Hospital Inpatient Quality Reporting (IQR) Program

**Overview of the FY 2019
HAC Reduction Program and HRRP**

Presentation Transcript

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Bethany Wheeler-Bunch: Hello and welcome to the Overview of the Fiscal Year 2019 Hospital-Acquired Condition Reduction Program and Hospital Readmissions Reduction Program webinar. My name is Bethany Wheeler-Bunch and I am with the Hospital Inpatient VIQR Support Contractor. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation and the questions and answers [Q&A] will be posted to the inpatient website, *www.QualityReportingCenter.com*. If you registered for this event, a reminder email and the slides were sent out to your email about two hours ago. If you did not receive that email, you can download the slides at the inpatient website, *www.QualityReportingCenter.com*. If you have a question as we move through the webinar, please type your question into the chat window with the associated slide number and we will answer as many questions as time allows. Applicable questions that are not answered during our question and answer session will be posted to the *QualityReporting.com* website in the upcoming weeks.

I would like to welcome our speakers for today's event. Angie Goubeaux is the Program Lead for the Hospital-Acquired Condition Reduction Program at HQRPS. Kati Michael is the Program Lead for the Hospital Readmissions Reduction Program, also at HQRPS, and Kristin Maurer is the Analytic Lead for the Hospital Readmissions Reduction Program also at HQRPS. Thank you to all three of you for agreeing to present today.

This event will provide an overview of the Fiscal Year 2019 HAC Reduction Program and Hospital Readmissions Reduction Program including the methodology, hospital-specific reports [HSRs], and program updates, and, finally, the review and corrections process.

Participants will be able to interpret the methodology used in both programs, understand the hospital's program results in the HSR, submit questions about a hospital's calculations during the HAC Reduction Program scoring calculations review and correction period, and submit questions about a hospital's calculations during the Hospital Readmissions Reduction Program review and correct period. At this time, I would now

like to pass the webinar over to Angie Goubeaux, the Program Lead of the HAC Reduction Program. Angie, the floor is yours.

Angie Goubeaux: Thank you, Bethany. To provide a little background on the program, the HAC Reduction Program was established to incentivize hospitals to reduce the number of hospital-acquired conditions, or HACs. HACs include patient safety events, such as falls, and healthcare-associated infections, such as surgical site infections [SSI]. The program was established under Section 1886 of the Social Security Act. CMS started applying payment adjustments beginning with the Fiscal Year 2015 discharges. Hospitals that rank in the worst-performing quartile, or 25 percent, of all subsection (d) hospitals receive a one percent payment adjustment.

All subsection (d) hospitals are subject to the HAC Reduction Program. CMS exempts certain hospitals and units from the program, such as critical access hospitals, rehab hospitals, long-term care hospitals, psychiatric hospitals, children hospitals, PPS-exempt cancer hospitals, short-term acute care hospitals located in certain islands listed here, and religious non-medical healthcare institutions. Maryland hospitals are exempt from payment reductions under the HAC Reduction Program.

This table shows which measures were included in each Fiscal Year of the program. Fiscal Year 2019 includes the modified CMS PSI [Patient Safety Indicator] 90 measure, CLABSI [central line-associated bloodstream infection], CAUTI [catheter-associated urinary tract infection], SSI, MRSA [Methicillin-resistant *Staphylococcus aureus*], and CDI [*Clostridium difficile* infection], and these are the same measures that were included in Fiscal Year 2018.

The measures are grouped into two domains. Domain 1 is PSI 90. Domain 2 includes CDC [Centers for Disease Control and Prevention] NHSN [National Healthcare Safety Network] measures. Fiscal Year 2019 has an updated performance period of October 1, 2015, through June 30, 2017, which includes only ICD-10 [International Classification of Diseases, 10th Revision] data for Domain 1. Domain 2 has an updated performance period of January 1, 2015, through December 31, 2017. The two domains

are weighted the same as last year with Domain 1 weighted at 15 percent and Domain 2 weighted at 85 percent of the total HAC score.

Fiscal Year 2019 uses the same Winsorized z-score score methodology that CMS adopted in Fiscal Year 2018. The Winsorized z-score method uses a continuous measure score rather than sorting measure results into ten deciles. Hospitals that perform worse than the mean will earn a positive Winsorized z-score, and hospitals that perform better than the mean will earn a negative Winsorized z-score. So, lower z-scores indicate better performance, and, for more information on the scoring methodology, you can refer to the resources slide towards the end of this presentation.

There are not a lot of changes for Fiscal Year 2019 compared to 2018. Along with updated performance periods and dates that I just mentioned, there are a few things to note. CMS used recalibrated version 8.0 of the CMS PSI software to calculate PSI 90 for Fiscal Year 2019. Last year in Fiscal Year 2018, they used recalibrated version 6.0.2. For Fiscal Year 2019, in order to align with the [Hospital] IQR [Inpatient Quality Reporting] Program quality reporting payment determination, CMS excluded CLABSI and CAUTI measure results for hospitals but did not indicate in NHSN that they had active ICU [intensive care unit] locations, medical wards, surgical wards, and medical-surgical wards for at least one quarter during their reporting period. This is referred to as "no mapped locations" and, if applicable to your hospital, will be noted with "NML" in your HSR. Lastly, in the past, CMS has publicly reported HAC Reduction Program data in December, but for Fiscal Year 2019, CMS will publicly report the data on the *Hospital Compare* website in January of 2019, instead of December.

How to Receive your HSR. CMS will begin distributing HSRs a couple of days before the start of the review and corrections period. The HAC Reduction Program scoring calculations review and correction period, for those that might be wondering, is scheduled to begin on July 27. A *QualityNet* notification indicating the reports are available via email to those who registered for notifications. Hospital users with the Hospital Reporting Feedback (Inpatient Role) and the File Exchange and Search

Role will have access to the HSRs. The HSRs and the user guide can be located in the My *QualityNet* Secure File Transfer Inbox on the *QualityNet* website. It's also important to note to keep your *QualityNet* account up to date, so that you're able to access your hospitals HSR as soon as it becomes available. If you have questions about your account, you can contact the *QualityNet* Help Desk.

The HAC HSR provides hospitals the following information: contact information and resources for the program, performance on Total HAC Score and domain scores, measure results and Winsorized z-scores, performance on CMS PSI 90, discharge-level information for CMS PSI 90, as well as performance on CDC HAI measures.

I'm going to give a brief walkthrough of a mock HSR. This is a screenshot of Table 1, which shows a hospital's total HAC score performance. This table includes Domain 1 and Domain 2 scores, if applicable, the weight of each domain, the contribution of each domain to your hospital's total HAC score, your total HAC score, and the last column indicates if your hospital is subject to a one percent payment reduction. If a hospital has only one domain score, CMS applies a weight of 100 percent to that domain.

This is a screenshot of Table 2 which shows a hospital's Winsorized z-score for each measure, as well as the Domain 1 and Domain 2 score. The Domain 1 score equals the CMS PSI 90 measure score because Domain 1 only includes one measure. The Domain 2 score equals the average of the Winsorized z-scores for the CDC measures. In this HSR example, MRSA has "INS" for insufficient data, so their Domain 2 score will be based on an average of four measures instead of five.

This is the screenshot of Table 3, which shows a hospital's measure results and Winsorized z-scores for each measure. For each measure, CMS calculates Winsorized measure results for each hospital based on raw measure results in the fifth and 95th percentile result for all eligible hospitals. So, if a hospital's measure result falls between the minimum and the fifth percentile, CMS sets the hospital's measure result equal to the fifth percentile, and if a hospital's measure result falls between the 95th

percentile and maximum, CMS sets the hospitals measure result equal to the 95th percentile. The CAUTI measure here is an example of this in the mock HSR. Winsorization does not affect hospitals with measure results between the fifth percentile and 95th percentile. These hospitals' Winsorized measure results equal the hospitals/ raw measure results in the second column. CMS then subtracts the mean Winsorized measure result for all eligible hospitals from a hospital's Winsorized measure result and divides by the standard deviation of Winsorized measure results for all eligible hospitals. So, this is how CMS calculates the Winsorized z-score, or measure score, for each measure found in the last column.

Table 4 shows your hospital's performance on PSI 90 and the component PSI measures. Any measures with an outcome noted in the third row of the table will be included on the next table, Table 5.

Table 5 includes information on discharges that were included in the numerator of one or more CMS PSIs. Note this table does include PII [personally identifiable information]. So, if you need to email any questions about a particular discharge, you should use the ID number listed in the first column and leave out any patient identifying information.

Table 6, the last table in the HSR, contains your hospital's performance on the five CDC NHSN measures that make up Domain 2.

This graphic shows the data flow of claims-based data. The CMS PSI 90 measure is based on Medicare Fee-For Service [FFS] claims data. Approximately 90 days after the end of the reporting period, which is usually in September, CMS effectively takes a snapshot of the claims data, and then hospitals receive their HSR's and have a 30-day scoring calculations review and correction period to review their data. Then, the hospital's data is publicly reported, which this year will be in January.

For [CMS] PSI 90, hospital results will only reflect edits that comply with the time limits in the Medicare Claims Processing Manual. The snapshot of the data for Fiscal Year 2019 was September 29, 2017. Only corrected claims processed by September 29, 2017, were included for Fiscal Year

2019. If hospitals submitted a corrected claim after the snapshot date, the hospital's HSR results will not include the corrected claim data.

This graphic depicts the flow of HAI data from when it's generated through to pubic reporting. First, HAI data is generated by events during a patient's hospitalization. Under the Hospital IQR Program, hospitals can submit, review, and correct their HAI data in NHSN for four and a half months following the end of their reporting quarter. Hospitals are strongly encouraged to review and correct their data prior to the HAI submission deadline. Then, next on the graphic, you can see that, immediately following the submission deadline, the CDC creates a snapshot of the data and sends it to CMS and CMS does not receive or use data entered into NHSN after the submission deadline. CMS then uses the chart-abstracted data submitted through NHSN to calculate the CLABSI, CAUTI, SSI, MRSA, and CDI measure scores. These scores are also included in your HSR and sent to hospitals at the beginning of the scoring calculations review and correction period and then the data will be publicly reported in January.

This slide reiterates what we covered with the previous data flow graphic.

The HAC Reduction Program scoring calculations review and correction period begins on July 27, 2018, and ends on August 27, 2018. As we mentioned, CMS distributes HSRs via the *QualityNet Secure Portal* and you can expect to receive your HSR a day or two before the start of the review and corrections period. Any questions about your HSR data or program-related questions should be sent to the HAC Reduction Program Support Team via email at hacrp@lantanagroup.com or via the *QualityNet* Question and Answers tool as soon as possible, but no later than 11:59 p.m. Pacific Time [PT] on August 27.

This slide shows what is and what is not allowed during review and corrections period. A common question we receive is hospitals wanting to correct their underlying data included in their HSR. The purpose of the scoring calculations review and correction period is to allow hospitals an opportunity to submit questions about the calculation of your hospital

results and request corrections of potential calculation errors. It does not allow hospitals to submit additional corrections related to underlying claims or NHSN data.

For more information, the HSR user guide and the mock HSR will also be posted for the public on the *QualityNet* website. Hospitals can also request a copy of Example Replication Instructions from the HAC Reduction Program Support Team, which includes example calculations and formulas in Excel using the mock HSR. You can also visit the scoring calculations review and corrections web page, and you can request a copy of the recalibrated version 8.0 of the CMS PSI software from the HAC Reduction Program Support Team, and you can refer to the Fiscal Year 2019 Replication Instructions document which is on the *QualityNet* CMS PSI resources web page for instructions on how to use the PSI software. This document only applies to the SAS version of software.

In January 2019, CMS will release the following Fiscal Year 2019 HACRP [HAC Reduction Program] information on *Hospital Compare,* which will be the CMS PSI 90 Composite CLABSI, CAUTI, SSI, MRSA Bacteremia, CDI measure scores, Domain 1 and Domain 2 scores, total HAC score, and Payment Reduction Indicator.

This slide just includes additional resources for the HAC Reduction Program on the *QualityNet* website, as well as contact information for the HAC Reduction Program Support Team for any questions, located at the bottom.

Now, I will turn it over to Kati to cover HRRP. Thank you.

Kati Michael: Thank you, Angie. As previously mentioned, I am Kati Michaels, Program Lead for the Hospital Readmissions Reduction Program under the HQRPS contract for CMS.

In Fiscal Year 2013, Section 3025 of the Affordable Care Act added Section 1886(q) to the Social Security Act, which established the Hospital Readmissions Reduction Program. By establishing this program, hospitals are financially encouraged to evaluate the entire spectrum of care that they

deliver to patients and more carefully coordinate and transition patients with respect to post-discharge planning. Overall, 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 eight types of hospitals that are not included in subsection D and you can see them listed here in this slide. As a reminder, Maryland operates under a waiver agreement with CMS, which makes the hospitals exempt from the payment reductions under HRRP.

HRRP currently has four diagnoses and two procedure readmission measures: acute myocardial infarction [AMI], heart failure [HF], pneumonia, chronic obstructive pulmonary disease [COPD}, elective primary total hip and/or total knee arthroplasty [THA/TKA}, and coronary artery bypass graph [CABG] surgery. The Fiscal Year 2019 performance period for these measures covered discharges occurring July 1, 2014, through June 30, 2017. This performance period includes both ICD-9 and ICD-10 coding and each condition is based on a specific list of codes as defined within the measures specifications.

The 21st Century Cures Act requires CMS to assess penalties based on performance relative to other hospitals with similar proportions of dual-eligible patients. As part of the Cures Act, estimated payments under the stratified methodology are required to equal the estimated payments under the non-stratified methodology. This is referred to as budget neutrality.

The stratification approach was arrived at after considering rule comments, the ASPE [Assistant Secretary for Planning and Evaluation] report, and the requirements of the Cures Act. CMS finalized a policy which requires the secretary to compare cohorts of hospitals based on their proportion of dual-eligible beneficiaries or dual-eligible proportion in determining the extent of excess readmissions. The Fiscal Year 2018 HRRP final rule accounted for social risk by adjusting performance scores by stratifying hospitals based on the dual-eligible proportions.

Next, I will turn it over to Kristin who will discuss how the stratification will occur within the program and demonstrate how this accounts for social risk as defined by dual-eligible proportion. Kristin?

Kristin Maurer: Thanks, Kati. In this portion of the presentation, I will describe the stratified methodology that is being implemented in FY 2019 to calculate hospital payment adjustments and describe how this compares to the methodology that was previously used to calculate hospital payment adjustments.

This figure shows how hospital payment adjustment factors were determined in FY 2018 using the non-stratified methodology. As shown in Step 1, CMS assembles the hospital's Medicare claims and then identifies 30-day unplanned readmissions for six measures. As Kati already mentioned, 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 arthroplasty, or THA/TKA; and coronary artery bypass graph 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 not-socially at-risk patients, which are represented by red patient icons. Step 2 illustrates how for any given measure CMS calculates an excess readmission ratio, or ERR. An ERR is the ratio of a hospital's predicted readmissions to its expected readmissions. This figure shows all four hospitals in the same tier in order to represent how a hospital's ERR is measured relative to the performance of all other hospitals. Step 3 shows how ERRs enter the payment adjustment factor formula. If an ERR is greater than 1 and has at least 25 eligible discharges, then it enters the payment adjustment factor formula and a hospital may be subject to a penalty. An ERR of 1 is the average across all HRRP hospitals. Hospitals with ERRs greater than 1 are considered as having excess readmissions. In Step 4, CMS applies the payment reductions to all Medicare Fee-For-Service claims submitted by the hospital during the Fiscal Year, including patients admitted not only for the conditions included in the program but for any condition.

This figure shows how the Cures Act changes the HRRP payment adjustment factor methodology, beginning in FY 2019, to account for a hospital's proportion of dual-eligible patients. In this graphic, Step 1 and Step 2 are grayed out to show that these steps are not changing under a new stratified methodology. Hospitals still submit claims to Medicare and CMS calculates 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 HRRP hospitals. However, as shown in Step 3, under the stratified methodology, hospitals are stratified into peer groups based on the proportion of dual-eligible. 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 adjustments. The figure includes two peer groups for illustrative purposes, but in the FY 2018 IPPS final rule, CMS finalized the policy to stratify hospitals into five groups. In the next few slides, I will walk through these steps in more detail.

These first two steps show that hospital claims are used to calculate ERR 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 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 groups.

This slide shows more information about how the dual proportion is calculated. The numerator of the dual proportion includes all full-benefit dual-eligible stays. The source is from state and Medicare Modernization Act files, or the MMA files. 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 dually-eligible patients the hospitals served, particularly for hospitals in states with high managed care penetration rates. The data period for 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.

In Step 3, the median ERR is calculated for each measure and peer group. The peer group median replaces one in the non-stratified methodology as the threshold to determine excess readmissions. In Step 4, it shows how an assessment of performance and the case size are both considered when determining which ERRs will enter the payment adjustment factor formula. An ERR greater than the peer group median indicates that a hospital has excess readmissions relative to its peer group. If the 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 the hospitals performance. This is consistent with previous years.

In Step 5, the neutrality modifier is calculated. The neutrality modifier is the multiplicative factor that would apply to hospital payment reductions. It equates to total Medicare savings under the non-stratified and stratified methodologies and is calculated by estimating the total Medicare savings across all hospitals under both methodologies in the absence of a modifier. The inclusion of the neutrality modifier in the payment adjustment formula, the fulfills Cures Act requirements around the budget neutrality of the programs.

Step 6 shows how payment reductions are calculated. For each measure that meets the criteria to enter the payment adjustment factor formula, the amount contributing to the payment reduction is calculated using the amount of the ERR above the peer group median, the ratio of the DRG [diagnosis-related group] payments for the measure to total base operating DRG payments, and the neutrality modifier. The full formula for this calculation is shown on the next slide. The ERRs enter the payment adjustment formula additively. Each additional measure that meets the criteria increases the payment reduction. In Step 7, the payment adjustment factor is calculated. The maximum penalty for HRRP is three percent, which translates to a minimum payment adjustment factor of

0.97. The payment adjustment factor equals 1 minus the payment reduction. Hospitals with a payment reduction greater than 0.03 will have the minimum payment adjustment factor of 0.97.

This slide shows the formula for calculating the payment adjustment factor under the non-stratified methodology and under the stratified methodology being implemented in FY 2019. The formula adds the neutrality modifier as well as the peer group median replaces 1.0 for the threshold for determining access readmission in the second formula.

In the final step, the payment adjustment factor is applied to base operating DRG payment amounts to calculate total payments. Medicare Fee-For-Service base operating DRG payments are the base DRG payments without any add-on payments, such as disproportionate share hospital [DSH] and indirect medical education [IME] payments.

This figure shows the steps in the stratified methodology. In summary, there are three main changes to the payment adjustment factor formula being implemented in FY 2019. First, hospitals are stratified into five groups based on their dual proportions. Second, instead of being compared to the average ERR or 1, the threshold for determining excess readmissions is the peer group median. Third, a neutrality modifier is included in the formula. Now, I will turn back to Kati to discuss the HSRs in more detail.

Kati Michael: Thanks, Kristin. I will now provide hospitals with an understanding of the HRRP HSR's content, so that you can use the HSR to review the measure results and discharge-level data to replicate the PAF [payment adjustment factor] and component results. The Fiscal Year 2019 hospital-specific reports will now include updates to show the implementation of the new stratified methodology, which we will go over in the upcoming slides. Another note to add, due to the new HRRP data implementation, the public reporting on *Hospital Compare* will be delayed by one month, to be updated in January 2019 instead of December 2018.

For the Fiscal Year 2019 HRRP HSR, we used the same basic structure for consistency with tabs and tables that provide the following information: your hospital's contact, resources for the program, payment adjustment factor, dual stays, hospitals results, and discharge data for ERRs. As always, the user guide will also provide replication instructions to promote transparency into the calculations and data.

On the first tab is the HRRP HSR workbook. You will find detailed information to assist with the understanding of the data in the HSR and who to contact for questions about the program. I would like to point out here that HRRP questions should now be submitted via email to HRRP@lantanagroup.com. The second tab containing Table 1, shown here, is the payment adjustment tab which provides hospital-level data for the number of dual-eligible stays, number of eligible stays, dual proportion, peer group assignment, and neutrality modifier. Medicare Fee-For-Service and managed care patients will also be included in the numerator and the denominator calculations of the dual proportion. Hospitals are stratified into five peer groups. Peer groups are groups of hospitals with similar proportions of dual-eligible patients or dual proportions. The first peer group represents hospitals with the lowest quintile of dual proportions; whereas, the fifth peer group contains hospitals with higher dual proportions. The ranges of the dual proportions for each peer group are included in the Fiscal Year 2019 HSR user guide. The neutrality modifier is applied in the calculation of the payment adjustment factors to maintain budget neutrality. The last column in the table displays the payment adjustment factor information updated with the new stratified methodology which Kristin previously went over in depth. For Fiscal Year 2019, the hospitals subject to the Hospital Readmissions Reduction Program would have an adjustment factor that is between 1, which is no reduction, and 0.97, which is the greatest possible reduction.

Table 2 is the dual stays tab, which has been modified in this presentation to show just the first few and last few stays. The numerator includes only stays where a patient was dual-eligible for Medicare and Medicaid. CMS identifies full-benefit dual patients as Medicare Fee-For-Service and

managed care hospital inpatient stays if the patient has full-benefit dual status for the month the beneficiary was discharged from the hospital. Managed care and patient stays are included due to variation in hospital managed care population. This more accurately reflects the proportion of dual-eligible patients for all hospitals.

On the hospital results tab, I will only discuss the new fields, as the rest of the fields have not changed. One thing I would like to point out is that 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. A ratio greater than 1 indicates the hospitals performed worse on average than hospitals that admitted similar patients (i.e., patients with similar risk factors for readmission such as age and comorbidities). The penalty indicators indicate whether the ERR will enter the payment adjustment factor formula. If the penalty indicator equals Y or Yes, then the hospital has 25 or more eligible discharges in 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 or No. 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 reduction depends on your hospital's number of eligible discharges, ERR, and the peer group median ERR for each of these measures, as well as the neutrality modifier. For example, when a hospital has no eligible discharges, the hospital-specific report will express a value of NQ to indicate that there are no qualifying cases for the measure, which will also cause the value of the 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.

Tables 4 through 9 are the remainder tabs in the HSR. Each table provides discharge-level data for all Medicare Part A Fee-For-Service hospitalizations that occurred during the hospital discharge period where the patient was 65 years or older at the time of the admission with a

principal discharge diagnosis of either AMI, heart failure, pneumonia, COPD, or a procedure for CABG surgery, or primary elective total hip/knee. These tables indicate whether an unplanned or planned readmission for any cause followed the discharge within 30 days. HSRs include all discharges that meet the inclusion requirements for each measure and use the inclusion/exclusion indicator to identify discharges that were excluded from the measure. The risk factors for each measure with their corresponding condition category are included as well.

The next two slides will show the continuation of the available data in the discharge tabs which are further explained in great detail in the HSR user guide.

As stated earlier, CMS distributes HSRs via *QualityNet Secure Portal* at the beginning of the review and corrections period. Hospitals can review the data in their HSRs and replicate their PAF and component results. Hospitals can submit requests for corrections to their PAF, component results, and questions about their result calculations during the 30-day review and corrections period. The HRRP R and C period for Fiscal Year 2019 will begin August 16 and go through September 14, 2018. Again, please note that the submission email for R and C inquires is HRRP@lantanagroup.com.

Here is a list of what hospitals can and cannot correct during the HRRP R and C period. As a reminder, hospitals cannot submit corrections to the underlying claims data or add new claims to the data extracts CMS used to calculate the rates.

Nothing new is being added for public reporting on *Hospital Compare*. This slide shows exactly what will be updated on the CMS *Hospital Compare website* in January 2019 for the Fiscal Year 2019 HRRP measures results.

This brings us to the end of our Fiscal Year 2019 HSR and R and C overview presentation. For further information on the Hospital Readmissions Reduction

Program, we have provided a list of additional questions here on this slide. Thank you for your time. Now, back to you Bethany.

Bethany Wheeler-Bunch: Thank you so much. We will now start the question-and-answer session. The first question is in regard to the HAC Reduction Program. What is the 75th percentile threshold or cutoff for receiving a payment reduction for the HAC Reduction Programs this year?

Angie Goubeaux: Yes, this is Angie. For Fiscal Year 2019, the 75th percentile threshold is 0.3429. So, any hospital with a total HAC score greater than that will be subject to a payment reduction.

Bethany Wheeler-Bunch: Thank you. The next one is also in regard to HAC Reduction. Is there a Windows version of the 8.0 CMS PSI software available?

Angie Goubeaux: This is Angie again. There is both a SAS and Windows version of the PSI software available by request from hacrp@lantanagroup.com. As I said before, the replication instructions posted on the PSI resources page on *QualityNet* only applies to the SAS version.

Bethany Wheeler-Bunch: Thank you. I would now like to ask a Hospital Readmissions Reduction question., the first question for that team. How does the stratified methodology identify excess readmissions?

Kristin Maurer: This is Kristin. The ERR is the measure used to assess excess readmissions in the payment adjustment factor calculations. If the hospital has an ERR greater than the peer group median and has more than 25 eligible discharges for a condition or a procedure, the ERR will contribute to the hospital's payment adjustment factor. ERRs enter the payment adjustment factor formula additively. The amount above the peer group median and the ratio of DRG payments for the condition or procedure will determine the contribution of that ERR to the hospitals payment reduction.

Bethany Wheeler-Bunch: Thank you. Another question regarding HRRP: Why stratify hospitals into five peer groups?

Kristin Maurer: This is Kristin. CMS considered the advantages and disadvantages of stratifying hospitals into different numbers of peer groups. Stratifying hospitals into five peer groups creates peer groups that accurately reflect the proportion of duals in the hospitals population without the disadvantage of establishing a larger number of peer groups. As the number of peer groups increases, the likelihood that hospitals caring for a similar proportion of dual-eligible patients will be compared to different thresholds in the payment adjustments formula increase.

Bethany Wheeler-Bunch: Thank you. A follow-up question regarding peer groups: Which hospitals are included when you are calculating peer groups?

Kristin Maurer: All HRRP-applicable hospitals are stratified into the five peer groups, or quintiles, based on their dual proportions. Hospitals in the first peer group, or Peer Group 1, have the lowest dual proportions relative to all other HRRP applicable hospitals; whereas, hospitals in the fifth peer group, or Peer Group 5, have the highest dual proportions. CMS excludes Maryland hospitals when stratifying hospitals into peer groups. Maryland hospitals are not eligible to receive a payment adjustment factor under HRRP.

Bethany Wheeler-Bunch: Thank you. The next question is in relation to the HAC Reduction Program. When is the next claims snapshot date?

Angie Goubeaux: This is Angie. That's a good question. The claims snapshot date for Fiscal Year 2020 is September 28, 2018.

Bethany Wheeler-Bunch: Thank you. The next question: If I have any HRRP-related program data or review and correction questions, who should I contact?

Kati Michael: Hi, this is Kati. We are going to direct all new HRRP inquiries; so, any HRRP-related topics due to program data or review and corrections will be submitted via email to hrrp@lantanagroup.com, or, as always, there is still the option to submit through the Q&A tool on *QualityNet.org*.

Bethany Wheeler-Bunch: Thank you. Another question regarding peer groups: Why isn't the ERR calculated including Medicare managed care while these patients were included in peer group assignments?

Kristin Maurer: This is Kristin. Including Medicare and managed care patients in the calculation of dual proportions, which is then used to assign peer groups more accurately, represents the number of dual-eligible patients at a hospital. This is particularly the case in states with high Medicare and managed care penetration rates. Medicare or managed care patients are not included in the calculation of ERR due to limitations in the available data for these patients.

Bethany Wheeler-Bunch: Thank you. The next question is for the HAC Reduction Program. If we have questions about the data in our HSR, should we contact the hacrp@lantanagroup.com email address instead of the *QualityNet* Help Desk?

Angie Goubeaux: Yes, this is Angie. So, similar to what Kati just stated, this year, in an effort to streamline our inquiry process, all of our materials and communications direct hospitals to contact the HAC Reduction Program support team, either via the hacrp@lantanagroup.com email address or through the Q&A tool on *QualityNet*.

Bethany Wheeler-Bunch: Thank you, and to round out our Q&A session, I wanted to ask two questions regarding dual eligibility. The first one: How does CMS identify dual-eligible stays?

Kristin Maurer: This is Kristin. CMS identifies the dual patients as Medicare Fee-For-Service and managed care hospital inpatient stays if the patient has full-benefit dual status for the month the beneficiary was discharged from the hospital.

Bethany Wheeler-Bunch: Thank you and the second dual-eligible question: Where does CMS get the information on dual eligibility?

Kristin Maurer: CMS calculates the number of dual-eligible beneficiaries based on data from the Master Beneficiary Summary File, or MBSF. The data for dual eligibility in the MBSF is sourced from the state Medicare Modernization Act file.

Bethany Wheeler-Bunch: Thank you. That's all the time we have for questions today. Questions not answered during today's webinar will be responded to in the question-and-answer transcript and posted to the inpatient website *www.QualityReportingCenter.com* in the upcoming weeks. If you have an urgent question or would like to submit a review and correction request, please follow those specific steps covered in this webinar. Thank you again for joining today's webinar. I would also like to say thank you to our speakers today for coming and speaking to us and also answering those questions. I would now like to introduce Dr. Deborah Price to cover how to obtain continuing education credits for today's event. Dr. Price, the floor is yours.

Deborah Price: Well, thank you very much. Today's webinar has been approved for one continuing education [CE] 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, 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 a little gray box at the bottom right-hand corner that says Done. You will 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 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.

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 CE's, click Existing User. However, if this is your first webinar for credit, click New User.

This is what the New User screen looks like. Please register a personal email like Yahoo, 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 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 back issues and 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 that you registered with. Again, the User ID is the complete email address, including what is after the @ sign. Thank you for taking the time spent with me.