Hospital Value-Based Purchasing (VBP) Program

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

Overview of the FY 2023 HAC Reduction Program and the Hospital Readmissions Reduction Program Questions and Answer Summary Document

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

Question 1: **If CMS is going to continue to collect, calculate, and publicly report results for Patient Safety Indicator (PSI) 90, when will hospitals receive those results?**

Although CMS is not including the CMS PSI 90 measure results in the fiscal year 2023 Hospital-Acquired Condition (HAC) Reduction Program Hospital-Specific Reports (HSRs), CMS will collect, calculate, and confidentially report hospital healthcare-acquired infection (HAI) measure and CMS PSI 90 results via measure-specific reports. CMS will publicly report those results on the Care Compare website to provide transparency to the public on important infection and patient safety metrics during the public health emergency (PHE).

CMS has not announced the timelines for measure-specific report delivery and public reporting. These timelines will be communicated through the QualityNet Listservs. If you are not signed up for the QualityNet Listservs, you can sign up for the email updates by going to the bottom of the QualityNet home page, at http://qualitynet.cms.gov, and clicking Join Now.

Question 2: **Will patient- and encounter-level PSI data be available again in our HSRs? If so, when?**

As described in the Fiscal Year (FY) 2023 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule, CMS aims to resume use of measure data for the purposes of scoring and payment adjustment beginning with the FY 2024 HAC Reduction Program HSRs.

There are a few changes to the measures worth noting: For the CMS PSI 90 measure, beginning with the FY 2024 program year, the CMS PSI 90 measure software will include a COVID-19 diagnosis as a risk adjustment parameter, which will help the measure account for the impact of the COVID-19 PHE on calendar year 2021 and subsequent years of data.

The FY 2024 performance period for the CMS PSI 90 measure will be January 1, 2021–June 30, 2022.

For the HAI measures, under current data collection processes for the measures, we are not able to risk-adjust or otherwise account for a COVID-19 diagnosis. Therefore, we must exclude data to account for the impact of the COVID-19 PHE on calendar year 2021 data. As finalized in the FY 2023 IPPS/LTCH PPS final rule, the exclusion of calendar year 2021 HAI data will result in a FY 2024 performance period for the HAI measures of January 1, 2022–December 31, 2022.

Question 3: **What is the difference between a measure score and a measure result?**

For the HAC Reduction Program, the measure result is a hospital's performance value for a given measure. For the CMS PSI 90 measure, a hospital's measure result is its CMS PSI 90 composite value. For the HAI measures, a hospital's measure result is its standardized infection ratio (SIR) for the given measure.

Measure scores are a calculation of hospital relative performance on the measure compared to other hospitals that are included in the HAC Reduction Program. Specifically, CMS calculates hospitals' measure score for a given measure as the Winsorized *z*-score of their measure results. A negative measure score means that the hospital's measure result is below the national average, and indicates better performance, whereas a positive measure score means that the hospital's measure result is above the national average, and indicates worse performance. As previously discussed, no hospital is receiving a measure score for any measure for the FY 2023 program year.

Question 4: **Regarding the HAC program, how is the SIR calculated?**

For the HAI measures, CMS relies on calculations produced by the Centers for Disease Control and Prevention (CDC). The CDC calculates the SIR for each HAI measure as the ratio of a hospital's observed HAIs to its predicted HAIs.

The CDC determines predicted HAIs for each measure using a risk-adjustment process based on hospital information submitted to the CDC's National Healthcare Safety Network (NHSN).

Central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI) are risk adjusted at the hospital and the patient-care-unit levels. Surgical site infections (SSIs) are risk adjusted at the procedure level. The SSI measure is a pooled measure based on the number of SSIs following abdominal hysterectomy and colon procedures. Methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* Infection (CDI) are risk adjusted at the hospital level.

Question 5: **When will the pneumonia 30-day readmission measure data be reported on Care Compare?**

Although CMS is not including the pneumonia readmission measure results in the fiscal year 2023 HRRP payment reduction calculations, CMS is still collecting, calculating, and confidentially reporting hospital pneumonia readmission measure results in the HRRP and measure-specific reports and will publicly report those results on the Care Compare website for transparency.

CMS has not announced the timelines for measure-specific report delivery and public reporting. These timelines will be communicated through the QualityNet Listservs. If you are not signed up for the QualityNet Listservs, you can sign up for the email updates by going to the bottom of the QualityNet home page, at http://qualitynet.cms.gov, and clicking Join Now.

Question 6: **Do the elective Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA) readmission rates only include inpatient stays?**

Yes, for each readmission measure in HRRP, including the hip/knee surgery measure, only inpatient stays at subsection (d) hospitals that occurred during the performance period are included.

Question 7: **How does CMS know from the claim that a readmission is planned or unplanned?**

CMS does not count planned readmissions in the HRRP readmission measures because planned readmissions are not considered an indicator of quality of care. CMS uses an algorithm to identify readmissions that are typically planned and can occur within 30 days of discharge from the hospital. A planned readmission is defined as a non-acute readmission for a scheduled procedure. Some types of care are always considered planned, such as transplant surgery, maintenance chemotherapy or immunotherapy, and rehabilitation. Admissions for acute illnesses or complications of care are never considered planned.

For the FY 2023 program year, CMS identifies planned readmissions using version 4.0 2022 of its Planned Readmission Algorithm. For more information, visit the Readmission Measures Methodology page on the QualityNet website: https://qualitynet.cms.gov/inpatient/measures/readmission/methodology.

Question 8: **Why are my pneumonia readmission measure results included in the HSR if the pneumonia readmission measure is suppressed in FY 2023?**

As finalized in the FY 2022 IPPS/LTCH PPS final rule, the pneumonia readmission measure is suppressed in FY 2023 HRRP payment reduction calculations due to COVID-19's substantial impact on this measure. The pneumonia readmission measure results are shown in the HSR for informational purposes only; the pneumonia readmission measure results do not contribute to FY 2023 HRRP payment reduction calculations. Additionally, the pneumonia readmission measure results will be publicly reported on CMS's Provider Data Catalog for transparency of the effects of the COVID-19 PHE.

Question 9: **Why is the first part of the HRRP performance period only through December 1, 2019? Isn't it supposed to go through December 31, 2019? It says that it goes through Quarter 4 of 2019.**

The FY 2023 performance period is impacted by the national Extraordinary Circumstance Exception (ECE) granted by CMS in response to the COVID-19 PHE. CMS will not use claims reflecting services provided January 1, 2020, through June 30, 2020 (Quarter 1 and Quarter 2 2020) in its calculations for HRRP (85 FR 54832). Since the readmission measures used in HRRP identify readmissions within 30 days of each index stay, the first part of the HRRP performance period ends 30 days before January 1, 2020, on December 1, 2019, so that no claims from Quarter 1 and Quarter 2 2020 are used in the measure or program calculations. Therefore, the FY 2023 performance period includes data from July 1, 2018, to December 1, 2019, and July 1, 2020 to June 30, 2021.

Question 10: **When should hospitals expect their PSI 90 score to become publicly available?**

Although CMS is not including the CMS PSI 90 measure results in the FY 2023 HAC Reduction Program HSRs, CMS will collect, calculate, and confidentially report hospital CMS PSI 90 results via measure-specific reports and publicly report those results on the Care Compare website to provide transparency to the public on important infection and patient safety metrics during the PHE.

CMS has not announced the timelines for measure-specific report delivery and public reporting. These timelines will be communicated through the QualityNet Listservs. If you are not signed up for the QualityNet Listservs, you can sign up for the email updates by going to the bottom of the QualityNet home page, at http://qualitynet.cms.gov, and clicking Join Now.

Question 11: **We noticed a dramatic difference in primary elective total hip and knee cases due to surgery case restrictions in all of 2020 (not just excluded months) and the move to the outpatient arena for Total Hip Replacement/Total Knee Replacement (THR/TKR). For example, we went from 500 cases down to 300 cases. This has a statistically significant effect on readmission rates. Does CMS plan to re-look at this before penalizing hospitals this year?**

CMS continues to closely monitors changes in care and quality measures to determine the suitability of measures included in HRRP. CMS analyses found that the distribution of THA/TKA results for the FY 2023 program year was similar to FY 2022. Additionally, hospitals that perform fewer elective total hip and knee cases due to the shift to the outpatient setting may no longer meet the 25-case threshold required for the measure to be included in the program.

CMS continues to monitor the volume of index admissions for the conditions and procedures included in HRRP to make sure that the measures remain appropriate. CMS makes changes to the program requirements, such as the set of included readmission measures, through rulemaking. CMS publishes these changes annually with the IPPS/LTCH PPS final rule following a public comment period.

Question 12: **In the HRRP, can you explain how an increase in the peer group assignment affects the payment reduction percentage?**

If a hospital's peer group assignment changes, then the threshold used to assess performance will change. Under HRRP, hospitals are sorted into one of five peer groups, based on the proportion of Medicare Fee for Service (FFS) and managed care stays in a hospital during the performance period in which the patient was dually eligible for Medicare and full Medicaid benefits. A hospital's payment reduction is determined as a weighted average of a hospital's performance across the condition- or procedure-specific readmission measures during the performance period. CMS compares each hospital's performance relative to the peer group median excess readmission ratio (ERR) for each condition or procedure. Readmission measures with 25 or more eligible discharges and an ERR above the peer group median ERR contribute to the size of the payment reduction. If a hospital switches peer groups then the value of the peer group median ERR may also change, changing the size of the contribution of the measure to their payment reduction factor.

Question 13: **In the HRRP, is a more negative number for the readmission data risk factor coefficients average effect/hospital effect indicative of a higher risk factor?**

The average hospital effect represents the underlying risk of a readmission at the average hospital after accounting for patient risk. The hospital-specific effect represents the underlying risk of a readmission at the specific hospital, after accounting for patient risk. The more negative the average and hospital effect, the lower the risk factor.

The average hospital effect is added to determine expected readmission rate and the hospital-specific effect is added to determine the predicted readmission rate. The ERR is the risk-adjusted ratio of the predicted readmission rate to the expected readmission rate. For a given measure, if your hospital performs better than an average hospital that admitted similar patients, the ERR will be less than 1.0. If your hospital performs worse than an average hospital with similar patients, the ERR will be greater than 1.0. Therefore, a larger ERR is "worse." Since the average effect is added to determine the predicted readmission rate, a larger negative average effect results in a smaller predicted readmission rate and similarly, the hospital effect is added to determine the expected readmission rate so a larger negative hospital effect results in a smaller expected readmission rate.

Question 14: **Will the displayed HAIs on Care Compare suppressed for the HAC Reduction Program be calculated on star rating results?**

Yes, publicly reported HAI data will continue to be included in the Overall Star Rating results. CMS will collect, calculate, and confidentially report hospital HAI results via measure-specific reports. CMS will publicly report those results on the Care Compare website to provide transparency to the public on important infection and patient safety metrics during the PHE.

CMS has not announced the timelines for measure- specific report delivery and public reporting. QualityNet Listservs will communicate these timelines.

If you are not signed up for the QualityNet Listservs, you can sign up for the email updates by going to the bottom of the QualityNet home page, at http://qualitynet.cms.gov, and clicking Join Now.

Question 15: **Is there a calendar with timelines, submission dates, review and correction timetables, and Care Compare posting dates?**

The HAC Reduction Program Matrix of Key Dates is available on the QualityNet HAC Reduction Program Resources page. It provides information on the performance periods for CMS PSI 90 and HAI measures, the claims snapshot date, Scoring Calculations Review and Corrections Period, payment reduction dates, and public reporting timeline on the Provider Data Catalog for each program year. The Matrix of Key Dates also includes quarterly submission deadlines for NHSN data.

Question 16: **Is the O/E ratio here predicted over expected?**

The ERR is a measure of a hospital's relative performance compared with all other HRRP hospitals. CMS calculates ERRs as the ratio of the predicted readmission rate to the expected readmission rate.

The predicted readmission rate is the predicted 30-day readmission rate for a hospital, based on that hospital's performance for its specific patient case mix (its hospital-specific effect on readmissions, reported in its discharge-level data in the HSR).

The expected readmission rate is the expected 30-day readmission rate for a hospital, based on readmission rates at an average hospital with a patient case mix similar to that hospital's (if patients with the same characteristics had been treated at an average hospital, rather than that individual hospital).

Question 17: **How can we obtain prior reports? Are they available on the QualityNet website for historical data?**

Previous years of the mock HSRs are available on the QualityNet HAC Reduction Program Reports page. Previous years of the mock HRRP HSRs are available on the QualityNet HRRP Reports page.

Hospitals can request previous years of their HSRs by submitting a request through the QualityNet Question & Answer Tool. Select Ask a Question and HACRP – Hospital-Acquired Condition Reduction Program or HRRP – Hospital Readmissions Reduction Program under the program list, depending on the program for which you are requesting your hospital's HSR. Then, choose Hospital-Specific Report & Requests from the topic list.

Question 18: **Does the HRRP only apply when the patient readmits to the hospital for the original admission?**

Under HRRP, CMS defines readmissions as unplanned admissions to the same or another applicable hospital (subsection (d) hospital) within 30 days of discharge.

Question 19: **On what table/spreadsheet can I find the percentage of reduction lost?**

Your hospital's HRRP payment reduction percentage is available on Table 1: Payment Adjustment of your hospital's HRRP HSR. The payment reduction is the percentage a hospital's base operating diagnostic-related group (DRG) payments will be reduced based on its performance in the program.

Question 20: **When will CMS include PSI 90 data in the payment reduction adjustment?**

In the FY 2024 program year, CMS will once again include the CMS PSI 90 measure in the HAC Reduction Program HSRs and the payment reduction calculations. As described in the FY 2023 IPPS/LTCH PPS final rule, CMS emphasizes the long-term importance of value-based care and incentivizing quality care tied to payment.

The goal is to continue resuming the use of measure data for the purposes of scoring and payment adjustment beginning with the FY 2024 program year HAC Reduction Program HSRs.

For the CMS PSI 90 measure, beginning with the FY 2024 program year, the CMS PSI 90 measure software will include a COVID-19 diagnosis as a risk adjustment parameter. This will help the measure account for the impact of the COVID-19 PHE on calendar year 2021 and subsequent years of data. The FY 2024 performance period for the CMS PSI 90 measure will be January 1, 2021–June 30, 2022.

Question 21: **If your peer group is matched via the volume/percentage of dual eligible patients, is this the total dual eligible patients admitted or just the duel eligible patients admitted in those categories of AMI, COPD, pneumonia, and so on? Is it the total admitted during the previous calendar year or fiscal year (October to September)?**

No, the dual proportion is not restricted to only those stays that qualify for inclusion in the HRRP condition/procedure-specific measures. A hospital's dual proportion is the proportion of all Medicare FFS and managed care stays where the patient was dually eligible for Medicare and full-benefit Medicaid during the HRRP performance period.

For example, the FY 2023 program year dual proportion is calculated as the number of Medicare FFS and managed care stays between July 1, 2018, to December 1, 2019, and July 1, 2020, to June 30, 2021, where the beneficiary was dually eligible for Medicare and full-benefit Medicaid.

Question 22: **For HRRP, can you review how the expected readmission rate is calculated?**

The expected readmission rate is the expected 30-day readmission rate for a hospital based on readmission rates at an average hospital with a patient case mix similar to that hospital's (if patients with the same characteristics had been treated at an average hospital, rather than that hospital).

Additional information on how to calculate your hospital's expected readmission rate using the data in your HRRP HSR is available in the FY 2023 HRRP HSR User Guide (HUG) on the QualityNet website.

Question 23: **How can I determine how much money we are expected to lose in the HRRP? Can you review the payment reduction slides?**

CMS transforms the payment reduction into a payment adjustment factor (PAF) to determine how much a hospital's payments will be reduced. CMS applies the payment adjustment factor to all Medicare base operating DRG payments during the fiscal year. To determine the dollar value of your hospital's payment reduction, multiply your hospital's base operating DRG payments by your hospital's payment reduction.

Question 24: **Why is there no pneumonia list of included codes for 2022?**

Although CMS is not including the pneumonia readmission measure results in the fiscal year 2023 HRRP payment reduction calculations, CMS is still collecting, calculating, and confidentially reporting hospital pneumonia readmission measure results in the HRRP and measure specific reports. CMS will publicly report those results on the Care Compare website for transparency.

The pneumonia measure specifications, including the list of included codes for 2022, and results for 2022 confidential and public reporting of the pneumonia readmission measure have been delayed by CMS. Later in 2022, CMS anticipates that updated specifications and measure results will be published. The pneumonia measure specifications will be available on the Readmission Measures Methodology page of the QualityNet website at: https://qualitynet.cms.gov/inpatient/measures/readmission/methodology

CMS has not announced the timelines for measure-specific report delivery, the 2022 Condition-Specific Readmission Measure Updates and Specifications Report for pneumonia, and public reporting. These timelines will be communicated through the QualityNet Listservs.

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Question 25: **Why are the data delayed by more than two years? Can we get more recent discharges into the dataset (2020, 2021) instead of those from 2018 and 2019?**

Although it might take longer for the ERRs to reflect hospital improvements, CMS calculates the ERRs using a rolling multi-year performance period. Using multiple years of data improves the reliability of the ERRs, enabling CMS to better identify variations in hospital performance. In addition, using multiple years of data allows the program to include more hospitals by increasing the number of discharges for a given hospital during the performance period.