Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Overall Hospital Quality Star Ratings on *Care Compare*: 2021 OPPS Final Rule Methodology

Presentation Transcript

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Candace Jackson Good afternoon, and welcome to the *Overall Hospital Quality Star Ratings on Care Compare: 2021 OPPS Final Rule Methodology* webinar. My name is Candace Jackson. I'm at Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be hosting today's event. Before we begin, I would like to make a few announcements. This program is being recorded. A transcript of the presentation along with the question-and-answer summary will be posted to the inpatient website, www.QualityReportingCenter.com, in the upcoming weeks. If you are registered for this event, the link to the slides were sent out a few hours ago. If you did not receive that e-mail, you can download the slides at again www.QualityReportingCenter.com. This webinar has been approved for one continuing education credit. If you would like to complete the survey for today's event, please stand by after the event. We will display a link for the survey that you would need to complete for continuing credit. The survey will no longer be available if you leave the event early. If you do need to leave prior to the conclusion to the event, a link to the survey will be available in the summary e-mail one to two business days after the event. If you have questions as we move through the webinar, please type the questions into the Ask a Question window with the slide number associated and we will answer as many questions as time allows after the event. I would like to welcome our speakers for this webinar. Dr. Michelle Schreiber is the deputy director of the Center for Clinical Standards and Quality. Annese Abdullah-Mclaughlin is a nurse consultant, both with the Center for Clinical Standards and Quality, Quality Measures and Value Based Incentives Group with the Centers for Medicare & Medicaid Services. Arjun Venkatesh, MD, is with the Yale New Haven Health Services Corporation/Centers for Outcomes Research and Evaluation.

This interactive session will highlight the overall star ratings methodology for reporting in 2021 and beyond.

At the end of this presentation, participants will be able to understand the overall hospital quality star ratings methodology to interpret the hospital results.

These are the acronyms that are used in this presentation.

I will now turn the presentation over to Dr. Schreiber for her opening remarks. Dr. Schreiber, the floor is yours.

Michelle Schreiber, MD

Thank you and good afternoon. Welcome to the overall hospital stars ratings methodology. I'm speaking live, not prerecorded, and it is a pleasure having you participate today. I am also the deputy director for Center for Clinical Standards and Quality. We're excited about the changes in the hospital stars methodology as we continue to improve our value-based and incentive programs. I want to particularly thank our staff who are on the call today. They all worked very hard on this. Dr. Venkatesh has been working very hard in the analysis and helping us improve this program. You've heard some of the introductions today. Annese Abdullah-Mclaughlin is the nurse consultant, so, thank you. More importantly to all of you who are in hospitals, hospital associations or providers in hospitals or who are healthcare workers, thank you. We recognize that 2020 was just an extraordinary year of great challenge with the COVID pandemic and we hope that 2021 improves with the vaccines. On behalf CMS we thank you working in hospitals. Healthcare workers who have provided essential care are truly heroes.
The value-based programs support the highest quality value and best healthcare for all beneficiaries. Our goal is to provide a simple, easy-to - understand, and fair comparison for beneficiaries to make healthcare choices. This is a modernization to the program. It was done through extensive feedback that we have made these changes and, you have seen, we recently released the previous reports. These reports are based on 2019 data, so largely pre-pandemic. Today's webinar will outline these changes and provide an opportunity for questions and answers, but please do submit all questions through the chat function. Even if we don't address them today, I guarantee you we will review them. I also report that, for hospital star ratings, there can be and will be annual updates also with public comments.

There will be opportunities sent on an annual basis to modernize and our programs. Again, thank you for everything that you do in healthcare, and we look forward to your presentation. Thank you.

Annese Abdullah-Mclaughlin Good afternoon, everyone, and thank you for joining our call today. My name is Annie. I am the CMS lead for overall hospital quality star ratings. As previously noted, we will be discussing the updated star ratings methodology as finalized in the outpatient perspective payment system rule. We are pleased to have Dr. Venkatesh. Dr., the floor is yours.

Arjun K. Venkatesh, MD Thank you. I'm going to spend a little bit today walking through the star ratings methodology as well as the key highlights as part of this new updated version. As a reminder to everybody, the broader objective of this project can develop measure information that is already on Care Compare. Many of you may have known it as Hospital Compare as a way that is easy to interpret for patients and caregivers. This was a project that was launched back in 2016. There have been multiple versions of the star ratings methodology, version 3.0 in 2017. Public reporting is now initiated for its new iteration.

The star rating methodology has always been grounded in several principles. They have been in place since the inception of the project to develop methods scientifically and to accommodate known and expected changes in the underlining measures over time. Our hope in developing these methods is, first, to ensure that we are online with the Compare site that reports individual measures along with other information, as well as other CMS programs. We want to ensure that the methods' development as well as their dissemination and the process is always responsive to stakeholder input.

I won't get into the details of this timeline. but over the past five years stakeholder engagement has occurred in multiple venues and channels. Multiple expert channels have been convened and we have had multiple meetings throughout the years and shared publicly input.

The public had the opportunity to comment on new updates of the methodology. In addition to the various efforts that have been publicly engaging of groups, we have convened several work groups. Since the beginning, a patient and patient advocate work group was created, and soon after, a provider leadership group was created to ensure that the patient's voice was guided from beginning to end and incorporated to each iteration and methodology. I would like to walk through the key updates that we have recently become aware of.

Our approach to the star ratings methodology has been consistent over time on what we hear from stakeholders via the public comment period. We gather as much feedback as possible, translate it into possible goals and questions we can answer, and use scientific methods.

We focused on three primary themes. The first was to make it easier for providers to understand and explain to stakeholders. The second was to predict, it doesn't mean ensuring, the comparability between hospitals that select stakeholders often feel that were different but being compared on a common scale.

This graphic shows the prior methodology. It shows the star ratings broken into six steps. The first step is to collect the measures and standardize their scores that are suitable for combination. In Step 2, those groups were grouped together into seven domains. In Step 3, the statistical model, up here to calculate a group score for each of the 7 groups. In Step 4, the seven group scores were combined in a weighted average into the hospital summary score. In Step 5, that hospital summary score had a reporting threshold applied, so only hospitals with three measures in three groups will receive a star rating. Finally, in Step 6, a clustering algorithm was used to group hospitals into star rating categories. It has remained unchanged as we move forward to the new iteration.

This is the new methodology in version 4.0. We select the standardization of those measure scores. That's largely unchanged. In Step 2, there are only five measure groups. In Step 3, a substantial change was made which was replacing the modeling approach with a more explicit model

calculation. Step 4 combines those scores that each created the group level. In Step 5, the reporting threshold has been updated based on stakeholder feedback. Step 6, another new step, is peer grouping in which hospitals are grouped to be more comparable and more similar to other hospitals. Hospitals with only three measure groups of information are kept together. Those with four and five are kept together and then cluster the grade star rating.

I'll walk these steps with more detail. First, Step 1… The data set from which they are derived from are unchanged. It is publicly reported. These are individual measures on the Care Compare site, and we need to have as inclusive as possible in these measures. In version 3.0, these measures were selected and standardized so that they can be combined using Z-score standardization. Step 2 of the methodology is the grouping of measures and we see some versions of 3.0 and 4.0 of the methodology. In version 4.0, we group measures into five groups. In version 3.0, there were seven measure groups listed in the slide.

The five measure groups that now exist in 4.0 are largely through the grouping of the mortality, safety of care, readmission, patient experience, timeliness of care, effectiveness of care and efficient use of medical imaging. Some were combined into a single process called timely and effective care. This was done in the Meaningful Measures initiatives that resulted in fewer measures being reported, making them more amenable to combination. It was vetted and supported through multiple stakeholder activities.

So, what was this impact? In a test data set, we found that 180 more hospitals met the reporting threshold to receive a star rating, 157, or 87 percent of these hospitals, were critical access hospitals. This was likely due to these hospitals having a few select measures in each of the process groups that were previously reported now being combined into a single group that allowed them to have enough measures within a measure group to meet the reporting threshold and receive a star rating. It's important to note that this analysis was done in a test data set, and isolated to look at one step in the methodology.

Taken in conjunction with the other changes in the methodology, it does not necessarily mean that 180 more hospitals will receive a star rating, but that this updates the methodology to be more inclusive of bringing hospitals into star ratings for public reporting.

Step 3 is the measure of group score calculations step. In this step, we shifted away from the statistically based approach.

In version 3.0, a latent variable statistical model was used to calculate the group score. In version 4.0 a simple average of measure scores is calculated. A simple average assumes equal weight is given to each measure group but that that weight may vary from hospital to hospital based on the number of measures reported. Each of the measure group scores after being calculated in a simple average are then standardized so they can be compared and combined into the hospital summary score at the end.

Here is an example. As you can see here, this is the safety of care measure group for a hospital that has all 7 measures. They have an example measure score in the first column. That example measure score is then standardized into a Z-score, so these measures that have different distributions and different units can be combined. Then each measure is given 12 and a half percent and a weighted standardized measure score exist that combines these scores together to result in a measure group score.

What would happen if that hospital didn't have one measure? In this case the hospital doesn't have PSI 90, the same measure scores exist. Scores are there in column one. They are still standardized. The measure weight only reflects the division of equal weighting again but on a fewer number of measures that's results in a different way to standardize measure scores and a different total group score for this hospital. This is repeated, a simple transparent way that any hospital can use to replicate and calculate for themselves.

Ultimately, the creation of each of those group scores requires combination into the hospital summary score and that is step four of the methodology.

In version 3.0, and this has been true since 2016, the outcome groups mortality, safety of care, readmission and patient experience was 22 percent. In version 4.0 of the methodology, those groups had the same 22 percent weight now have their effective weight also combined and make up 12 percent of the final score.

In Step 5, of the methodology an update was made based on the recording requirements. What measures are required to be reported in order for a hospital to receive a star rating?

In version 3.0, and again this is has been true since the initial star rating in 2016, the minimum reporting threshold to receive a star rating was for hospitals to report at least three measures in three measure groups. One of which at the time had been an outcome group admission, mortality, or safety of care. In version 4.0 now and moving forward to receive a star rating hospital they must report approximate three measures which is mortality or safety of care. That means that there may be a small number of hospitals that didn't have many mortality or safety care measures because they were able to achieve a readmission group score. Now the emphasize on requiring on mortality or safety of care from what we heard from stakeholders that have emphasized to patients and providers and captured on Care Compare. One of the most important they consider, the quality of care, so that emphasize is included in the star rating.

What is the impact of this change? Again, using data from October 2019, Hospital Compare, now referred as Care Compare, the requirement to have a mortality of safety of care score before you are eligible for a star rating resulted in 125 hospitals no longer receiving star ratings, and 16 of these were specialty hospitals. These are relatively small proportions of the hundreds of hospitals in these groups, but they reflect hospitals that may have the admission outcome scores but not outcome scores in the mortality or safety.

I'm going to turn to a new Step 6: peer grouping. Version 3.0 did not include peer grouping. Version 4.0 has peer grouping supported by a hospital. Simply put, this was introduced to address regarding the

comparability between hospital. We know that hospitals report different measures because of differences in their case mix and service finding. In order to reflect those known differences between those hospitals and what we observe in different measures that are reported, we found that measure group reporting was a very natural way that could be used to distinguish between hospitals as well as make the star rating ultimately more comparable.

This was introduced prior to clustering. They are in the data set the grouping of measures, the calculation of the group score the combination into a summary score and then after the subset of hospitals of the 4,000+ hospitals in Hospital Compare are selected for star rating. Only those are subsequently peer grouped into each of these group three measure group reporting or four measure group reporting or five measure group reporting.

That means that hospitals that report three measure groups are only compared to other hospitals with three measure groups. Hospitals that report four measure groups are only compared to other hospitals with four measure groups and the same for five measure groups. What we found in the October 2019 data set is that the majority, 73 percent of hospitals, report five measure groups and are peer grouped into that largest group. These are sizable groups. Those 583 hospitals are compared to each for the purpose of the star rating and the smallest proportion, 348 hospitals, only report three measures groups and they are compared to each other. These groups appear to be stable over time. We found that greater 95 percent of hospitals remain in the same group over time.

There are changes of case and hospitals will merge. That largely seems to not result in hospitals structuring from group to group and there is predictability in the group assignments. They reflect many of the differences between hospitals that stakeholders were not being reflected in star rating. For example, hospital bedside, hospital volumes, seemed to be reflected in this measure group reporting pattern. Hospitals with greater than three measures in the three and four measure groups are more likely to be critical care hospitals. And so, while these are not exact comparisons to the characteristics, it certainly is grouping hospitals by the number of

measures groups, the report does distinguish between some of the characteristics that main stakeholders have been concerned about. Most importantly perhaps in grouping by the number of measure groups we see on this table that it does reflect differences in the information and therefore the comparability of the star rating between hospital.

As you can see, hospitals that report three measure groups are much less likely to report safety of care and patient experience. As a result, those hospitals are largely being compared to each other based on the performance and mortality, admission, and timely and effective care. Hospitals that report four measure groups ordinarily do not report safety of care often. That may be because these continue to be hospitals that lack the ability to report. They have a return survey to receive patient experience scores and, as a result, hospitals that are compared only to each other in the four measure group are rarely compared to each other on mortality, medication, timely and effective care and readmission.

Finally, the ones that have five measure groups are hospitals that have all five measure groups as well and this is how we achieve more. The measure of information use as part of reviewing and methodology.

What do the distribution of scores look like? As you can see in this graph, the green curb reflects the distribution of scores amongst hospitals with all five measure groups reporting. The red with four groups and green with three. They are different in terms of where they are centered as well as their distribution and so this supports the notion of clustering hospitals and comparing hospitals for star rating within each of the separate curve as opposed to grouping them together in a single comparison. Finally, in the last step of the star rating hospitals within each of the peer group refer is largely unchanged. The same clustering to converge is used in version 3.0 and 4.0 of the methodology. The only natural update which I mentioned earlier it’s in the peer groups that hospitals have been assigned.

What is the impact of these updates particularly on peer grouping? Fifty percent of hospitals receive the same star rating, and 45 percent of hospitals however shift up or down one-star rating. This is not surprising,

and it should be expected. There are many hospitals in the methodology that are clustered into five groups that live very near borderline between star ratings 1 and 2, 2 and 3 and so on. It substantially changes the comparison set. Currently 35- or 36 -hundred hospitals around cannot. Their peer group of 3 for roughly 2,000 hospitals that have five measures. That shift for change and the different distribution of scores for those hospitals result in some changes in star rating. A very small number observe the shift of up or down two stars as a result of these changes. The overall distribution of the star rating largely remains unchanged. You can see comparing version 4 to version 3 that as in prior years the 3-star categories generally remain the most frequent star rating. There are more 5-star hospitals than 1-star hospitals and more four stars . In 2-star hospitals, the general performance is largely changed. More interestingly through the application of peer grouping is to consider the star ratings between peer groups and what we say whether it be in the 3, 4 or 5 measure peer group the distribution is very similar to the ratings overall. Again, there are more 5 than 1-star hospitals. Most hospitals are rated at 3 or 4 stars. I'm going to turn it over to Candace who is going to review a variety of the implementation and we'll have questions.

Candace Jackson Before we go into our live Q&A session, I would like to turn the presentation to address our next slide. So, we'll go to the next slide and Annese the floor is yours.

Annese Abdullah-Mclaughlin Consistent with prior overall rating releases, hospitals have the opportunity to review their star rating results before publication on Care Compare. For the upcoming publication of the overall star rating, hospitals may review the results now through February 26, 2021. During the preview period hospitals, should have received their preview report and will receive, if they haven't already, their overall star rating specific report. The hospital specific report contains details on your hospital's individual measured scores, group scores, using October 2020 Care Compare data. It will be publicly reported in 2021. We will now go into

	our live Q&A session. There have been quite a few questions submitted, so unfortunately, we won't be able to address some of the questions that were submitted today, but we will attempt to address as many as we can. All of the questions that were submitted today will be responded to and posted to our Quality Reporting Center website at a later date. So, let's go ahead and get started. So, our first question is, "Will CMS always use the October release to calculate the star ratings for each year?"
Michelle Schreiber, MD	So this is Dr. Schreiber. Hopefully, yes, and it's not always been true but, that would be our intent.
Candace Jackson	Thank you, doctor. Kind of on that same note: "Will any of this change with the new administration, or is it all set for 2021?"
Michelle Schreiber, MD	It is currently set for 2021. Clearly the new administration will have an opportunity to make their desires known, and through future rule making there could, of course, be changes in the program.
Candace Jackson	Before we go on to maybe a different topic, any chance CMS would use the October data and the star outcome using the previous methodology for hospitals to compare?
Michelle Schreiber, MD	I'm going to ask you to take that because we certainly have all of the data. I'm sorry because I know the person asking probably can't answer me. Would there be confidential feedback to hospitals because hospitals should clearly be able to understand their data. Although, if they wanted it with new methodology, we have to consider the resources it would take to do that. I don't know if you want to comment.
Arjun K. Venkatesh, MD	Sure. I think we heard this question. Some of the differences people see in the previous reports are with the new methodology. An example that

	comes to mind is, previously, the use of the latent variable model allows… As a result, you may have seen in your preview report something like a group category score for readmission. Were you better than the national average? Because it no longer uses the model and those performance groups can't be generated. While it is possibly possible to look at prior publications of the methodology and code and apply it to the data set to understand, there is a lot of related changes to that one thing and so I think it's not one of those easy things we're just sort of switching to the old model. You need necessarily unique insights because there have been changes in the methodology, so I think the goal is to target and identify improvements, focusing on the new methodology and not just a few of the changes but the total changes are a good place to start.
Candace Jackson	Thank you. Before we move on to some methodology questions, I know COVID has been on everyone's mind. Will you be covering outpatients?
Michelle Schreiber, MD	So, while I can't answer your questions right now, I will tell you that CMS is doing everything regarding it.
Candace Jackson	Thank you, doctor. Now, changing topic to some methodology questions, "What are the dates used in the new methodology, Hospital Compare data, calendar year 2019, what month, and for how long?"
Arjun K. Venkatesh, MD	So, I can help characterize this a little bit. We will be providing more detailed responses in a document that's maybe better for this question. The star rating is merely a summary of the individual measures that are already reported in Care Compare. They have some variation, so they have adequate case count for reliability because of the different types of data that they collect. So, the data that you see in your preview report right now, that will be reported in April 2021, it was for 2020 Care Compare.

Candace Jackson Thank you. Our next question: "Now that there are five group measures, will the percentages be 22, 22, 22, 22 and now 12 percent for the timely and effective care?"

Michelle Schreiber, MD Yes, that is what they are currently doing, 22 percent for mortality, safety, readmission, and 12 percent for process. Based on the stakeholder feedback in the future, those could be subject to change.

Candace Jackson Thank you, doctor. If we could go to slide 23 for our next question. Where can a hospital identity what category a measure would fall into?

Michelle Schreiber, MD Do you want to take that? It's been pretty explicit which measures fall into which, but maybe you can answer a specific place hospital can find that.

Arjun K. Venkatesh, MD I think it lives in an appendix table. They are included in the comprehensive methodology report which was posted with this star rating. If you look into the dictionary, Table D, it has a listing of the each of the groupings as well as the methods that are in group. There has been no change in the prior period. They continue to be under Care Compare, but otherwise measures in mortality, patient experience remain the same.

Candace Jackson Thank you. If we could go up to slide 27? Why would process groups not be tabulated equally across the outcome measures?

Arjun K. Venkatesh, MD I believe this is asking about the weighting these groups. The strategies CMS has had has been emphasizing outcomes over outcomes of care, and 12 percent for the process groups was in some ways a consensus, but as the doctor just mentioned based on future feedback that we collect in a variety of mechanisms these may change in the groups. First of all, we left most of the weighting unchanged because we wanted to preserve as much of the program as we could and also it was based on stakeholder feedback. That being said, there was healthy debate, for example, whether or not

	mortality should be weighted more heavily, or care should be weighted more heavily, and those ongoing discussions will continue into the future.
Candace Jackson	Thank you. Our next question: "Are peer groups going to be available?"
Arjun K. Venkatesh, MD	I think the question is regarding the peer group that each hospital is assigned to. You should be able to see in your preview report. For example, the number of hospitals in each peer group or the star rating cut off or even the distribution by certain characteristics across these groups. Once that data are available in the comprehension methodology report and, as it currently stands in the Care Compare website, the star rating doesn't include the peer group designation, but I believe that CMS continues to collect both feedback. Those were the Care Compare side.
Candace Jackson	Thank you. On that same topic, does it reflect on your report which group you are grouped in? I was just saying that's a good reminder that the Compare website has the Provider Data Catalog that has more detailed information for providers and researchers but acceptable to patients.
Arjun K. Venkatesh, MD	Yes, on the correct hospital specific report, it should say which peer group you have been assigned to. Did CMS consider using the same grouping for the Hospital Readmission Reduction Program? This was part of the request for information in last's years writing, whether or not in this methodology we should be stratifying hospitals based on statistics in the readmission group. We had extensive stakeholder feedback from many stakeholders. In the end CMS chose not to present with stratification for a number of reasons, including the fact that, after analyzing the data carefully, it did not make the impact that we hoped it would. I don't know if you want to comment more than on that, but I will say this was definitely considered, and in the end CMS chose not to do that.

Michelle Schreiber, MD	I think it's a great summary. We have mountains worth of feedback and analysis over the past several years. We sought feedback for the use of the same cut off for the readmission measure group. The feedback on that was mixed with many people commenting that there was interest but maybe not necessarily do all measures, which is a public reporting purpose. The second concern from stakeholders that would potentially match certain disparities and cause misalignment on Care Compare that are not adjusted as well as the star rating that has not been and then sort of the leg of that stool was to trying to better understand the analysis. And so, kind of putting those three things together the designation was made not to make that update in the methodology. Thank you.
Annese Abdullah-Mclaughlin	I just wanted to go back to the previous question, not the one that he just answered, but the one prior to that about where the peer grouping can be found. It can be found in the HSR in Table 1, so it won't be on the star rating report. So, I just wanted to throw that out there.
Candace Jackson	Thank you, Annese. For our next question then: 'These new scores are based on the same data as the last release. Is that correct? So, any increase in stars is related to methodology and not improvement. Is that correct?"
Arjun K. Venkatesh, MD	I can take this one. Several things have changed. The first is that the data set did change. The prior release of star ratings was based on October 2019 data. What you are viewing in your hospital specific report now is based on October 2020 data, so both the number of percent and the underlying distribution of performance and any given hospital's performance may have changed in that one year and the methodology also changed. So, both the methods have changed in what you view now.
Candace Jackson	The next question: "How many total hospitals shifted down?"

Arjun K. Venkatesh, MD So, I'm pulling up the numbers. In general, we think about how many hospitals shifted down and star ratings. This is sort of related to the last question. The last release of star rating, that's challenging to interpret because it includes the data set change. That was very substantial. Within that given data set of October 2020, which hospitals star ratings changed, and what we find within that 1500 don't change their star ratings, and 45 percent of hospitals shift up or down. Then approximately 3 percent of hospitals shift star ratings. Its comparing the prior methodology with the new methodology. It gives you a general feel for it and in general the hospitals moving up and down is fairly similar, fairly balanced and that's because of the several of the changes that are changed that really change the star rating and the shift to a latent variable model which shifts how much emphasis is given and the use of peers.

Candace Jackson Thank you. Our next question, we have had several questions that are specific to critical access hospitals. So, I would like to address a couple of those. The first thing is, "How is a rating scored if a critical access hospital reports in all five majors but doesn't have sufficient data in each measure?"

Michelle Schreiber, MD I'll just briefly answer that. There has to be a certain amount of data to be able to qualify for being included and as we've outlined there has to be at least three measures with appropriate amounts of data to receive. If you've reported in all five categories but didn't have enough data for three measures you would not receive a star rating.

Candace Jackson Thank you. Go ahead.

Arjun K. Venkatesh, MD As Michelle said, it's really depends on how many measures you have in at least three groups. With the new added requirement, which elevating the requirement that the hospital have three measures. The nuance is not there, which is if that reporting threshold is met and you have additional measure groups that may have fewer than three measures, those measure groups are

still counted in our overall score and that's not a change in the methodology, that's been in place since the inception of star ratings.

Candace Jackson Our next question: "Have there been any changes to risk adjustment?"

Arjun K. Venkatesh, MD There is not risk adjustment per se in the star ratings in the way people think of it the way that it's used in individual measures. From that perspective there is no change. What there is that is new to the methodology, the concept of peer grouping. So now in the final step, meeting the reporting threshold, must have been three measures and one of those groups must be mortality or safety. Those hospitals are broken down into three groups. Those are three groups, four groups and five groups and they are receiving star ratings only in the hospital of peer groups. It's one way in which sort of differences in hospital are accounted for one the stars are calculated.

Candace Jackson Thank you. We have time for maybe one or two more questions and the next one is: "Can you explain why the readmission calculation was based on excess days rather readmission like dual care groups?"

Arjun K. Venkatesh, MD I think I can address it. I'll go back to the prior answer a little here which is what was done. Information to assign hospitals to different groupings within the readmission group is similar in the HRRP program. That change was not finalized for the star rating methodology so there is no dual eligibility. The excess days I think it's in acute-care measures which are included in the readmission measure group because those measures from our conceptual and clinical standpoint reflect on the quality of care transitions and the quality of discharge. That's why they are in that measure group.

Candace Jackson Thank you very much. That ends our Q&A session. Again, I'd like to thank the doctors and Annese for joining us today with all of this wonderful information. I hope it has been helpful for everyone.

You will see that this presentation has been approved for one continuing education credit. To be able to get that you would just check on the CE credit link on the slide.

That concludes our webinar today and we hope you have a wonderful day. Thank you