



Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Hospital Readmissions Reduction Program Early Look Hospital-Specific Reports

Presentation Transcript

Moderator

Candace Jackson, ADN
Program Lead, Hospital IQR Program
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor

Speakers

Tamyra Garcia
Deputy Division Director
Division of Value, Incentives, and Quality Reporting (DVIQR)
Centers for Medicare & Medicaid Services (CMS)

Kati Michael
Program Lead
Hospital Readmissions Reduction Program (HRRP)
Hospital Quality Reporting Program Support (HQRPS)

Kristin Maurer, MPH
Analyst
HRRP, HQRPS

March 29, 2018
2 p.m. ET

DISCLAIMER: This transcript was current at the time of publication and/or upload onto the *Quality Reporting Center* and *QualityNet* websites. Medicare policy changes frequently. Any links to Medicare online source documents are for reference use only. In the case that Medicare policy, requirements, or guidance related to this transcript change following the date of posting, this transcript will not necessarily reflect those changes; given that it will remain as an archived copy, it will not be updated.

This transcript was prepared as a service to the public and is not intended to grant rights or impose obligations. Any references or links to statutes, regulations, and/or other policy materials included in the presentation are provided as summary information. No material contained therein is intended to take the place of either written laws or regulations. In the event of any conflict between the information provided by the transcript and any information included in any Medicare rules and/or regulations, the rules and regulations shall govern. The specific statutes, regulations, and other interpretive materials should be reviewed independently for a full and accurate statement of their contents.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Candace Jackson: Thank you, everyone, for joining today's presentation titled, *Hospital Readmissions Reduction Program, Early Look Hospital-Specific Reports*. I am Candace Jackson, the Project Lead for the Hospital Inpatient Quality Reporting Program with the Hospital Inpatient Values, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be the moderator for today's event. Before we begin, I would like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with the questions and answers, will be posted to the inpatient website, www.QualityReportingCenter.com and to the *QualityNet* site at a later date. If you are registered for this event, a reminder email, as well as the slides, was sent out to your email about a few hours ago. If you did not receive the email, you can download the slides at our inpatient website, again at www.QualityReportingCenter.com. If you have a question as we move through the webinar, please type your question into the chat window. We will not be using the raised-hand feature for today's webinar. For presenters to best answer your questions, we request that at the beginning of your question, please type the slide number into the chat window with it. As time allows, we will have a short answer-and-question session at the conclusion of the webinar. Applicable questions that are not answered during the question-and-answer session at the end of the webinar will be posted to the [QualityReportingCenter.com](http://www.QualityReportingCenter.com) website at a later date. I would like to welcome and introduce our guest presenters for today. Tamyra Garcia, the Deputy Division Director for the Division of Value, Incentives, and Quality Reporting at the Centers for Medicare & Medicaid Services. Kati Michael, the Program Lead for the Hospital Readmissions Reduction Program with the Hospital Quality Reporting Program Support. And Kristin Maurer, an analyst under the Hospital Readmissions Reduction Program with the Hospital Quality Reporting Program Support.

I would now like to turn the presentation over to Tamyra. Tamyra, the floor is yours.

Tamyra Garcia: Good afternoon and thank you for joining us today. I'm going to speak to you all about the Meaningful Measures Framework. While continuing to

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

focus on value and quality, CMS is moving toward a new direction via the Meaningful Measures initiative. This framework puts patients at the center of everything we do, as it serves to focus on measures that matter. It takes into account opportunities to reduce paperwork and reporting burden on providers associated with quality measurements, by helping us to find the highest quality measurement and improvement priorities that are most important to improve patient outcomes. Based on the growing number of quality measures in CMS programs, and the burden associated with reporting on these quality measures, CMS sought out and incorporated diverse stakeholder feedback to develop the Meaningful Measures initiative.

The goal: to focus on core quality priorities that are most vital to providing high quality care and improving patient outcomes. Meaningful Measures truly supports the Patients over Paperwork initiative by helping to do the following: lower provider reporting burden, focus on quality improvement in only the most critical areas, adopt the most meaningful measure of quality measures, and to get better patient outcomes at lower cost. As seen in slide seven, using the Meaningful Measures Framework will let us to use measures that are most prudent; least burdensome; well understood by external stakeholders; helpful in guiding quality-measurement efforts; measures that are aligned to reduce clinician and provider burden; and measures that are really focused on ensuring patients have access to their electronic medical records in a portable format, as well as high quality patient care.

And moving on to slide eight, we see a figure associated with the framework. There's a lot of information here, so, I'm going to do a bit of explaining so that you can sort of understand how the framework works. As you can see, it's based on four strategic goals, which are found at the center of slide four. And those four goals are aligned to 19 meaningful measure topics. These 19 topics can be found on the perimeter of slide eight, and are closely linked to six quality priorities. For example, the quality priority, Promote Effective Prevention and Treatment of Chronic Disease, includes five meaningful measure areas, as you can see in the

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

top-right corner. By focusing on this meaningful measure area and the others, we can find where there are gaps in measurement and quality improvement, and then look to our partnership with states and communities to improve health outcomes. The framework truly guides CMS in reducing paperwork and reporting burden associated with quality measurement for clinicians and other providers. Using the Meaningful Measures Framework will truly allow for the most parsimonious and least burdensome measure sets that are focused on health outcomes that are important to patients and their providers. Thank you for sharing with us today, and I'm going to turn it over to Kati for more information on the Hospital Readmissions Reduction Program.

Kati Michael:

Thank you, Tamyra. Good afternoon, everyone. As Candace mentioned, my name is Kati Michael, and I am the Program Lead for the Hospital Readmissions Reduction Program under the HQRPS contract for CMS. In today's webinar, we will be discussing the Early Look Hospital-Specific Report or HSR, for the Hospital Readmissions Reduction Program that your hospital received recently. Later in the presentation, we will go over the Early Look HSR in detail. Our purpose is to provide hospitals an understanding on the estimated hospital-level dual proportions, peer group assignments, and payment adjustment information for the new stratified methodology using fiscal year 2018 data, which is, eligible hospital discharges that occurred from July 1, 2013, through June 30, 2016, which is highlighted in the Early Look HSR. The Early Look HSRs will not reflect actual payment adjustments for fiscal year 2019.

At the conclusion of this presentation, participants will be able to understand all that we have listed here.

For your reference, here is a list of all the acronyms that we will use throughout the presentation.

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act, which established the Hospital Readmissions Reduction Program. Hospitals are financially encouraged to evaluate the entire spectrum of care that they deliver to patients and more carefully

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

coordinate and transition patients with respect to post-discharge claiming. HRRP aims to improve the quality of care, while reducing the cost of care.

Hospitals included in HRRP are subsection (d) hospitals and Maryland hospitals participating in the All-Payer Model. There are six types of hospitals that are not included in subsection (d), and you can see them listed here in this slide.

As CMS moves forward in its consideration of options to address social risk in its value-based purchasing programs, dual eligibility will be used as a proxy measure of social risk. The use of dual eligibility as a proxy measure is founded on a recent ASPE report that found dual eligibility to be the most powerful predictor of adverse health outcomes of those social risks compared in the study. HQRPS is currently testing methods to reward and incentivize hospitals' achievement, and/or improving quality of care for patients with social risk factors. Once tested, these methods will be evaluated for implementation into HRRP. With this measure being available for all HRRP hospitals, it allows for the improvement of health disparities to increase transparency and CMS being able to compare disparity across hospitals.

The fiscal year 2018 payment methodology does not include the implementation of the 21st Century Cures Act statute, nor the finalized policy provision to assess performance relative to other hospitals with similar proportion of dual-eligible patients. This new stratified methodology will be implemented with fiscal year 2019 payment determination.

The stratification approach was arrived at after considering the rule comments, the ASPE report, and the requirements of the Cures Act. CMS finalized policy, which requires the secretary to compare cohorts of hospitals based on the proportion of dual-eligible beneficiaries, or dual-eligible proportions in determining the extent of excess readmissions. The Fiscal Year 2018 HRRP Final Rule accounts for social risk by adjusting performance scores, by stratifying hospitals based on the dual-eligible proportion. Next, I will turn it over to Kristin, who will discuss how the

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

stratification will occur with the program, and demonstrate how this accounts for social risk as defined by dual-eligible proportion. Kristin?

Kristin Maurer: Thanks, Kati. As Candace mentioned, my name is Kristin Maurer and I'm an Analyst for the Hospital Readmissions Reduction Program under CMS's Hospital Quality Reporting Program Support Contract. Under this portion of the presentation, I will provide an overview of the new stratified methodology and compare the methodology to how payment adjustments were previously calculated in the program.

This figure shows how payment adjustment factors are determined in fiscal year 2018 using the non-stratified methodology. As shown in step one, CMS assembles a hospital's Medicare claims and then identifies 30-day unplanned readmissions for six measures. The six measures included in the program are acute myocardial infarction or AMI, heart failure or HF, pneumonia, chronic obstructive pulmonary disease or COPD, elective primary total hip and/or total knee surgery, and coronary artery bypass surgery or CABG. In this figure, the hospitals are colored blue if they predominantly care for socially at-risk patients, which are represented by the blue patient icon. A hospital is colored orange if it predominantly cares for non-socially at risk patients, which I represented by the red patient icon. So, the process for assembling Medicare claims and identifying unplanned readmissions does not vary depending on the type of hospital. Step two illustrates how for any given measure, CMS calculates an excess readmission ratio or ERR. This is the ratio of a hospital's predicted readmissions to its expected readmissions. This figure shows all four hospitals in the same tube in order to represent how a hospital's ERR is measured relative to the performance of other hospitals. Step three shows how ERRs enter the payment formula. If an ERR is greater than 1.0 and has at least 25 eligible discharges, when it enters the payment adjustment formula, the hospital may be subject to a penalty. In the ERR, 1.0 is the average across all HRRP hospitals. Hospitals with an ER—with ERRs greater than 1.0 are considered as having excess readmissions. In step four, CMS applies the payment reduction to all Medicare Fee-for-Service claims submitted by the hospital during the fiscal year, including patients

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

admitted not only for the conditions included in the programs, but for any condition.

This figure shows how the Cures Act changes the Hospital Readmissions Reduction Program payment adjustment factor methodology, beginning in fiscal year 2019 to account for a hospital's proportion of dual-eligible patients. In this graphic, step one and step two are grayed out to show that these steps are not changing under the new stratified methodology.

Hospitals will still submit claims to Medicare, and CMS will calculate excess readmission ratios for the six measures included in the program. Since CMS is not changing the first two steps, hospital ERRs are still being determined relative to all other applicable hospitals. However, action in step three under the stratified methodology, hospitals are stratified into peer groups based on their proportion dual-eligible patients. The blue hospitals with a high proportion of dual-eligible beneficiaries are compared to one another. And the orange hospitals with a low proportion of dual-eligible beneficiaries are compared to one another when calculating payment adjustment. The figure includes two peer groups for illustrative purposes. But, in the fiscal year 2018 IPPS Final Rule, CMS finalized the policy to stratify hospitals into five peer groups. In the next few slides, I will walk through these steps in more detail.

These first two charts show the hospital claims used to calculate ERRs and dual proportions. The ERR is calculated using Medicare Fee-for-Service claims and is the ratio of predicted to expected readmissions. As mentioned on the previous slide, this calculation is not changing with the new methodology. The other side of this slide shows that Medicare Fee-for-Service and managed care claims are used to calculate the dual proportion for each hospital, and stratify hospitals into five peer groups.

So, the numerator of the dual-proportion calculation includes all dual benefits to a hospital patient and is sourced from the State Medicare Modernization Act file. The denominator of the dual proportion is the total number of Medicare patients, including all Medicare Fee-for-Service and Medicare Advantage patients. Medicare Advantage patients are included in the calculation to accurately represent the proportion of dual-eligible

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

patients that hospitals serve, particularly for hospitals in states with high managed-care penetration rates. The data used period for the dual proportion is the same three-year period used to calculate ERRs. In fiscal year 2019, this will be discharges between July 1, 2014, and June 30, 2017.

Moving on to the next step. In step three, the median ERR is calculated for each measure and peer group. The peer group median ERR replaces 1.0 in the non-stratified methodology as the threshold to determine excess readmissions. In step four, which ERRs entered the payment adjustment formula are determined by assessing hospitals' performance and the case size. In ERRs, figures on the peer group median indicate that a hospital has excess readmissions relative to its peer group. If an ERR is greater than the peer group median and has 25 or more eligible discharges, it will enter the payment adjustment formula, and the hospital may be subject to a penalty. The minimum case size of 25 eligible discharges ensures that there's enough information to reliably calculate ERRs and assess a hospital's performance. This case-size criteria is consistent with previous years.

In step five, the neutrality modifier is calculated. The neutrality modifier is the factor than when applied to hospital payment reduction equates total Medicare savings under the non-stratified and stratified methodology. It is calculated by estimating the total Medicare savings across all hospitals under the non-stratified methodology and the stratified methodology in the absence of a modifier. The inclusion of the neutrality modifier in the payment adjustment factors both requirements around the budget neutrality of the program.

In step six, the payment reduction is calculated. For each measure that meets the criteria to enter the payment adjustment formula, the amount contributing to the payment reduction is calculated using the amount of the ERR above the peer group median, the ratio of DRG payment for the measure to total base operating DRG payments, and the neutrality modifier. The full formula is shown on the next slide; the ERRs under the payment adjustment formula at a fee. Each of the shown measure that

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

meets the criteria increases the payment reductions. In step seven, the payment adjustment factor is calculated. The maximum penalty for the Hospital Readmissions Reduction Program is three percent, which translates to a minimum payment adjustment factor of 0.97. So, payment adjustment factor equals one minus the payment reduction for hospitals that have a payment reduction less than or equal to 0.03. Hospitals with a payment reduction greater than 0.03 will have the minimum payment adjustment factor of 0.97.

This slide shows the payment adjustment factor formula under the non-stratified and the stratified methodology. The boxes in the bottom of this slide indicate the portions that are different from the non-stratified methodology. The blue box indicates that the neutrality modifier was added to the formula to maintain budget neutrality. The red box indicates that the peer group median replaces 1.0 as the threshold for determining excess readmissions in the formula.

In the final step, the payment adjustment factor is applied to base operating DRG payment amount to calculate total payments. Medicare Fee-for-Service operating DRG payments are the base DRG payment without any add-on payment, such as disproportionate share hospital, or indirect medical education payments.

This figure shows all of the steps from a stratified methodology. In summary, there are three main portions of the methodology that are changing with this stratified methodology. First, hospitals are stratified into five peer groups based on their dual proportion. Second, instead of being compared to the average ERR or 1.0, the threshold for determining excess readmissions is the peer group median. And third, a neutrality modifier is included in the formula to maintain budget neutrality.

Now I will turn it back to Kati to discuss the Early-Look Hospital-Specific Reports.

Kati Michael:

Thank you, Kristin. I will now go over details on receiving the Early Look HSR, content and layout of the HSRs, implementation of the new user-

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

centered design approach, and the upcoming fiscal year 2019 information. CMS released the following documents in the new *QualityNet* Early Look section, which you can locate in the link here at the bottom of the slide.

A *QualityNet* notification indicating the reports are available is sent via email to those who registered for notifications regarding the Hospital Readmissions Reduction Program. Hospital users with the Hospital Reporting Feedback-Inpatient role and the File Exchange and Search role will have access to the Early Look HSRs and the user guide. For those with the correct access, the HSRs and the user guide will be in their *My QualityNet* Secure File Transfer inbox.

The *HRRP Early Look User Guide* PDF document, includes additional information about the content and provides assistance in navigating the Early Look HSR. The user guide will also provide replication instructions to promote transparency with the calculations and data.

For the Early Look HSR, we use some of the basic structure for consistency, with tabs and tables that provide the following information: your hospital's contact and resources for the program, estimated payment adjustment factor, and performance details. Please note that the data contained within this presentation is mock data.

Shown here is the tab that introduces the Early Look HSR. On it, you will find detailed information on references for assisting with the data and who to contact with direct questions on the program.

The HRRP Early Look HSR is laid out to provide estimated hospital-level dual proportions, peer group assignment, and neutrality modifier. The last two columns in the payment adjustment tab will show the stratified estimated payment adjustment information for the stratified methodology using fiscal year 2018 data, and the payment adjustment factor for the same year using the non-stratified methodology.

On table two, the following hospital performance information for the six Hospital Readmissions Reduction Program measures will display eligible discharges, ERR, peer group median ERR, non-stratified methodology

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

penalty indicator, stratified methodology penalty indicator, and the ratio of DRG payments per measure to total payments. We will break down this tab in the upcoming slides.

This slide shows an example of how the performance information would look with hospitals having fewer than 25 eligible discharges that are not eligible for penalty. The payment adjustment factor formula would not include these ERRs.

This example shows the different penalty indicators between non-stratified and stratified methodology on heart failure and total hip/knee arthroplasty. If the penalty indicator equals Y, as shown here in heart failure for the non-stratified penalty indicator, then the hospital has 25 or more eligible discharges and an ERR greater than 1.0. If the hospital has less than 25 eligible discharges or an ERR of less than 1.0 for that measure, the penalty indicator will equal N, as shown here in hip/knee. 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 ERR. If the hospital has less than 25 eligible discharges or an 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.

The last example we will discuss is when a hospital has no eligible discharges. The HSR will express a value of NQ to indicate there are no qualifying cases for the measure, which will also cause the value of the ERR to display as NQ. CMS cannot calculate an ERR without a qualifying case for a measure. NQ will also display for the ratio of DRG payments per measure to total payments for the hospitals with no qualifying cases because they will have no base operating DRG payments for that measure.

For fiscal year 2019, the review and corrections period will include the modified HSRs. HSRs will now include the hospital's dual proportion, peer group assignment, and the payment adjustment factor. These HSRs will be available late summer or early fall. The link here goes to the new

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

CMS HSR tutorial video released to assist the Hospital IQR Program participants with interpreting and understanding their HSRs. Although the video is not specifically for HRRP, we think it may be helpful to HRRP participants, as well.

Now that you have heard about the updates to the methodology, CMS would like to hear what you think. With a new user-centered design approach to developing the HSRs in mind, CMS will reach out to stakeholders for feedback. If you would like to engage CMS in this discussion, contact the HQRPS Support Team at the email shown here, using the subject line “HSR Feedback.”

This brings us to the end of our Early Look HSR presentation. For further information on the Hospital Readmissions Reduction Program, we have provided a list of additional resources listed here on this slide. Thank you. Now back to you, Candace.

Candace Jackson: Thank you, Kristin and Kati. That was a lot of valuable information, and I’m sure it will be beneficial for all those who are listening today. As we indicated before, we will have time for a Q&A session. Just to remind everyone that we will not be using the raise-hand feature today, and your questions must be submitted to the chat box. And again, those, all questions, and including those that we do not get to today, will be posted at a later time on our *Quality Reporting Center* website. So, our first question for today is, are both Medicare and Medicare risk-managed-care patients included in the denominator and numerator?

Kristin Maurer: This is Kristin. Yes. Both Medicare and Medicare Advantage patients will be included in the denominator and the numerator in the calculation of dual proportion.

Candace Jackson: Thank you, Kristin. And our next question. Is the Security Administrator the only person who can access the reports?

Kati Michael: Hi. This is Kati Michael. In regards to the Security Administrator, as long as you have—anyone with a secure *QualityNet* portal account with the appropriate roles, which is the inpatient-feedback and the file and

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

exchange roles for their CCN and for their hospital, and have gone through the registration, they will automatically have access to their hospital's reports and their Secure File Transfer inbox.

Candace Jackson: Thank you, Kati. Our next question. What does dual eligibility mean?

Kristin Maurer: This is Kristin. Dual eligibility means that a patient is eligible for both Medicare and Medicaid.

Candace Jackson: Thank you. Next question. What dates of service will the revised HRRP measure include?

Kristin Maurer: This is Kristin, again. First, the measures the ERRS for the program will not be revised. These will still be calculated in the same format as was done previously. These will, for fiscal year 2019, they will be calculated using discharges from July 1, 2014, through June 30, 2017.

Candace Jackson: Thank you. Our next question. When was the last HSR available?

Kati Michael: This is Kati. The last years would have been fiscal year [20]18 and those were released on June 1, 2017, in your secure *QualityNet* portal account.

Candace Jackson: Okay. Thank you. Next question and it is in regards to slide 21. If we could go to that slide, please. And, I think we answered it, but we'll go ahead and answer it again. Are both Medicare and Medicare risk-managed-care patients included in the denominator and the numerator?

Kristin Maurer: This is Kristin, and yes, they are both included in the denominator and the numerator.

Candace Jackson: Our next question. What is the performance period again for fiscal year 2019?

Kristin Maurer: This is Kristin. The performance period is July 1, 2014, through June 30, 2017.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

- Candace Jackson:** And our next question on slide 23, please. The five peer groups are defined by Fee-for-Service plus MA populations. Are the readmission ERRs going to include MA discharges, too?
- Kristin Maurer:** This is Kristin. No. The ERRs will continue to only include Fee-for-Service patients. However, peer groups are calculated using Fee-for-Service and managed-care patients.
- Candace Jackson:** Thank you, Kristin. And just to make sure everybody is clear, can you please define what the acronym MA is that they were referring to in this question?
- Kristin Maurer:** MA refers to Medicare Advantage.
- Candace Jackson:** Thank you. Our next question. Will you provide the neutrality modifier calculated with this 2018 data example?
- Kristin Maurer:** Yes. The neutrality modifier is included in the hospitals—in the Early Look Hospital-Specific Reports.
- Candace Jackson:** Our next question. What are the peer groups? How are they defined?
- Kristin Maurer:** The peer groups are groups of hospitals with similar proportions of dual-eligible patients. Hospitals are stratified into five groups based on the quintile of dual proportions.
- Candace Jackson:** Okay. Thank you. And our next question. Will the HSR automatically be made available to hospitals or will we have to request the file?
- Kati Michael:** This is Kati. You won't have to request the file if you have the appropriate roles that we listed earlier in secure *QualityNet* portal; would be the inpatient-feedback roll and the file and exchange role. And if you have it for your CCN, it will be automatically put into your Secure File Transfer.
- Candace Jackson:** Thank you, Kati. Our next question. When will we know what our peer groups will be?

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

- Kristin Maurer:** This is Kristin. The peer group assignment is included in the Early Look Hospital-Specific Reports. The peer group assignment for fiscal year 2019 will also be included in hospital-specific reports.
- Candace Jackson:** Thank you. And our next question. Please define mock data. I was led to believe that this would represent fiscal year 2018 data if the new methodology was in place.
- Kati Michael:** This is Kati. In regards to one of the slides, I do state that this is mock data in the slides, not for the Early Look HSR that you received in your inbox. That would be data represented to—using your fiscal year 2018 data—to if the new methodology was put in place.
- Candace Jackson:** Thank you. And the next question. When will the fiscal year 2019 HSR be available?
- Kati Michael:** This is Kati. For the fiscal year 2019 HSRs, those will be released in late summer, early fall, which is a couple of months later than we normally have is—and which is—in regards to the new methodology being placed and all of the other data factors that go into calculations.
- Candace Jackson:** Okay. Thank you. And our next question. When does this new methodology start affecting payments? Is it October 2019?
- Kristin Maurer:** This is Kristin. The new methodology will begin affecting payments on, in August—October, excuse me, October of 2018.
- Candace Jackson:** And our next question. Can you explain the peer group number? Is 2.0 in the higher or lower level of dual proportion?
- Kristin Maurer:** This is Kristin again. So, 1.0 is, represents the peer group with the lowest number of dual proportions whereas five is hospitals with higher dual proportions.
- Candace Jackson:** Thank you. And our next question. Will peer group data be reported just nationally or will state or regional performance data?

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

- Kristin Maurer:** No. There are no plans to report peer group data nationally or at the state or regional level. Peer groups are calculated specifically at the hospital level.
- Candace Jackson:** Okay. Thank you. And our next question. Does the age group of 65 and older still remain in effect with a cohort or will patients under 65 years be included?
- Kati Michael:** This is Kati. It will still be the age group of 65 and older for the cohort.
- Candace Jackson:** Thank you. And the next question. When will the early-look reports be available?
- Kati Michael:** This is Kati. The Early Look HSRs have been made available on March 19 to your secure *QualityNet* portal account. If you do not have the report, please give us a contact call at the end there in the resources. Not a call, but an email if you want to request it, but please make sure that you have the appropriate roles. And, if you do not, make sure you contact the *QNet* Help Desk.
- Candace Jackson:** Thank you. And our next question. Are you able to provide us with the percentage of dual eligible for each peer group?
- Kristin Maurer:** This is Kristin. No, we are not providing this information at this time. We are just able to show the percent of dual eligibles for a specific hospital.
- Candace Jackson:** And our next question is, is the peer group on the early-look report the same that will be on the actual fiscal year 2019 report? Are peer groups reassessed each year moving forward?
- Kristin Maurer:** Dual proportion in the Early Look Hospital-Specific Report will not be the same as what is in the fiscal year 2019 report. The dual proportion will be calculated for each program year using the performance period that is the same for the measure calculations. So, for fiscal year 2019, it's July 1, 2014, through June 30, 2017. The Early Look Hospital-Specific Report that reflects one year previous, of previous data.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

- Candace Jackson:** Thank you. And our next question. What did you use to define the peer groups?
- Kristin Maurer:** We used the dual proportion to define peer groups. The dual proportion is calculating using as the numerator with number of dual-eligible patients. This is sourced from the state Medicare Modernization Act file. In the denominator of the calculation, it includes the total number of Medicare Advantage and Medicare Fee-for-Service stays at a hospital.
- Candace Jackson:** Okay. Thank you, Kristin. And our next question. How many administrators can you have for a hospital?
- Kati Michael:** This is Kati. We—I don't for sure know that answer. What I would recommend is reaching out to the *QualityNet* Help Desk who helps set up those accounts. They should be able to provide you with any further information in regards to setting up accounts, how many can set up accounts, and from there, and go from there.
- Candace Jackson:** Thank you, Kati. And our next question is, where does CMS get the dual-eligible numbers?
- Kristin Maurer:** The CMS gets the dual-eligible numbers in the Medicare Beneficiary Summary file. The data for dual eligibility is sourced though from the MMA file, the Medicare Modernization Act.
- Candace Jackson:** Thank you. And our next question. Can you clarify which email address to use to send a request if we don't have our early-look report yet?
- Kati Michael:** That—this is Kati. I would recommend reaching out to the—it's for the early look? You can reach us at the Lantana one. I believe it's on slide 41. And that can be HRRP@lantanagroup.com. And we can get that resent to you in your Secure File Transfer.
- Candace Jackson:** Thank you, Kati. And our next question. What are the risk social factors associated with each peer group?
- Kristin Maurer:** Would you mind repeating that question?

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

- Candace Jackson:** Sure. What are the risk social factors associated with each peer group?
- Kati Michael:** This is Kati. I'm going to actually turn that over to Kim if she is available.
- Kim Glenn:** Hi. Sorry about getting that. Would you repeat that one more time for me?
- Candace Jackson:** Of course. What are the risk social factors associated with each peer group?
- Kim Glenn:** Well, the dual proportion is being used to be able to estimate social risk for the peer groups. In the ASPE report that was published, it was found that dual proportion is the greatest predictor of social risk. If—we can also, you know, send you to the—sorry—the ASPE paper's findings for what dual proportion will be able to be a proxy for. Yes, we recognize that there are other factors, but the report found that it was the strongest predictor.
- Candace Jackson:** Thank you very much. And our next question is, an impact file was released last month publicly with all hospitals by CPM. Can you explain what is meant by penalty indicator for each condition?
- Kristin Maurer:** Yes. The penalty indicator, this is either listed as Y or N in the impact file and it is included for each measure. Basically, if it has a value of Y, it means that the hospital has excess readmissions compared to its peer group and may be subject to a penalty. If it is listed as N, then the hospital either does not have sufficient, a sufficient number, of discharges to be penalized or it does not have excess readmissions.
- Candace Jackson:** Thank you. And we have time here for one more question. And will fiscal year 2019 actual report show both stratified and non-stratified methodology ERRs or only stratified ERRs?
- Kristin Maurer:** The fiscal year 2019 will just show the stratified payment adjustment factor. The ERR calculation is the same under both the non-stratified and stratified methodologies.
- Candace Jackson:** Thank you, Kristin. And I, again, want to thank everyone for joining us today for our webinar, and a special thank you to Kristin and Kati for

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

presenting this information. As we indicated earlier, all questions that have been submitted through the chat box will be responded to and posted to the *Quality Reporting Center* website at a later date. I would now like to turn the presentation over to Dr. Debra Price, who will be going over our CEU process. Debra, the floor is yours.

Dr. Debra Price:

Well, thank you very much. Today's webinar has been approved for one continuing education credit by the boards listed on this slide. We are now a nationally accredited nursing provider. And as such, all nurses report their own credits to their boards, using the national provider number 16578. It is your responsibility to submit this number to your own accrediting body for your credits.

We now have an online CE certificate process. You can receive your CE certificate two ways. First way is if you registered for the webinar through ReadyTalk[®], a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate. We will also be sending out the survey link in an email to all participants within the next 48 hours. If there are others listening to the event that are not registered in ReadyTalk, please pass the survey to them. After completion of the survey, you'll notice at the bottom righthand corner a little gray box that says, "Done." You'll click the Done box, and then another page opens up. That separate page will allow you to register on our Learning Management Center. This is a completely separate registration from the one that you did in ReadyTalk. Please use your personal email for this separate registration so you can receive your certificate. Healthcare facilities have firewalls that seem to be blocking our certificates from entering your computer.

If you do not immediately receive a response to the email that you signed up with in the Learning Management Center, that means you have a firewall up that's blocking the link into your computer. Please go back to the New User link and register a personal email account. Personal emails do not have firewalls up. If you can't get back to your New User link, just wait 48 hours because, remember, you're going to be getting another link and another survey sent to you within 48 hours.

Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Okay. This is what the survey will look like. It will pop up at the end of the event, and will be sent to all attendees within 48 hours. Click Done at the bottom of the page when you are finished.

This is what pops up after you click Done on the survey. If you have already attended our webinars and received CEs, click Existing User. However, if this is your first webinar for credits, click New User.

This is what the New User screen looks like. Please register a personal email like Yahoo, or Gmail, or ATT, since these accounts are typically not blocked by hospital firewalls. Remember your password, however, since you will be using it for all of our events. You'll notice, you have a first name, a last name, and the personal email; and we're asking for a phone number in case we have some kind of backside issues that we need to get in contact with you.

This is what the Existing User slide looks like. Use your complete email address as your User ID, and of course, the password you registered with. Again, the User ID is your complete email address, including what is after the @ sign.

Thank you for taking the time spent with me.