



Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Overview of the FY 2021 Hospital Readmissions Reduction Program

Presentation Transcript

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August 7, 2020

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Bethany Bunch: Hello, and thank you for tuning in to the Hospital Readmissions Reduction Program (HRRP) On Demand webinar, covering an overview of the fiscal year (FY) 2021 program year.

My name is Bethany Bunch, and I am a Program Lead at CMS's Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be your virtual host for the webinar today. I would like to introduce our speakers for today's webinar. Kristin Maurer is the Hospital Readmissions Reduction Lead at CMS's Division of Value, Incentives, and Quality Reporting Program Support Contractor. Kristina Peris is the Hospital Readmissions Reduction Program Analyst at the same DPS contract. Welcome Kristin and Kristanna, and thank you for presenting today.

This event will provide an overview of the fiscal year 2021 Hospital Readmissions Reduction Program, including program updates, methodology, Hospital-Specific Reports (HSRs), and the review and correction period.

At the end of the event, participants will be able to interpret the methodology used in the program, understand your hospital's program results in your HSR, and understand how to submit questions about your hospital's calculations during the HRRP review and correction period.

If you have questions during the webinar, you may submit them to the following email address, WebinarQuestions@hsag.com. When sending questions, please use the webinar title in the subject line. The webinar title is *Overview of the FY 2021 Hospital Readmissions Reduction Program*. In the email body, please include your question, and, if your question pertains to a specific slide, please include the slide number for us to more efficiently assist you. We will answer your questions as soon as possible. If you have questions unrelated to the current webinar topic, we recommend searching for the topic in the *QualityNet* Inpatient Q&A tool. If you do not find a similar topic, feel free to use the tool to submit a new question. I will now pass the presentation over to Kristin Maurer. Thank you.

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Kristin Mauer: Thanks, Bethany.

HRRP is a Medicare value-based purchasing program that was established to reduce payments to hospitals with excess readmissions. Section 3025 of the Affordable Care Act required the Secretary of the U.S. Department of Health and Human Services to establish HRRP and reduce payments to hospitals with excess readmissions beginning October 1, 2012, or FY 2013. HRRP supports the CMS' goal of improving health care for Americans by linking payment to quality of hospital care. Under HRRP, hospitals are encouraged to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions.

HRRP includes all subsection (d) hospitals with eligible discharges for any of the six HRRP readmission measures. In general, 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 hospitals, and acute care hospitals in the 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.

CMS assesses hospitals' performance using data from a three-year performance period. The FY 2021 performance period includes hospital discharges that occurred from July 1, 2016, to June 30, 2019. This is the data period that CMS uses to calculate all components of the payment reduction, such as measure results, DRG payment ratio, and dual proportions. HRRP includes six conditions or procedure-specific 30-day risk-standardized unplanned readmission measures. The measure include acute myocardial infarction (AMI); chronic obstructive pulmonary disease (COPD); heart failure (HF); pneumonia; coronary artery bypass graft surgery (CABG); and elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA).

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From FY 2013 to FY 2018, CMS used a non-stratified methodology to assess hospital performance under HRRP. Under the non-stratified methodology, CMS used a threshold of 1.0, or the average ERR for hospitals that admitted similar patients, to assess hospital performance on each measure. Beginning in FY 2019, the [21st Century] Cures Act directed CMS to use a stratified methodology to evaluate a hospital's performance. The stratified methodology assesses hospital performance relative to that of other hospitals with a similar proportion of stays for patients who are dually eligible for Medicare and full Medicaid benefits. Dual-eligible status is an indicator of patients' social risk, and the approach of stratifying hospitals holds all hospitals to a high standard while also ensuring the program does not disproportionality reduce payments for hospitals serving at-risk populations. The 21st Century Cures Act also requires that the stratified methodology produce the same amount of Medicare savings generated under the non-stratified methodology to maintain budget neutrality. The neutrality modifier in the payment reduction calculation satisfies the Cures Act's requirements to maintain budget neutrality between the two methodologies.

The payment reduction is the percentage a hospital's payments will be reduced based on its performance in the program. The payment reduction is a weighted average of a hospital's performance across the six HRRP measures during the three-year HRRP 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 FFS base operating DRG payments during the fiscal year. The next few slides all 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 and an ERR for each of the six HRRP conditions and procedures. The ERR is a measure of a hospital's relative performance used in the payment reduction formula to assess whether a hospital's excess readmissions for each of the conditions or procedures included in HRRP. The ERR is the reliability-adjusted

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number of readmissions predicted at the hospital over the number of readmissions expected, based on patient risk factors and the average hospital's performance. 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 THA/TKA measure. This hospital did not have any eligible discharges for that measure, 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 stays for Medicare FFS and managed care beneficiaries who were eligible for full Medicaid benefits during the three-year HRRP performance period. 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 FFS and managed care stays. For this hospital, the dual proportion equals 894 divided by 3,389 total stays, or 0.2638.

This slide shows a little bit more information about the changes to the dual eligibility as finalized in the FY 2020 IPPS/LTCH PPS Final Rule. For FY 2021, CMS updated the definition of dual eligibility used in the dual proportion. Under the previous definition, dual-eligible stays included stays for Medicare beneficiaries with full Medicaid benefits for the month the beneficiary was discharged from the hospital. Under the new definition, beginning in FY 2021, dual-eligible stays are stays for Medicare beneficiaries with full Medicaid benefits for the month the beneficiary was discharged from the hospital. The exception are those patient beneficiaries who die in the month of discharge, and they are identified using the previous month's dual-eligibility status.

To calculate the payment reduction, CMS divides hospitals into five approximately equal groups based on their dual proportions. Hospitals are stratified 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 assignment 5, which has the highest dual proportions relative to other HRRP hospitals. For the example hospital, it has a dual proportion of .2634, and the hospital would be assigned to peer group 4, based off the

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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 image for Step 4 shows an example for the hospital of which measures will contribute to payment reduction. In this case, the COPD and pneumonia meet both of the criteria and will enter 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 because only COPD and pneumonia were determined to contribute to the payment reduction based off of Step 4, and 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 contribution the payment reduction is greater than 3 percent, CMS will apply a cap because the maximum payment reduction under the program is 3 percent. In this example, the hospital payment reduction is 1.02 percent.

In Step 7, CMS calculates the payment adjustment factor, which equals 1.0 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 payment for Medicare FFS claims submitted starting October 1 each year. In the example, it shows how the payment adjustment factor is applied to the total base operating DRG payment amounts and the result payment dollar amount of payments. In general, one thing to note, the base operating DRG payment amounts are the Medicare FFS base

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operating DRG payments without any add-on payments, such as Disproportionate Share Hospital payments or Indirect Medical Education payments. With that, I will turn it over to Kristanna for more specific details on the reports.

Kristanna Peris: Thank you, Kristin. In this section of the presentation, we will review specific aspects of the HSR, or the Hospital-Specific Reports. HSRs are reports that include hospital-level results and discharge-level data that CMS uses to calculate your hospital's payment adjustment factor and component results.

The FY 2021 HRRP HSR contains tabs that include the following hospital-specific information: your hospital's payment adjustment factor, measure results and ERRs, the neutrality modifier, information used in the stratified methodology, discharge-level information for readmission measures, and contact information for the program. The user guide includes replication instructions to promote transparency into the calculations and data.

On the first tab of the HRRP HSR workbook, the HSR is introduced and 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* (Inpatient) Q&A tool. The second tab in the HRRP HSR workbook contains Table 1: Payment Adjustment, shown here. This table shows summary information for your hospital. The table includes hospital-level data for number of dual eligible stays, total number of stays, dual proportion, peer group assignments, neutrality modifier, and payment adjustment factor. The dual proportion, shown in the third column, is calculated as the number of dual eligible stays, shown in the first column, divided by the total number of stays, shown in the second column on this slide. Medicare fee-for-service and managed care beneficiaries will be included in the numerator and denominator calculations of the dual proportion. Your hospital peer group assignment is shown in the fourth column. Hospitals are stratified into one of five approximately equal groups based on their dual proportion. Hospitals in peer group 1 have the lowest dual proportions relative to other HRRP

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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 FY 2021 HRRP HSR User Guide. The neutrality modifier, shown in the fifth column, is applied in the calculation of the final payment adjustment factor to maintain budget neutrality with the non-stratified methodology. 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 is 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. This table shows your hospital's number of eligible discharges, number of readmissions among eligible discharges, the predicted readmission rate, the expected readmission rate, the excess readmission ratio, or ERR, the peer group median ERR, penalty indicator, the ratio of diagnosis-related group (DRG) payment per measure to total payments, and the national observed readmission rate for each measure. The sixth column, the ERR, shows the predicted readmission rate, shown in the fourth column, to 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 (that is, patients with similar risk factors for readmissions, such as age and comorbidities), the ERR will be less than 1.0. If a hospital performs worse than average, the ERR will be greater than 1.0. The penalty indicator, shown in the eighth column on this slide, will indicate if that ERR will contribute to the payment adjustment factor. 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 adjustment factor and increase the size of the payment reduction.

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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 excess readmission ratio column for that measure. CMS cannot calculate an ERR without eligible discharges for a measure.

The next six tabs in the HSR show Tables 3 through 8 with discharge-level information for each readmission measure. This slide shows the first eight columns that will appear in each of these tables with example discharge-level data. Each table shows discharge-level data for all Medicare Part A fee-for-service hospitalizations that occurred during the HRRP performance period where the patient was age 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 above, 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 following two slides 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.

This slide shows the table in the last tab of the HSR: Table 9: Dual Stays. This tab shows information for the stays that meet the criteria for the numerator of the dual proportion. As mentioned before, the numerator for the dual proportion includes stays for Medicare fee-for-service and managed care beneficiaries who were also eligible for full Medicaid benefits during the three-year HRRP performance period. Beginning with FY 2021, dual-eligible stays are stays for Medicare beneficiaries with full

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Medicaid benefits for the month the beneficiary was discharged from the hospital. The exception are those patient beneficiaries who die in the month of discharge who are identified using the previous month's dual-eligibility status.

Once hospitals receive their HSRs, the 30-day review and correction period begins. As stated earlier, CMS distributes HSRs via *QualityNet Secure Portal* accounts at the beginning of the review and correction period. Hospitals can review the data in their HSRs and replicate their PAF and component results. Hospitals can also submit requests for corrections to their PAF (payment adjustment factor) 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 2021 will begin August 10 and go through September 9, 2020. HSR review and correction inquiries should be submitted to the *QualityNet* (Inpatient) Q&A tool. 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. As a reminder, hospitals cannot submit corrections to the underlying claims data or add new claims to the data used for the calculations during this period.

This slide shows the HRRP data elements that will be publicly reported on *Hospital Compare* or its successor website in early 2021 for hospitals with at least 25 discharges.

In addition to public reporting on *Hospital Compare*, CMS also reports hospital HRRP results along with the final rule. This slide shows the data elements that will be released in the IPPS/LTCH final rule Supplemental Data File following the review and correction period.

Please note that CMS will publicly report fiscal year 2021 HRRP data on *Hospital Compare* or a successor website in early 2021.

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

Any questions about HRRP should be submitted to the *QualityNet* (Inpatient) Q&A 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 questions. This brings us to the end of the formal presentation. Thank you for your time. Now back to you, Bethany.

Bethany Bunch: Thank you, Kristanna. Because this event is On Demand only, the speakers have a few frequently asked questions that we can address during the presentation. The first question is, “I didn’t receive an HSR. What should I do?”

Kristanna Peris: If your hospital is a subsection (d) hospital that was open as of April 2, 2020, and you want to review your HSR but do not have an active *QualityNet Secure Portal* user account, you must register a *QualityNet Secure Portal* account with the designated roles of Hospital Reporting Feedback – Inpatient role and File Exchange & Search role.

For help downloading your HSR from the *QualityNet Secure Portal*, please contact the *QualityNet* Help Desk at qnetssupport@hcqis.org or submit a question via the [QualityNet \(Inpatient\) Q&A tool](#). Include your hospital’s name and CMS Certification Number with your request.

Bethany Bunch: Thank you. The next question is, “I’m not sure if my hospital’s PAF is correct in my HSR. Where can I find information on how to confirm the results?”

Kristanna Peris: CMS provides [a few resources to support hospitals in replicating their PAFs](#). CMS provides replication instructions for the calculations and data in the HSR, including the PAF. Replication instructions for the PAF and component results are available in the FY 2021 HUG, or Hospital-Specific Report User Guide, on the [Reports page on the QualityNet website](#).

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The HUG includes screenshots for each step of the process. An Excel document, titled HRRP_FY2021_HSR_Replication_Instructions.xlsx, available upon request, combines the steps and related formulas. You can request this Excel document by submitting a request in the [QualityNet \(Inpatient\) Q&A tool](#). Select Ask a Question, and select HRRP – Hospital Readmissions Reduction Program under the program list. Then, choose HSR Replication Example from the topic list.

Bethany Bunch: Thank you. Why are my hospital's measure results worse than last year's results?

Kristin Maurer: CMS calculates measures using a rolling three-year performance period. Measure results are based on your hospital's performance compared with an average hospital with similar patients. For any given condition or procedure, about half of hospitals will have higher predicted readmission rates than [expected readmission rates](#) each year (that is, an ERR greater than 1.0). About another half of hospitals will have lower [predicted readmission rates](#) than expected readmission rates (that is, an ERR less than 1.0) given their patient case mix. This means that, although your hospital might have a similar number of readmissions as it did the prior year, your [ERRs](#) might change because other hospitals' performance shifted.

Bethany Bunch: Thank you. The next question is, "What is the difference between the predicted readmission rate and the expected readmission rate?"

Kristin Maurer: CMS calculates ERRs as the ratio of predicted readmission rate to the expected readmission rate. The predicted readmission rate is the predicted 30-day readmission rate based on your hospital's performance with a case mix and the effect on readmissions, that is the hospital-specific effect on your discharge-level data on your HSR. The expected readmission rate is the expected 30-day readmission rate based on the average hospital performance with your hospital's case mix and the average hospital effect. This is also provided in your hospital's discharge-level data on the HSR. If a hospital performed better than an average hospital that admitted similar patients, with patients that had similar risk factors during admissions such as age and comorbidities, the ERR will be greater than 1.

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- Bethany Bunch:** Thanks for that explanation. The next question is, “When does my FY 2021 payment reduction start affecting payment?”
- Kristin Maurer:** For FY 2021, the payment reduction will be applied to all Medicare fee-for-service base operating DRG payments beginning on October 1, 2020, through September 30, 2020.
- Bethany Bunch:** When does my FY 2021 payment reduction start affecting payments?
- Kristin Maurer:** For FY 2021, the payment reductions will be applied to all Medicare fee-for-service (FFS) base operating diagnosis-related group (DRG) payments beginning on October 1, 2020, through September 30, 2020.
- Bethany Bunch:** What should I do if I find an error in the calculation of my HRRP results?
- Kristanna Peris:** If you have concerns or questions about your hospital’s results as reflected in your HSR, please submit your inquiry to the [QualityNet Q&A \(Inpatient\) tool](#) no later than 11:59 p.m. Pacific Time on the final day of the review and correction period. Once you are in the tool, select Ask a Question. Select HRRP – Hospital Readmissions Reduction Program under the program list. Choose HRRP Review & Correction Request from the topic list. Finally, enter HRRP Review and Correction Inquiry in the subject line. Please include the following information in your inquiry: your hospital CMS Certification Number (CCN), hospital name, and the measure or component in question. Note, your HSR contains personally identifiable information (PII) and protected health information (PHI) protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any disclosure of PII and PHI should only be in accordance with, and to the extent permitted by, the HIPAA Privacy and Security Rules and other applicable laws. When referring to the contents of the HSR, use the ID Number.
- Bethany Bunch:** Thank you. The last question for today is, “Who do I contact for questions about the Hospital Readmissions Reduction Program?”

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Kristanna Peris: Hospitals can contact the Hospital Readmissions Program support team, through the *QualityNet* Inpatient Question and Answer (Q&A) tool. You can navigate to the tool from the *QualityNet* website, by selecting Help in the top right hand of the screen and then selecting Q&A Tool Main Page. From there, select Ask a Question, and then select HRRP - Hospital Readmissions Reduction Program under the program list. The Hospital Readmissions Reduction Program support team can provide clarification on measure methodology, payment reduction calculations, program dates, and program eligibility, as well as assist hospitals in accessing their HSRs.

Bethany Bunch: Thank you, Kristin and Kristanna. That concludes our webinar for today.

If you have questions about this webinar that weren't addressed during the presentation, you may submit them to the following email address: WebinarQuestions@hsag.com. When sending questions, please use the webinar title in the subject line. In the email body, please include your question, and, if your question pertains to a specific slide, please include the slide number for us to more efficiently assist you. We will answer your questions as soon as possible.

We appreciate hearing your feedback as we determine what education to provide in the future. Please help shape our education to your needs by completing this quick survey. Thank you and have a great day!