hospital will receive a payment reduction and how can I tell how much it will be?

Laura Blum: 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.

Bethany Bunch: Thank you. It looks like we have time for one more question. How do the HRRP readmission measure results differ from the *Hospital Compare* Public Reporting readmission measure results?

Laura Blum: Prior to July 2019, the *Hospital Compare* Public Reporting readmission measure results were reported as part of the Hospital Inpatient Quality Reporting Program. For fiscal year 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 *Hospital Compare* Public Reporting readmission measures. The *Hospital Compare* Public Reporting HSR reports the Risk-Standardized Readmission Rate, or RSRR, for each measure as well as performance categories assessing if the hospital performance is better, worse, or no different than the national average. HRRP and *Hospital Compare* Public Reporting 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. The ERR used in HRRP 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.

Bethany Bunch: Thank you, Laura. That's all the… It sounds like we are having technical difficulties. Sorry about that. Thank you for attending today.

On the next slide, we have information on the continuing education credit. This webinar was approved for one continuing education credit.

I want to thank April and Laura for speaking with us today. Everyone, have a great rest of your day.