Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Hospital Readmissions Reduction Program
Early Look Hospital-Specific Reports

Questions and Answers Transcript

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Hospital Inpatient Quality Reporting (IQR) Program

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The following questions were asked, and responses given by subject-matter experts, during the live webinar. Questions and answers may have been edited for grammar.

Question 1: **Are both Medicare and Medicare Risk (managed care) patients included in the denominator and numerator?**

Yes. Both Medicare and Medicare Advantage (MA) patients will be included in the denominator and the numerator in the calculation of dual proportion.

Question 2: **Is the Security Administrator (SA) the only person who can access the reports?**

Users with a *QualityNet Secure Portal* account with the appropriate roles assigned will automatically have access to their hospital's reports in their Secure File Transfer inbox. Users must register and ensure they are assigned the Inpatient Feedback and the File and Exchange roles for their CMS Certification Number (CCN).

Question 3: **What does dual eligibility mean?**

Dual eligibility means that a patient is eligible for both Medicare and Medicaid.

Question 4: **What dates of service will the revised Hospital Readmissions Reduction Program (HRRP) measure include?**

The excess readmission ratio (ERR) measures for the program will not be revised. These will still be calculated using the same measure methodology as prior years. For Fiscal Year (FY) 2019, they will be calculated using discharges from July 1, 2014, through June 30, 2017.

Question 5: **When was the last Hospital-Specific Report (HSR) available?**

The last Hospital-Specific Report was for FY 2018 and those were released on June 1, 2017, in your *QualityNet Secure Portal* account.

Question 6: **What is the performance period for FY 2019?**

The performance period is July 1, 2014, through June 30, 2017.

Question 7: **Slide 23. The five peer groups are defined by fee-for-service (FFS)/MA populations. Are the readmission ERRs going to include MA discharges too?**

No. The ERRs will continue to only include Medicare fee-for-service patients. However, peer groups are calculated using Medicare fee-for-service and managed care patients.

Question 8: **Can you please define the acronym MA?**

MA refers to Medicare Advantage.

Question 9: **Will you provide the neutrality modifier calculated with this 2018 data example?**

Yes. The neutrality modifier calculated using FY 2018 performance period data is included in hospitals' Early Look Hospital-Specific Report.

Question 10: **What are the peer groups? How are they defined?**

The peer groups are groups of hospitals with similar proportions of dual-eligible patients. Hospitals are stratified into five groups based on their dual

proportion.

Question 11: **Is the Hospital-Specific Report automatically available to hospitals or will we have to request the file?**

Hospitals will not have to request the file if the hospital has the appropriate roles assigned in the *QualityNet Secure Portal*. These are the Inpatient Feedback role and the File and Exchange role under your hospital's CCN. The Hospital-Specific Report will be automatically uploaded to your Secure File Transfer inbox.

Question 12: **When will we know what our peer groups will be?**

The peer group assignment based on the FY 2018 performance period data is included in the Early Look Hospital-Specific Reports. The peer group assignment for FY 2019 will also be included in the Hospital-Specific Report released in late summer or early fall.

Question 13: **Please define "mock" data. I thought that this would represent Fiscal Year 2018 data if the new methodology was in place.**

For this presentation, mock data was used. For the Early Look Hospital-Specific Report that you received in your inbox, the data represents your FY 2018 data if the new methodology was put in place.

Question 14: **When will the FY 2019 Hospital-Specific Report be available?**

FY 2019 Hospital-Specific Reports will be released in late summer/early fall, which is later than normal. This is due to the new methodology and the additional data factors needed for those calculations.

Question 15: **When does this new methodology start affecting payments? Is it October**

2019?

The new methodology will begin affecting payments in October 2018.

Question 16: **Can you explain the peer group number? Are two in the higher or lower level of dual proportion?**

The first peer group (i.e., peer group 1) represents the peer group with the lowest quintile of dual proportions; whereas, the fifth peer group (i.e., peer group 5) is made up of hospitals with higher dual proportions.

Question 17: **Will peer group data be reported only at the national level or will state and/or regional performance data also be reported?**

Dual proportions are calculated for each hospital separately. The dual proportion indicates the proportion of a hospital's total stays for Medicare FFS and Medicare Advantage patients in which the patient was enrolled in Medicare and Medicaid. Hospitals are divided into five peer groups based on their proportion of dual-eligible patients. There are no plans to report the average dual proportion nationally or at the state or regional level.

Question 18: **Does the age group of 65 and older remain in effect with a cohort or will patients under 65 years be included?**

It will still be the age group of 65 and older for the measure cohort.

Question 19: **When will the Early Look Hospital-Specific Reports be available?**

The Early Look Hospital-Specific Reports were made available on March 19, 2018, to your *QualityNet Secure Portal* account. If you do not have the report, please send a request via email to HRRP@lantanagroup.com.

Access the HSRs via the *QualityNet Secure Portal*. Previously registered

users should already have account access, and new users can create an account by visiting *www.QualityNet.org*, selecting Login, choosing a primary quality program, and then selecting Start/Complete New User Enrollment. When logged in to the portal, click Secure File Transfer in the top-right corner of the screen. From here, users can view their mailbox and select Auto Route Inbox to access their Hospital Readmissions Reduction Program (HRRP) HSR.

Hospital staff assigned the Hospital Inpatient Reporting Feedback and File and Exchange roles for their CCN should already have access to the HSRs in their *QualityNet Secure Portal* Secure File Exchange Auto Route Inbox. If hospital staff experience problems accessing the HSRs, they should contact the *QualityNet* Help Desk at qnetsupport@hcqis.org.

Question 20: **Are you able to provide us with the percentage of dual-eligible for each peer group?**

No, we are not providing this information at this time. The Early Look Hospital-Specific Reports show the percent of dual-eligibles for a specific hospital. The new stratified methodology hospital-level impact file on the *CMS.gov* website includes the dual proportions and peer group assignments for all hospitals based on data for the FY 2018 performance period.

Due to the high volume of requests for the ranges of the dual proportions for each peer group, CMS plans on including these ranges in the FY 2019 HRRP Hospital-Specific User Guide (HUG).

Question 21: **Is the peer group on the Early Look Hospital-Specific Report the same peer group on the actual FY 2019 report? Will peer groups be reassessed each year?**

The dual proportion in the Early Look Hospital-Specific Report will not be the same as in the FY 2019 report. The dual proportion will be calculated for

each program year using the same performance period as the measure calculation. For FY 2019, it is July 1, 2014, through June 30, 2017. The dual proportion in the Early Look Hospital-Specific Report reflects the FY 2018 performance period (July 1, 2013, through June 30, 2016).

Question 22: What did you use to define the peer groups?

We used the dual proportion to define peer groups. The dual proportion is calculated using a numerator with the number of dual eligible patients. This is sourced from the state Medicare Modernization Act (MMA) files. The denominator of the calculation includes the total number of Medicare Advantage and Medicare FFS stays at a hospital.

Question 23: How many administrators can you have for a hospital?

The *QualityNet* Help Desk can provide you with further information for setting up accounts.

Question 24: Where does CMS get the dual-eligible numbers?

CMS calculates the amount of dual-eligible beneficiaries based on data from the Master Beneficiary Summary File (MBSF). The data for dual eligibility in the MBSF is sourced from the state MMA files.

Question 25: Can you clarify which email address to use to send a request if we don't have our Early Look Hospital-Specific Report yet?

For the Early Look Hospital-Specific Report, you can email HRRP@Lantanagroup.com. The report can be resent to you in your Secure File Transfer Inbox.

Question 26: **What are the risk social factors associated with each peer group?**

The dual proportion is being used to estimate social risk for the peer groups. In the Office of the Assistant Secretary for Planning and Evaluation's (ASPE) *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs,* ASPE found that dual enrollment was typically the most powerful predictor of poor performance on quality measures among the social risk factors examined. ASPE's analysis was limited to social risk factors that could be defined using existing Medicare data.

Question 27: **A list of hospitals by CCN was publicly released last month in an impact file. Can you explain what is meant by "penalty indicator" for each condition?**

The penalty indicator in the Early Look Hospital-Specific Report is either "Y" (1 in the impact file) or "N" (0 in the impact file) for each measure. If it has a value of "Y," the hospital has excess readmissions compared to its peer group (i.e., an ERR above the peer group median ERR) and may be subject to a penalty. If it is listed as "N," then the hospital either does not have a sufficient number of discharges to be penalized (i.e., the case size is less than 25 discharges) or it does not have excess readmissions.

Question 28: **Will the FY 2019 actual report show both stratified and non-stratified methodology ERRs or only stratified ERRs?**

The FY 2019 Hospital-Specific Report will just show the stratified payment adjustment factor. The ERR calculation is the same under the non-stratified and stratified methodologies.

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The following questions were researched and answered by subject-matter experts after the live webinar.

Question 29: **What is Medicare Advantage? In the stratified method, what is full-benefit Medicaid?**

Medicare Advantage is a managed care program offered by private insurance companies. It is sometimes referred to as Medicare Part C. Individuals who are eligible for Medicare have the option to receive Medicare Part A (hospital benefits) and Medicare Part B (medical benefits) through a Medicare Advantage plan. The plans follow rules set by Medicare and cover all Medicare benefits. Medicare Advantage plans typically cover some extra benefits.

Full-benefit Medicaid refers to Medicaid coverage for comprehensive health services. Some states offer limited benefit packages that only cover some services like emergency services. For the HRRP, CMS identifies full-benefit dual status (i.e., numerator) using data from the Master Beneficiary Summary File, which it sources from the state MMA files. The methodology identifies full-benefit dual patient stays for patients identified as full-benefit dual status for the month the hospital discharged the beneficiary.

Question 30: **Will both the non-stratified methodology penalty indicator (c) and the stratified methodology penalty indicator (d) be used to calculate the penalty, or was the non-stratified indicator given to us just for reference? Why are both on the Hospital-Specific Report?**

The non-stratified and stratified methodology were both included in the Early Look Hospital-Specific Report to show differences between the two methodologies. The penalty indicators indicate whether the ERR will enter the payment adjustment factor formula under each of the methodologies.

Question 31: **To be at risk for penalty, does your ERR need to be in excess for BOTH the stratified and non-stratified methodology? My understanding was for FY 2019 performance, it was just based on the stratified methodology.**

No, the FY 2019 program will use the stratified methodology. The non-stratified and stratified methodology were both included in the Early Look Hospital-Specific Report to help hospitals understand the differences between the methodologies.

Question 32: **Why do our reports say they do not reflect actual payment adjustments for FY 2019 and you are saying October 2018?**

The Early Look Hospital-Specific Reports help hospitals understand the new stratified methodology CMS will use to assess hospital performance starting in the FY 2019 HRRP.

The Early Look Hospital-Specific Report provides a hospital's estimated hospital-level dual proportions, peer group assignments, and estimated payment adjustment information under the stratified methodology using FY 2018 performance period data (i.e., eligible hospital discharges that occurred from July 1, 2013, through June 30, 2016).

The report does not reflect actual payment adjustments for FY 2019. This is an estimate of how the stratified methodology will affect your hospital using FY 2018 data.

CMS will not implement the new stratified methodology until the FY 2019 program, which will use discharge data from July 1, 2014, to June 30, 2017.

Question 33: **Why isn't the ERR calculated including Medicare managed care when**

these patients were included in the peer group assignment?

Including Medicare managed care patients in the calculation of the dual proportion (which is then used to assign peer groups) more accurately represents the number of dual-eligible patients at hospitals, particularly in states with high Medicare managed care penetration rates. Medicare managed care patients are not included in the calculation of ERRs due to limitations in the available data for these patients.

Question 34: **Why isn't the actual number of readmitted patients included in this report?**

The purpose of the Early Look Hospital-Specific Report is to help hospitals understand the stratified methodology that will be used to calculate payment adjustment factors beginning with the FY 2019 program. Hospitals have already received information on the number of readmitted patients for each measure in their FY 2018 HRRP Hospital-Specific Report. Please refer to the FY 2018 Hospital-Specific Report released in summer of 2017 to determine the actual number of readmitted patients during the FY 2018 performance period.

Question 35: **Will the range of dual proportions for each quintile be available?**

Due to the high volume of requests for the ranges of the dual proportions for each quintile, CMS plans to include these ranges for the FY 2019 HRRP in the FY 2019 HRRP Hospital-Specific User Guide (HUG).

Question 36: **Will the peer group assignments be published in public use files or on *Hospital Compare*?**

Peer group assignments will not be posted on *Hospital Compare*. CMS does plan to publish peer group assignments in the FY 2019 Final Rule:

Hospital Readmissions Reduction Program Supplemental Data File.

Question 37: **If an inpatient facility just started having inpatients in quarter (Q)2 2017, when will a HRRP report be available for that facility?**

All open inpatient prospective payment system (IPPS) hospitals will receive a FY 2019 Hospital-Specific Report. The FY 2019 HRRP performance period includes hospital discharges from July 1, 2014, through June 30, 2017. If a hospital has an eligible discharge for any of the six readmission measures cohorts during that three-year performance period, then the hospital will receive information on its performance in the Hospital-Specific Report.

Question 38: **How will we know if we are subject to a penalty if we have a "Y" in the methodology fields? Can we tell by looking at our neutrality modifier?**

If a hospital has a "Y" in the penalty indicator field, it indicates that the hospital has excess readmissions for the measure and may be subject to a penalty. Due to rounding in the payment adjustment factor formula, a small number of hospitals with "Y" in the measure specific penalty indicator field are not penalized. To determine if your hospital is penalized, you should look at the penalty indicator field. A penalty indicator field that is less than 1 indicates that the hospital is penalized under the program.

Question 39: **Slide 38. Please repeat your explanation. When will hospitals be subject to a penalty reduction, when the stratified or non-stratified penalty indicator is "Y"?**

The example shows the different penalty indicators between non-stratified and stratified methodology on the heart failure and total hip/knee arthroplasty measures.

If the penalty indicator equals "Y" (as shown in heart failure) for the non-stratified penalty indicator, then the hospital has 25 or more eligible discharges and an ERR greater than 1. If the hospital has less than 25 eligible discharges or an ERR less than 1 for that measure, the non-stratified penalty indicator will equal "N" (as shown in the total hip/knee arthroplasty measures).

For the stratified methodology, if the penalty indicator equals "Y," then the hospital has 25 or more eligible discharges and an ERR greater than the peer group median. If the hospital has less than 25 eligible discharges or the ERR is less than the peer group median ERR for that measure, the penalty indicator equals "N."

For both methodologies, when the penalty indicator equals "Y," the ERR will enter the payment adjustment factor formula and the hospital may be subject to a payment reduction. To determine if your hospital is penalized, you should look at the PAF. A FY 2018 PAF that is less than 1 indicates that the hospital is penalized under the FY 2018 program, while a stratified estimated PAF less than 1 indicates that a hospital is penalized under the stratified methodology.

Question 40: **If your peer group median is less than 1.00, will your penalty be higher than it was in FY 2018 when it was 1.00?**

No, if the peer group median is less than 1.00 for a measure, it does not necessarily mean that your hospital will have a higher penalty than in FY 2018. The HRRP assesses performance on six measures. Measures enter the payment adjustment factor formula additively, each increasing the size of the payment adjustment. Whether your hospital will receive a higher penalty than in FY 2018 depends on your hospital's number of eligible discharges, ERR, the peer group median ERR for each of these measures, and the neutrality modifier.

Question 41: **Can we get our patient-level data to review the cases?**

The Early Look Hospital-Specific Report used data from the FY 2018 performance period (i.e., eligible hospital discharges that occurred from July 1, 2013, through June 30, 2016). Patient-level data used to calculate the ERRs are included in your FY 2018 HRRP Hospital-Specific Report that was delivered last summer.

Question 42: **Does our participation in an accountable care organization (ACO) affect the reductions or how they are factored?**

The HRRP includes providers participating in an ACO as long as it is an applicable hospital.

"Applicable hospitals" with respect to the HRRP include subsection (d) hospitals and Maryland hospitals participating in the all-payer model. As finalized in the FY 2013 IPPS/LTCH PPS Final Rule, for purposes of the HRRP, subsection (d) hospitals do not include the following types of hospitals and hospital units:

- Long-term care hospitals
- Critical access hospitals
- Rehabilitation hospitals and units
- Psychiatric hospitals and units
- Children's hospitals
- PPS-exempt cancer hospitals

Question 43: **How is the peer group defined? How many dual-eligible beneficiaries are in each peer group?**

Peer groups are defined by stratifying hospitals into five groups based on

their dual proportion. Hospital peer group assignment is numbered 1 through 5. Hospitals in the first peer group (peer group assignment = 1) have the lowest dual proportion and hospitals in the fifth peer group (peer group assignment = 5) have the highest dual proportion. The peer groups have approximately the same number of hospitals, but do not have the same number of dual-eligible patients.

Question 44: **Is including Medicare Advantage in the numerator and denominator different than the current HRRP measure, which is only traditional Medicare?**

Yes, ERRs are calculated using Medicare FFS patients. The dual proportion is calculated using Medicare Advantage and Medicare FFS patients.

Question 45: **Were the managed care Medicare patients included in the Early Look Hospital-Specific Reports?**

Yes, they are included in the dual proportion provided in the Early Look Hospital-Specific Reports. CMS provided the dual proportion for each hospital, which is the proportion of Medicare FFS and managed care stays in a specific hospital, where the patient was dually eligible for Medicare and full-benefit Medicaid during the FY 2018 HRRP performance period (July 1, 2013, to June 30, 2016).

Question 46: **Does CMS use the three-year measure performance period to calculate a hospital's assigned dual-eligible cohort? In other words, does CMS look at three years of data for dual-eligible patients?**

Yes, the dual proportion is calculated using the same three-year performance period as calculating a hospital's ERRs. The Early Look Hospital-Specific Report is based on eligible inpatient hospital discharges

that occurred during the FY 2018 performance period from July 1, 2013, through June 30, 2016.

Question 47: **How is the expected rate determined for each measure?**

The expected 30-day readmission rate is based on average hospital performance with your hospital's case mix and the average hospital effect which are provided in your hospital discharge-level data of the Hospital-Specific Reports. The Early Look Hospital-Specific Report does not show discharge-level (patient) information used to calculate the ERRs. Please refer to the FY 2018 Hospital-Specific Report for this information.

Question 48: **In slide 39, how has the ERR value been calculated?**

When a hospital has no eligible discharges, the Hospital-Specific Report will express a value of NQ to indicate there are no qualifying cases for the measure. This will also cause the value of ERR to display NQ. CMS cannot calculate an ERR without a qualifying case for a measure. The hospital also cannot be penalized for the measure, so the penalty indicator has a value of "N" in the Hospital-Specific Report.

Question 49: **If your penalty indicator is a "Y" for just one of the disease states, will the hospital have a penalty?**

In most cases, a hospital that has a penalty indicator of "Y" for one measure will be penalized. There are a small number of cases where a hospital has a "Y" value for the penalty indicator and is still not penalized. A value of "Y" indicates that the ERR is included in the calculation of the payment adjustment factor. In the formula, the payment adjustment factor is rounded to four decimal places. It is possible for a hospital with a "Y" value to have its payment adjustment factor rounded up to 1, indicating that

it is not penalized.

Question 50: **Could hospitals have a different dual-eligible cohort for each CMS disease/procedure category or, once a hospital is assigned a cohort, is it used for all CMS disease categories?**

Although it is possible for hospitals to see a different mix of dual-eligible patients depending on the disease/procedure category, for the purposes of HRRP, the dual proportion is calculated across all Medicare FFS and Medicare Advantage inpatient stays regardless of disease/procedure category.

Question 51: **Does the neutrality modifier calculation exclude the 3 percent penalty cap step when comparing the old and new method? How does this affect budget neutrality?**

The neutrality modifier includes the 3 percent penalty cap when comparing the old (non-stratified) and new stratified methodologies. To calculate the neutrality modifier, CMS determines hospitals' penalties using the old methodology and caps penalties at 3 percent. CMS then estimates total Medicare savings under the old methodology and the new methodology (in the absence of a modifier). The neutrality modifier is the multiplicative factor that equates savings under the non-stratified and stratified methodologies. CMS then uses the neutrality modifier in the payment adjustment factor formula to calculate the penalty under the new stratified methodology. This approach maintains budget neutrality.

Question 52: **How does the percentage of dual-eligible patients factor into the readmission payment reduction?**

The proportion of dual-eligible patients is used to determine a hospital's peer group. Hospitals are stratified into five peer groups based on their dual

proportion. In the calculation of the payment reduction, hospital performance for each measure is assessed relative to the peer group median ERR.

Question 53: **Could you please clarify the definition of "predicted" versus "expected"?**

ERRs are calculated as the ratio of predicted readmissions to expected readmissions:

Predicted readmissions are the number of 30-day readmissions predicted for your hospital on the basis of your hospital's performance with its observed case mix and its estimated effect on readmissions. The predicted readmission term is also referred to as the adjusted actual readmissions in Section 3025 of the Affordable Care Act.

Expected readmissions are the number of 30-day readmissions expected for your hospital on the basis of average hospital performance given your hospital's case mix and the average hospital effect.

Question 54: **Are Programs of All-inclusive Care for the Elderly (PACE) patients included in the denominator?**

All Medicare FFS and Medicare Advantage stays are included in the denominator of the dual proportion calculation. The dual proportion is calculated for a HRRP applicable hospital.

Question 55: **If the adjustment factor increased in the new methodology, is that an indication that the new methodology will be more stringent for FY 2019?**

Payment adjustment factors range from 0.9700 for hospitals that receive the maximum penalty of 3 percent to 1.0000 for hospitals that are not

penalized. A higher payment adjustment factor under the new methodology indicates the hospital will receive a lower penalty. The stratified payment adjustment factor formula is different from the non-stratified payment adjustment formula in two ways: ERRs are compared to the peer group median (rather than 1) and a neutrality modifier is added to the formula to maintain budget neutrality. Whether a hospital receives a higher penalty under the new stratified methodology depends on factors such as your hospital's ERRs, peer group median ERRs, and the neutrality modifier.

Question 56: **If there is a "Y" in the penalty indicator line/column, could the facility have a penalty reduction in the final report. Does an "N" in this column indicate no penalty for this time period?**

Yes, when the penalty indicator equals "Y," the ERR will enter the payment adjustment factor formula and the hospital may be subject to a payment reduction. When the penalty indicator equals "N," the ERR will not enter the payment adjustment factor formula. Note that the penalty indicators are specific to a measure. To determine overall penalty status, you should refer to the payment adjustment factor. If the payment adjustment factor is less than 1, your hospital would have a penalty.

Question 57: **On slide 21, since the numerator says Medicare FFS only, is the numerator based on one set of data and the denominator based upon another set of data (FFS + MA)?**

No, Step 2 of the slide represents the dual proportion which is the numerator and denominator calculations.

The numerator includes Medicare FFS and managed care stays (Medicare Advantage [MA]) where the patient was dually eligible for Medicare and full-benefit Medicaid for the month they were discharged from the hospital. The denominator includes all Medicare FFS and managed care stays (MA).

Both the numerator and denominator are calculated among discharges during the FY 2019 HRRP applicable period (i.e., stays from July 1, 2014, through June 30, 2017).

Question 58: **If the stratified methodology penalty indicator was "Y," facilities may be subject to a penalty. Are there cases where a facility has a "Y" value and does not receive a penalty? Is there a rounding factor that applies?**

Yes, there are a small number of cases where a facility has a "Y" value for the penalty indicator and is still not going to be penalized. A value of "Y" indicates that the ERR is included in the calculation of the payment adjustment factor. In the formula, the payment adjustment factor is rounded to four decimal places. It is possible for a hospital with a "Y" value to have its payment adjustment factor rounded up to 1, indicating that it is not penalized.

Question 59: **Are the peer groups compared within the state or across the country? For example, if a facility is in Group 5 in California, is it compared to Group 5 California hospitals or Group 5 hospitals nationwide?**

Peer groups are not calculated by state. In the example provided, the California hospital in the Group 5 peer group would be compared to all other HRRP-applicable hospitals in the Group 5 peer group.

Question 60: **Does the number of the quintile assignment reflect more dual-eligible patients for #1 or for #5?**

Hospitals are stratified into five peer groups, or quintiles, based on the dual proportion. Hospital peer group assignment is numbered 1 through 5. Hospitals in the first peer group (peer group assignment = 1) have the lowest dual proportion and hospitals in the fifth peer group (peer group

assignment = 5) have the highest dual proportion.

Question 61: **Will the "dual eligibility proportion" indicator carry over into other quality performance programs, such as Hospital-Acquired Condition (HAC) Reduction Program?**

No, the dual proportion is only calculated for the HRRP at this time.

Question 62: **Is it possible for our payment adjustment factor to be the same under both methodologies?**

Yes, it is possible for a hospital to have the same payment adjustment factor under both methodologies. The stratified payment adjustment factor formula is different from the non-stratified payment adjustment formula in two ways: ERRs are compared to the peer group median (rather than 1) and a neutrality modifier is added to the formula to maintain budget neutrality. The calculated payment adjustment factors may be the same under both methodologies depending on a hospital's ERRs, the peer group median for each measure, and the neutrality modifier. In addition, under both methodologies, the calculated payment adjustment is rounded to four decimal places. As a result, small differences may result in the same payment adjustment factor after rounding.

Question 63: **Will this new methodology be used for the adjustment factor released later this year and used for all payment adjustments affecting reimbursement starting with October 2018 discharges?**

Yes, the stratified methodology will be implemented in the FY 2019 HRRP. The performance period includes hospital discharges that occurred from July 1, 2014, through June 30, 2017. For FY 2019, the payment adjustment will apply to payment for patient stays starting on or after

October 1, 2018, through September 30, 2019.

Question 64: **Is dual proportion related to social risk because dual coverage is reserved for those at a lower income level?**

Yes, the dual proportion is related to social risk because dual eligibility is a proxy for low income. Dual eligibility is an indicator of socioeconomic position which is one category of social risk factors.

Question 65: **If the payment penalty is applied on a hospital overall base diagnosis-related group (DRG), then what is the logic for calculating ERRs for an individual included diagnosis?**

Section 3025 of the Affordable Care Act required the Secretary of the Department of Health and Human Services to establish the HRRP and reduce payments to inpatient prospective payment system hospitals for excess readmissions.

The program supports the national goal of improving healthcare for Americans by linking payment to the quality of hospital care. CMS includes measures of conditions and procedures that significantly affect the lives of large numbers of Medicare patients. Research shows large variation in hospital readmission rates across the nation, highlighting an opportunity to improve the quality of care and save taxpayer dollars by incentivizing providers to reduce excess readmissions.

Question 66: **Can you explain what the "ratio of DRG payments per measure to total payments" means?**

The ratio of total base operating DRGs per measure to total payments is the weight attributed to excess readmissions for each measure (i.e., ERR minus peer group median ERR) in the payment adjustment factor formula.

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