Hospital Value-Based Purchasing (VBP) Program

Inpatient, Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor

Overview of the FY 2022 HAC Reduction Program and HRRP

Presentation Transcript

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Maria Gugliuzza: Hello and welcome to today's webinar, *Overview of the FY 2022 HAC Reduction Program and HRRP*. My name is Maria Gugliuzza, and I am the Hospital Value-Based Purchasing Program Lead for Outreach and Education at CMS's Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be your moderator for today's event. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with a summary of the questions asked today, will be posted to the inpatient website, www.QualityReportingCenter.com, in the upcoming weeks. If you registered for this event, a reminder email and a link to the slides were sent out to your email about two hours ago. If you did not receive that email, you can download the slides at our inpatient website, www.QualityReportingCenter.com.

I would now like to introduce today's speakers. Madeline Pearse is the HAC Reduction Program Manager at the DVIQR Program Support, or DPS, contractor. Kristanna Peris is the HRRP Manager at the DPS contractor.

Today's event will provide an overview of the fiscal year 2022 HAC Reduction Program and HRRP, including program updates, the methodology used, Hospital-Specific Reports, and the review and correction period.

Participants will be able to interpret the program methodology, understand your hospital's program results in your HSR, and be able to submit questions about your hospital's calculations during the HAC Reduction Program scoring calculations review and correction period and the HRRP review and correction period.

I will now turn the call presentation over to our first speaker. Madeline, the floor is yours.

Madeline Pearse: Thank you, Maria. As Maria stated, my name is Madeline Pearse and I am the HAC Reduction Program Manager for the Division of Value, Incentives, and Quality Reporting Program support contractor.

Today, I am going to discuss background on the HAC Reductions Program and updates to the program for fiscal year 2022, provide an overview of the scoring methodology for the program, and describe how hospitals can review their program results for the fiscal year 2022 program year. This webinar is pre-recorded and we will have live questions following the presentation.

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

CMS evaluates overall hospital performance by calculating a Total HAC Score for each hospital which is the equally weighted average of their scores across measures included in the program. Hospitals with a Total HAC Score greater than the 75th percentile, that is the worst performing quartile of all Total HAC Scores, will be subject to the 1 percent payment reduction.

The HAC Reduction Program includes all subsection (d) hospitals which are broadly defined as general acute care hospitals. A complete list of the excluded hospital types, such as critical access hospitals, can be found in the frequently asked questions for the fiscal year 2022 HAC Reduction Program, available on the Resources page of the QualityNet website. Maryland hospitals are exempt from payment reductions under the HAC Reduction Program due to an agreement between CMS and Maryland. More information on the Maryland total cost of care model can be found on the CMS website.

As shown in the table below, the six measures included In the fiscal year 2022 HAC Reduction Program have remained the same since the fiscal year 2018 program year.

These include one claims-based composite measure of patient safety, the CMS PSI 90, and five chart-abstracted or laboratory identified healthcare-associated infection surveillance measures based on data that hospitals submit to the Centers for Disease Control and Prevention's National Healthcare Safety Network.

First, I'll cover updates to the program for the FY 2022 program year.

For the fiscal year 2022 program year, CMS updated the version of the CMS PSI software used to calculate results for the CMS PSI 90 measure from version 10 to version 11 and updated the performance period for CMS PSI 90 to include patient discharges from July 1, 2018, to December 31, 2019, and for the CDC's NHSN HAI measures to include patient discharges from January 1, 2019, through December 31, 2019. There were no scoring or methodological changes made to the program for the fiscal year 2022 program year.

The fiscal year 2022 HAC Reductions Program performance periods are impacted by the Extraordinary Circumstances Exceptions granted by CMS on March 27, 2020, and updated in the September 2, 2020, COVID-19 Interim Final Rule with Comment Period. CMS will continue to use any HAI data that hospitals optionally submitted for quarter four 2019; however, CMS is excluding calendar year 2020 data from all program calculations for the HAC Reduction Program. CMS is automatically excluding all HAI and claims data representing quarter one and quarter two 2020. CMS will also automatically exclude all HAI and claims data for quarter three 2020 and quarter four 2020 as part of the measure suppression policy finalized in the fiscal year 2022 final rule. For the fiscal year 2022 program year, the CMS PSI 90 measure includes all Medicare fee for service patient discharges from July 1, 2018, to December 31, 2019. The five CDC NHSN HAI measures include all patient discharges from January 1, 2019, through December 31, 2019.

Next, I will review the scoring methodology for the program. As noted previously, there were no changes to the scoring methodology for the fiscal year 2022 program year.

The HAC Reduction Program scoring methodology consists of four high-level steps. The first step in the scoring methodology is to determine measure results for each of the measures included in the program.

For the claims-based CMS PSI 90 measure, each hospital's measure result is their CMS PSI 90 composite value, which is a composite score based on 10 component patient safety indicator measures. For the five healthcare-associated infection measures, each hospital's measure result is their standardized infection ratio, which is calculated by the CDC. The standardized infection ratio is equal to the number of infections the hospital reports for the measure divided by the number of predicted infections for the measure which CDC calculates based on hospital characteristics and case volume. For all of the measures included in the program, lower value means better performance.

Once measure results have been calculated, the next step in the scoring methodology is to calculate measure scores.

CMS calculates a hospital's measure score as the Windsorized z-score using measure results for the given measure. CMS adopted this approach to calculating measure scores beginning with the fiscal year 2018 program year. Calculating Windsorized z-scores contains two steps. First, hospital measure results are Windsorized and then those are used to calculate z-scores. Let's review those steps.

Windsorization is a process that reduces the impact of extreme or outlying measure results, but it preserves hospital relative results. As shown in the table, hospitals with measure results less than the fifth percentile of all measure results will have their measure result reset to the 5th percentile value. Likewise, hospitals whose measure results are greater than the 95th percentile of all measure results will have their measure result reset to the 95th percentile value. For the vast majority of hospitals whose results fall between 5th and 95th percentile values, Windsorization will not impact their measure results.

After hospitals measure results are Winzorized, they are used to calculate a measure score relative to all hospitals, their Windsorized z-score. As a general principle, hospitals that perform worse than the mean will earn a positive Windsorized z-score, while hospitals that perform better than the mean will earn a negative Windsorized z-score. Once measure scores have been calculated, these are used to calculate hospital Total HAC Scores.

CMS calculates each hospital's Total HAC Score as the equally weighted average of their measure scores. CMS adopted this approach to calculating Total HAC Scores beginning with the fiscal year 2020 program year. The calculation of Total HAC Scores only includes measures for which a hospital receives a measure score. More information on scenarios where a hospital might not receive a measure score for one or more of the measures can be found in the frequently asked questions for the fiscal year 2022 HAC Reductions Program, available on the Resources page of QualityNet. In general, higher Total HAC Scores indicate worse overall performance by hospitals; whereas, lower Total HAC Scores indicate better overall performance.

Once Total HAC Scores are calculated, CMS can use those scores to determine the worst performing quartile.

As noted earlier, higher Total HAC Scores indicate worse overall performance. Hospitals whose Total HAC Score is greater than the 75th percentile Total HAC Score among all eligible hospitals may receive a payment reduction for fiscal year 2022. CMS exempts Maryland hospitals from payment reductions under the HAC Reduction Program due to an agreement with Maryland. Because of this, they are excluded from the distribution of hospitals used to determine the 75th percentile.

This slide shows the scoring calculations for how raw measure results get Windsorized and Total HAC Scores get calculated for a hypothetical hospital under the HAC Reduction Program. The values in this example are hypothetical and not actual values for the fiscal year 2022 HAC Reduction Program.

Because the hospital's Total HAC Score is less than the hypothetical 75th percentile Total HAC Score, it will not be subject to the payment reduction.

For hospitals that are subject to the 1 percent payment reduction, this payment reduction is applied to the overall Medicare payment amount for all Medicare fee for service discharges during fiscal year 2022, that is from October 1, 2021, to September 30, 2022.

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

Each year CMS provides hospitals with 30 days to review their program data, submit questions about calculations, and request corrections to their scoring if appropriate. This is known as the scoring calculations review and correction period. Hospitals have the opportunity to review their data and results via the HSRs and should use this guide to review their scoring calculations.

The HAC Reduction Program HSR provides hospitals the necessary information to review their program results, replicate the program calculations, and submit correction requests if applicable. Along with the HSRs, CMS delivers an HSR User Guide which can guide hospitals through the process of reviewing their data and replicating program results using the HSR.

HSRs are accessible to users in your organization who have basic Hospital Quality Reporting System Managed File Transfer permissions and Auto-Route IQR permissions. An email notification indicating that HSRs are available is sent to users who have the necessary permissions. For those with the necessary permissions, the HSRs and user guide will be in their Managed File Transfer inbox. The HSR User Guide is also made publicly available on the QualityNet website. Hospitals that are having trouble accessing their HSRs should reach out via the QualityNet Q&A tool on the QualityNet website.

The HAC Reduction Program HSR contains the following information: contact information for the program and additional resources, their payment reductions status for fiscal year 2022, their Total HAC Score, measure scores, measure results, discharge-level information for the claims-based CMS PSI 90 measure, and hospital-level information for the HAI measures.

This is an example of Table 1 in the fiscal year 2022 HAC Reduction Program HSR. Table 1 contains the contribution of each measure to the Total HAC Score, along with the Total HAC Score, the actual 75th percentile Total HAC Score for the fiscal year 2022 program, and the payment reduction status for this example hospital. Because the example hospital's Total HAC Score is less than the 75th percentile threshold, the hospital will not be subject to a payment reduction.

This is an example of Table 2 in the fiscal year 2022 HAC Reduction Program HSR. Table 2 contains measure results for each of the measures, along with the necessary information to calculate Windsor z-scores. In this example, the hospital's measure results all fall between the 5th and 95th percentile of measure results, except for CAUTI and SSI. The SSI Windsorized measure result is equal to the 95th percentile measure results. For the other measures, excluding CAUTI, the Windsorized measure results are equal to their measure results. Windsorized z-scores for each of the measures are equal to the Windsorized measure result minus the mean Windsorized measure result all divided by the standard deviation of Windsorized measure results. The example hospital performs better than the mean on the CMS PSI 90, CLABSI, and CDI, and worse than the mean on the SSI and MRSA bacterium measures. Because the example hospital received a measure score for five of the six measures included in the program, they are all weighted at one-fifth. The contribution of each measure's Windsorized z-score to the Total HAC Score equals the value in Table 1 of the HSR.

This is an example of Table 3 in the fiscal year 2022 HAC Reduction Program HSR. Table 3 in the HSR shows users the necessary information to reproduce their measure results for the CMS PSI 90 measure, the CMS PSI 90 composite value. The CMS PSI 90 is a composite measure that combines results from 10 component patient safety indicator measures shown in the top row of the table. Each component patient safety indicator measures rate is weighted to form the composite value. More information on the measure methodology for the CMS PSI 90 measure can be found on QualityNet. In the example, the hospital's CMS PSI 90 composite value can be found in the top left. As noted more information on the CMS PSI 90 measure methodology and instructions for replicating the CMS PSI 90 composite value can be found in the HSR User Guide.

This is an example of Table 4 in the fiscal year 2022 HAC Reduction Program HSR. Table 4 shows discharge-level information for the CMS PSI 90 measure. If you are referring to information from this table when submitting review and corrections requests, it is important that you do not share the Personally Identifiable Information that it contains. Please use the ID number when submitting this request.

This is an example of Table 5 in the fiscal year 2022 HAC Reduction Program HSR. Table 5 shows hospital-level information for the five HAI measures. This includes the reported and predicted number of HAIs. The standardized infection ratio shown in Row 4 of the table is equal to the reported number of infections divided by the predicted number of infections.

The scoring calculations review and corrections period for the fiscal year 2022 HAC Reduction Program begins on August 16, 2021, and ends on September 14, 2021. Hospitals have the 30-day period to review their data, submit questions about the calculation of their results, and request corrections to calculation errors. Hospitals must submit corrections requests to the HAC Reduction Program support team via the QualityNet Q&A tool no later than 11:59 Pacific Time on September 14, 2021, to be considered for review and corrections.

There is a very specific set of items that hospitals have the opportunity to request corrections to during the scoring calculations review and corrections period. Hospitals can request corrections to their measure result for the CMS PSI 90 measure, their measure score for all of the measures in the program based on the measure results presented in the HSR, their Total HAC Score, or their payment reductions status. Importantly, hospitals cannot request corrections that rely on corrections to the underlying data because hospitals have already had the opportunity to review and correct those data. For the CMS PSI 90 measure, this means that the underlying claims data that are used to calculate results. This includes adding new claims to the data extract. For the five HAI measures, this includes the reported number of HAIs, the standardized infection ratios, or various volume variables for the HAI measures. All of these pieces of information for the HAI measures can be found on Table 5 of the HSR.

As noted, hospitals cannot request corrections to underlying data during the scoring calculations review and corrections period. Hospitals already had the opportunity to review and correct those data. For the CMS PSI 90 measure, CMS takes an annual snapshot of claims data to perform measure calculations for claims-based measures for all of their hospital quality reporting and value-based purchasing programs. The snapshot for the fiscal year 2022 program year occurred on September 25, 2020. All corrections to underlying claims must be processed by the snapshot date, and claims edits after the date are not reflected in program results. The next claim snapshot for the fiscal year 2023 program year will occur on September 24, 2021.

This image demonstrates the flow for claims-based data for the CMS PSI 90 measure. The claim snapshot occurs approximately 90 days after the end of the performance period. Hospitals can review their calculations during the scoring calculations review and correction period before their HAC Reduction Program results are publicly reported on the Provider Data Catalog the following January.

As noted, hospitals cannot request corrections to underlying data during the scoring calculations review and corrections period.

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

As shown in the table below, the NHSN submission deadline occurs 4.5 months following the end of each reporting quarter. For reporting quarter one, the NHSN submission deadline is August 15; likewise, the quarter two submission deadline is November 15. The quarter three deadline is February 15 of the following year, and the quarter four deadline is May 15 of the following year. In all instances, if the 15th of the month falls on a Friday, Saturday, Sunday, or a federal holiday, the NHSN submission deadline is the following business day.

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

More information on the HSRs and scoring calculations review and correction process is available on the QualityNet website. This includes the HSR User Guide and a mock version of the HSR. For more information on replicating results found in HSRs, hospitals should refer to the HSR User Guide and submit any questions to the HAC Reduction Program support team via the QualityNet Q&A tool.

In early 2022, CMS will release the following fiscal year 2022 HAC Reduction Program information on the Provider Data Catalog:

measure scores, Windsorized z-scores for each of the measures included in the program, Total HAC Score, and payment reductions indicators.

General information on the HAC Reduction Program can be found in the HAC Reduction Program section of the QualityNet website. This includes information on program scoring methodology, the scoring calculation review and correction process, and additional resources, such as frequently asked questions and program fact sheets. As noted elsewhere, if you have questions about the HAC Reduction Program, you can submit them directly to the HAC Reduction Program support team via the QualityNet Q&A tool. You do not need to register for an account to submit questions via this tool.

To submit questions about the HAC Reduction Program to the Quality Q&A tool, select Ask a Question. Then, use the table below to determine which program topic and subtopic to select.

Now, I'll turn it over to Kristanna Peris who will review the Hospital Readmissions Reductions Program.

Kristanna Peris: Thank you, Madeline. As Madeline stated, my name is Kristanna Peris. I am the HRRP Manager on the DPS contract. In this portion of the presentation, I will briefly discuss program background information, go through an example that explains the program methodology, and review the HRRP HSR.

The Hospital Readmissions Reductions Program, or HRRP, is a Medicare value-based purchasing program that began on October 1, 2012, to reduce payments to hospitals with excess readmissions. HRRP supports CMS's 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. Hospitals with excess readmissions may receive payment reductions.

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 acute care hospitals in US territories. CMS exempts Maryland hospitals from HRRP payment reductions because of an agreement between CMS and the state of Maryland. Although Maryland hospitals are exempt from HRRP payment reductions, CMS publicly reports measure results for Maryland hospitals and includes Maryland hospitals in the calculation of the access readmission ratios, or ERRs.

HRRP includes six condition and procedure-specific 30-day risk standardized unplanned readmission measures. The measures include AMI, COPD, HF, pneumonia, CABG, and hip/knee replacement surgery.

For fiscal year 2022, CMS shortened the HRRP performance period due to the Extraordinary Circumstances Exception granted by CMS on March 27, 2020, and updated in the September 2, 2020, interim final rule in response to the COVID-19 public health emergency. CMS will not use claims reflecting services provided January 1, 2020, through June 30, 2020, that is the quarters 1 and 2 of 2020. Since the readmission measures used in HRRP identify readmissions within 30 days of each index stay, the performance period for HRRP will end 30 days before January 1, 2020, on December 1, 2019, so that no claims from Q1 and Q2 2020 are used in the measure of program calculations. The HRRP performance period for fiscal year 2022 is July 1, 2017, to December 1, 2019.

From fiscal year 2013 to fiscal year 2018, CMS used a non-stratified methodology to assess hospital performance under HRRP. Under the non-stratified methodology, CMS used a threshold of 1 or the average ERR for hospitals that admitted similar patients to assess hospital performance on each measure. Beginning in fiscal year 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 patient social risk and the approach of stratifying hospitals holds all hospitals to a high standard while also making it so that the program does not disproportionately 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 reductions calculation satisfies the Cures Act 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 performance period. In order to administer payment reductions, CMS transforms the payment reductions into the payment adjustment sector, or the PAS. CMS applies the PAS to all Medicare fee for service base operating DRG payments during the fiscal year. The next few slides will walk through the steps involved in calculating the payment reductions in more detail. The slides will show the example calculations for a hospital using mock data.

For Step 1, CMS calculates a dual proportion for each hospital and an ERR for each of the six HRRP conditions and procedures. The ERR is a measure of a hospital's relative performance used in the payment reductions formula to assess whether a hospital has excess readmissions for each of the conditions or procedures included in HRRP. The ERR is the reliability-adjusted number of readmissions predicted at the hospital over the number of readmissions expected based on the 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 hip/knee measure. this hospital did not have any eligible discharges, so it did not have an ERR calculated for that measure. The dual proportion is also shown on this slide.

It is the proportion of stays for Medicare fee for service and managed care beneficiaries who were eligible for full Medicaid benefits during the HRRP performance period. For the example hospital, it shows 894 stays where the beneficiary was dually eligible for Medicare and full Medicaid benefits and 3,389 total Medicare fee for service and managed care stays. For this hospital, the dual proportion equals 894 divided by 3,389 total stays which is equal to 0.2638.

To calculate the payment reductions, 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 one, which has the lowest dual proportions relative to other HRRP hospitals, to peer group assignment five, which has the highest dual proportion relative to other HRRP hospitals. For the example hospital, which has a dual proportion of 0.2638, the hospital would be assigned to peer group four based off the dual proportion ranges for each of the peer groups. CMS then calculates a median ERR for each peer group in 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 ERR for each of the peer groups.

For Step 4, CMS determines which ERRs will contribute to the payment reductions. For an ERR to contribute to the payment reductions, it must meet two criteria. First, the ERR must be greater than the peer group median ERR. Second, the hospital must have 25 or more eligible discharges for the measure. The table on this slide shows an example hospital and how measures will contribute to the payment reductions. In this case, the COPD and pneumonia measures meet both of the criteria and will contribute to the payment reduction calculation.

In Step 5, CMS calculates each measure’s contribution to the payment reductions. The slide shows an example of how that is calculated.

Since only COPD and pneumonia were determined to contribute to the payment reductions, based off of Step 4, only those measures are included in the example calculations on this slide.

In Step 6, CMS sums the measure contributions to the payment reductions. If the sum of the measure contribution is greater than 3 percent, CMS will apply a cap because the maximum payment reduction allowed under the program is 3 percent, so the hospital's payment reduction is 1.02 percent.

In Step 7, CMS calculates the payment adjustment factor which equals 1 minus the payment reduction. The image on this slide shows an example for the hospital. Then, in Step 8, CMS applies the payment adjustment factor to payments for Medicare fee for service claims submitted starting October 1 each year. In this example, it shows how the payment adjustment factor is applied to the total base operating DRG payment amounts and the resulting dollar amount of payments. In general, the base operating DRG payment amounts are the Medicare fee for service base operating DRG payments without any add-on payments, such as the disproportionate share hospital payments or indirect medical education payments.

In this section of the presentation, we will review specific aspects of the HRRP 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 reductions percentage and component results. The fiscal year 2022 HRRP HSR contains tabs that include the following hospital-specific information: your hospital payment reductions percentage payment adjustment factor, measure results in ERRs, the neutrality modifier, information used in the stratified methodology, discharge-level information for readmission measures, and contact information for the program. The first tab of the HRRP HSR workbook introduces the user to the HSR 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 Q&A tool.

The user guide that accompanies the HSR includes more detailed information, including replication instructions to promote transparency into the calculations and data.

The second tab in the HRRP HSR workbook contains Table 1: Payment Adjustment shown here. This table shows summary information for your hospital. The dual proportion, shown in the third column, is calculated as the number of dual eligible patients shown in the first column divided by the total number of stays shown in the second column. On this slide, the hospital peer group assignment is shown in the fourth column. As noted before, hospitals in peer group one have the lowest dual proportions relative to other HRRP hospitals. Hospitals in peer group five have the highest dual proportions relative to other HRRP hospitals. The ranges of the dual proportions for each peer group are included in the user guide. The neutrality modifier, shown in the fifth column, is applied to the calculation of the payment reduction to maintain budget neutrality with this non-stratified methodology. The payment reductions percentage, shown in the sixth column, shows the percentage your hospital's payments that will be reduced, ranging from 0 percent to 3 percent. The last column in Table 1 shows the hospital's payment adjustment factor. The payment adjustment factor may be between 1, which means no reductions, 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. The sixth column, the ERR, shows the predicted readmission rate, shown in the fourth column, divided by the expected readmission rate, shown in the fifth column for that measure. If a hospital performs better than an average hospital that admitted similar patients, the ERR will be less than 1. If a hospital performs worse than average, the ERR will be greater than 1. The penalty indicator, shown in the eighth column on this slide, will indicate if that ERR will contribute to the payment reduction. The penalty indicator is Yes for a measure when a hospital has 25 or more eligible discharges and an ERR greater than the peer group median ERR for that measure.

The penalty Indicator is No for a measure when your hospital has fewer than 25 eligible discharges or the ERR is less than the peer group median for that measure. Each measure with a penalty indicator equal to Yes will contribute to your hospital's payment reduction and increase the size of the payment reduction. When a hospital has no eligible discharges for a measure, a value of NQ will be displayed in the number of eligible discharges column to indicate that there are no qualifying cases for the measure. This will also cause the value of NQ to display in the 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 65 years or older at the time of admission with a principal discharge diagnosis of either AMI, COPD, heart failure, or pneumonia, or procedures for CABG surgery or primary elective total hip/knee. These tables indicate whether a planned or unplanned readmission for any cause followed the discharge within 30 days. HSRs include all discharges that meet the inclusion requirements for each measure. The cohort inclusion/exclusion indicator shown in the table on this slide is used to identify discharges that were excluded from the measure. The risk factors for each measure for their corresponding condition category are also included in these tables.

This slide and the next slide show the continuation of the data available in the discharge tabs. The HSR User Guide contains detailed descriptions for each of these columns.

These are more columns that you will see in Tables 3 through 8 of your HSR. The last two columns show your hospital-specific effect and the average effect. The hospital effect represents the underlying risk of readmission at your hospital after accounting for patient risk.

The average effect represents the underlying risk of a readmission at the average hospital after accounting for patient risk.

This slide shows the table in the last tab of the HSR, Table 9: Dual Stays. This tab shows information for the stays that meet the criteria for the numerator of the dual proportions. 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 HRRP performance period.

Once hospitals receive their HSRs, the 30-day review and correction period begins. CMS distributes HSRs via the Hospital Quality Reporting System Managed File Transfer Inbox at the beginning of the review and correction period. Hospitals can review the data in their HSRs and replicate their payment reduction percentage and component results. Hospitals can also submit requests for corrections to their payment reductions percentage and component results and submit questions about the result calculations during the 30-day review and correction period. The HRRP review and correction period for fiscal year 2022 began August 9 and will go through September 8, 2021. HSR review and correction inquiries should be submitted to the QualityNet 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. Hospitals cannot submit corrections to the underlying claims data or add new claims to the data used for the calculations during this period.

Hospitals with at least 25 discharges will have the data elements listed on this slide publicly reported on the Provider Data Catalog website in early 2022.

In addition to public reporting on the Provider Data Catalog, 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 PPS final rule supplemental data file following the review and correction period.

More information on HRRP HSRs and readmission measures is available on QualityNet. The links on this slide can be used to navigate to specific web pages on QualityNet for further Information on HRRP, as well as to the HSR User Guide and the mock HSR.

Questions about HRRP should be submitted to the QualityNet 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 question. This brings us to the end of the formal presentation. Thank you for your time. Now back to you, Maria.

Maria Gugliuzza: Thanks, Kristanna. It looks like we have a few minutes for some questions. Let's get started. First question: What will the performance period be for fiscal year 2023 for the HAC Reduction Program?

Aaron Swaney: My name is Aaron Swaney. I'm Program Lead for the DVIQR program contract for the HAC Reduction Program. To answer your question, the fiscal year 2022 performance period for the CMS PSI 90 measure is July 1, 2018, to December 31, 2019. For the HAI measures the performance period is January 1, 2019, through December 31, 2019. The fiscal year 2023 performance period for the CMS PSI 90 measure will be July 21, 2019, through December 31, 2019, and January 1, 2021, through June 30, 2021. For the HAI measures, the performance period will be January 1, 2021, through December 31, 2021. These performance periods are impacted by the nationwide extraordinary circumstances exception granted by CMS granted in March of 2020 and updated in the September 2, 2020, COVID-19 interim final rule with comment period. CMS will continue using any HAI data that hospitals optionally submitted for quarter four 2019. However, CMS is excluding all calendar year 2020 data from program calculations for the HAC Reduction Program. As finalized in the September 2, 2020, COVID-19 interim final rule, CMS is automatically excluding all HAI and claims data representing quarter one and quarter two of 2020.

CMS will also automatically exclude all HAI and claims data for quarter three and quarter four 2020 as part of the COVID-19 measure suppression policy finalized in the fiscal year 2022 IPPS/LTCH final rule. These data exclusions effectively shorten performance periods of future program years. CMS made no methodological changes to the HAC Reduction Program because of the COVID-19 public health emergency. More information on the HAC Reduction Program performance periods and CMS response to the COVID-19 public health emergency, including a graphic depiction of the impact of data exclusions on performance periods can be found in the program's frequently asked questions document available on the Resources page of the QualityNet web site.

Maria Gugliuzza: Thanks, Aaron. Next question: Hello, our HAI data on the report does not match reporting from NHSN from the same reporting period using the CMS/NHSN report. There does not appear to be any issues related to these data in NHSN. I've queried NHSN about this. Is there a contact on the HAC site who can help me troubleshoot this issue?

Aaron Swaney: Thanks, Maria. This is Aaron again. Hospitals have the opportunity to submit, review, and correct the CDC chart-abstracted and laboratory identified data in the four and half months after the end of the reporting quarter up until the CMS submission deadline. Immediately after the submission deadline, the CDC creates a data file for CMS's use for quality reporting and pay for performance programs. This data file is a snapshot of data at the time of the submission deadline. CMS understands that hospitals can update data in the NHSN system after the submission deadline. CMS does not, however, receive or use data entered or revised after the submission deadline. Expects hospital to review and correct data before HAI submission deadline. CMS expects hospitals to review and correct their data before the HAI submission deadline. If you want to submit a request for the scoring calculation during the review and corrections period or have questions or concerns about your hospital calculations, please direct them to the QualityNet Q&A Tool before the final day of the scoring calculation review and scoring period.

When you enter the tool, select Ask a Question. Then, select HACRP, Hospital-Acquired Condition Reduction Program, under the program list. Then, choose HACRP review and correction as the topic. Finally, enter HACRP scoring calculations review and corrections inquiry on the subject line.

Maria Gugliuzza: Great. Our next question: Yesterday, CMS sent out updated HSRs for the PSIs released In May. Will that end up requiring an update to the PSI 90 HAC scores if they were impacted?

Aaron Swaney: Thanks, Maria. No, the PSI results in the FY 2022 HAC Reduction Program HSRs are not impacted by the updated public reporting PSI HSRs. The CMS PSI 90 HSR for July 2021 public reporting preview period were originally released on May 3, 2021. They were redelivered on August 18, 2021, due to missing denominator exclusion codes for PSI 03 in the original HSRs. Only PSI 03 and PSI 90 scores were impacted by the issue and have corrected data. The CMS PSI 90 calculations in the FY 2022 HAC Reduction Program HSRs released on August 13, 2021, use the same performance period as the July 2021 public reporting HSRs. Results for the CMS PSI 90 measure and in the fiscal year 2022 HAC Reduction Program are calculated with the updated with PSI 03 denominator exclusion codes. Results may be slightly different from the public reporting HSRs because national values for the public reporting HSRs include Veteran Affairs hospitals; whereas, the HAC Reduction Program results are limited to subsection (d) hospitals. A new 30-day preview period for the July 2021 public reporting PSI 90 HSRs began on August 18, 2021, when the recalculated HSRs were made available to hospitals. It will end on September 17, 2021.

Maria Gugliuzza: Thanks, Aaron. Next question: Why does the time period only go through December 1, 2019, for the HRRP HSRs? Isn't it supposed to go through December 31, 2019? On the Care Compare report, it says that it goes through quarter four of 2019.

Kristanna Peris: Thanks, Maria. This is Kristanna. CMS granted an extraordinary circumstances exception, ECE, on March 27, 2020, and updated the ECE in the September 2019 COVID-19 interim final rule with comment period in response to the COVID-19 public health emergency. So, CMS will not use or report claims reflecting services provided January 1, 2020, through June 30, 2020, in calculations for HRRP. The readmission measures in HRRP identify readmissions within 30-day of each index stay. Therefore, the performance period for HRRP will end 30 days before January 1, 2020, on December 1, 2019, so that no claims from Q1 or Q2 2020 are used in the measure or program calculations.

Maria Gugliuzza: Thanks, Kristanna. We have time or one more question. Can you explain the difference between predicted readmission rates and expected readmission rates?

Kristanna Peris: This is Kristanna again. CMS calculates ERRs as the ratio of predicted readmission rates and expected readmission rates. The predicted readmission rates is the predicted 30-day readmission rate for your hospital based on your hospital performance for your specific patient case mix. That is your hospital-specific effects on readmission provided in your discharge-level data in your HSR. The expected readmission rate is the expected 30-day readmission rate for your hospital based on its readmission rate at an average hospital with a patient case mix similar to your hospital. That is patients with the same characteristics have been treated at an average hospital, rather than at your hospital. If a hospital performs better than an average hospital that admitted similar patients, the patients that had similar risk factors during admission such as age and comorbidities, the ERR will be greater than 1.

Maria Gugliuzza: Thanks, Kristanna. That looks like that's all the time we have for questions today. If your question wasn't answered, please use the question-and-answer tool. The instructions are on the slides previous. I'd like to thank everybody for their attendance today, and I hope you have a great day. Thanks.