Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Overview of the FY 2019 HAC Reduction Program and HRRP

Q&A Transcript

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

Question 1: **What is the 75th percentile threshold or cutoff for receiving a payment reduction for the HAC Reduction Program this year?**

For Fiscal Year (FY) 2019, the 75th percentile threshold is 0.3429. Any hospital that is subject to the FY 2019 HAC Reduction Program with a Total HAC Score greater than 0.3429 will receive a 1% payment reduction.

Question 2: **Regarding the HAC Reduction Program, is there a Windows version of the 8.0 CMS (Patient Safety Indicator) PSI software available?**

Yes, A SAS and Windows version of the CMS PSI software is available by request from hacrp@lantanagroup.com. The replication instructions posted on the Overview - CMS PSI page on *QualityNet* only applies to the SAS version.

Question 3: **How does HRRP stratified methodology identify excess readmissions?**

The excess readmission ratio (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 at least 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 Diagnosis Related Group (DRG) payments for the condition or procedure will determine the contribution of that ERR to the hospital's payment reduction.

Question 4: **For HRRP, why stratify hospitals into five peer groups?**

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 hospital's 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 adjustment formula increase.

Question 5: **Which hospitals are included when calculating peer groups?**

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.

Question 6: **When is the next claims snapshot date for the HAC Reduction Program?**

The claims snapshot date for FY 2020 is September 28, 2018.

Question 7: **If I have any HRRP-related program data or review and correction questions, who should I contact?**

For questions or comments about calculating and reporting for HRRP or interpreting Hospital-Specific Reports (HSRs), please contact the Hospital Quality Reporting Program Support contractor at hrrp@lantanagroup.com. Include "Hospital Readmissions Reduction Program" in the subject line.

Question 8: **Why isn't the ERR calculated by including Medicare managed care patients when these patients were included in peer group assignments?**

Including Medicare and managed care patients in the calculation of dual proportion (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 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 9: **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?**

You may contact the HAC Reduction Program support team either via the hacrp@lantanagroup.com email address or through the Q&A tool on *QualityNet*.

Question 10: **How does CMS identify dual-eligible stays?**

CMS identifies dual patients among all Medicare fee-for-service (FFS) and managed care hospital inpatient stays during the three-year HRRP performance period. For FY 2019, the performance period is July 1, 2014 through June 30, 2017. A beneficiary is considered dual-eligible if the patient has full-benefit, dual status during the month of discharge from the hospital.

Question 11: **Where does CMS get the information on dual eligibility?**

CMS identifies dual-eligible beneficiaries based on data from the master beneficiary summary file (MBSF). The data for dual eligibility in the MBSF comes from the State Medicare Modernization Act (MMA) files.

Question 12: **Does the HAC Reduction Program information in this presentation reflect any changes in the inpatient prospective payment system (IPPS) FY 2019 proposed rule?**

No, this presentation does not cover any changes in the proposed or final rule. CMS released the FY 2019 IPPS/Long-Term Care Prospective Payment System (LTCH PPS) Final Rule, available here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page.html

Question 13: **When and where can hospitals find their FY 2019 percentage payment reduction for HRRP?**

Hospitals can calculate the payment reduction percentage based on their payment adjustment factor. Hospitals can use their FY 2019 HSRs to review their measure results and discharge-level data, to replicate their payment adjustment factor, and to replicate or verify component results (dual stays [numerator], dual proportion, peer group assignment, neutrality modifier, ERRs, and peer group median ERRs). HSRs will be released in August and will be available via the *QualityNet Secure Portal*.

To determine the payment reduction percentage, hospitals can subtract the payment adjustment factor from 1.0000 and multiply the result by 100. If the adjustment factor is 1.0000, then the hospital will not receive a payment reduction.

Example: Hospital "A" has a readmission payment adjustment factor of 0.9750. To determine the percentage reduction of Hospital A's payment, subtract the readmission adjustment factor from 1.0000 and multiply by 100 (see below).

1.0000 - 0.9750 = 0.025 x 100 = 2.5% reduction

Question 14: **Can you tell me where "Falls with Trauma" will be publicly reported? I can easily find PSI 08 "IP Falls with Hip Fx," but I am speaking to falls with "other" fractures.**

The Falls with Trauma measure is included under Deficit Reduction Act (DRA) HAC Reporting which is separate from the HAC Reduction Program. The 2018 DRA HAC Reporting data will be publicly reported on *data.CMS.gov* in August 2018.

Question 15: **Regarding slide 15, which technical version of the PSI specifications are associated with version 8.0? Is it version 6.0.2 or version 7?**

Version 7.0 of the PSI technical specifications apply to recalibrated version 8.0 of the CMS PSI software. A link to the version 7.0 PSI measure specifications can be found on the CMS PSI Resources page on *QualityNet*.

Question 16: **What are the key differences in the PSI 90 recalibrated version 8.0 and 6.0.2?**

Recalibrated version 8.0 of the CMS PSI software uses an updated reference population (i.e., October 2015 to September 2016) of Medicare FFS discharges. The FY 2018 HAC Reduction Program used recalibrated version 6.0.2 of the CMS PSI software, which used a different reference population (i.e., July 2013 to June 2015) of Medicare FFS claims data. CMS version 8.0 PSI software includes several updates from CMS version 6.0.2 PSI software (e.g., coding system, measure specifications, recalibration method, number of risk factors, reference population period, and CMS PSI 90 component weights).

Question 17: **Will critical access hospitals (CAHs) receive an HSR, even though they are not in the Hospital IQR Program? This information would be helpful for benchmarking.**

No, CAHs are excluded and will not receive a HAC Reduction Program or HRRP HSR.

Question 18: **What's the difference between CMS PSI 90 and the Agency for Healthcare Research & Quality (AHRQ) PSI 90? Does CMS use the same codes to identify if a patient qualifies for PSI, both numerator and denominator?**

The AHRQ PSIs focus on the all-payer population; however, the CMS PSIs in the hospital quality reporting programs focus on the Medicare FFS population. The Medicare FFS population is generally older and sicker than the all-payer population. The CMS PSIs are based on the FFS population and are categorized as recalibrated to differentiate them from AHRQ's all-payer population.

Question 19: **Does CMS AHRQ recalibrated version 8.0 have only ICD-10 recalibrated component weights?**

The CMS PSIs in FY 2019 only use International Classification of Diseases-10th Revision (ICD-10) data and include updates to the following: coding system (i.e., ICD-10 Clinical Modification/Procedure Coding System

[CM/PCS] from ICD-9-CM), measure specifications, component weights, and risk-adjustment models based on Medicare data.

Question 20: **What is our best resource for the means and standard deviation of the measures ahead of time?**

Two days before the start of the Scoring Calculations Review and Correction Period, CMS published measure means and standard deviations in Table A of the FY 2019 HAC Reduction Program HSR User Guide and in the HAC Reduction Program Mock HSR found on the *QualityNet* Hospital-Specific Reports: HAC Reduction Program page.

Question 21: **How can we determine what the 1% reduction will be if we are subject for the reduction (slide 18)?**

Hospitals in the FY 2019 HAC Reduction Program with a Total HAC Score greater than the 75th percentile of all Total HAC Scores (i.e., hospitals in the worst-performing quartile) will receive a 1% payment reduction. For the FY 2019 HAC Reduction Program, this payment reduction applies to all Medicare discharges between October 1, 2018 and September 30, 2019 (i.e., FY 2019). The payment reduction occurs when CMS pays hospital claims. CMS notifies hospitals whether they will receive a payment reduction in FY 2019 in the HAC Reduction Program HSR, which CMS delivered to hospitals via the *QualityNet Secure Portal* in July 2018.

CMS first applies the Hospital VBP Program payment adjustment, HRRP payment adjustment, and disproportionate share hospital (DSH) and indirect medical education (IME) payment adjustments. Then, CMS applies the HAC Reduction Program payment reduction.

For example, if both the Hospital VBP Program and HRRP payment adjustments are based on a $1,000,000 base operating DRG payment amount and the hospital loses 2% in the Hospital VBP Program and 2% in HRRP, the net loss is $40,000. If the hospital is also subject to the HAC Reduction Program payment reduction, then CMS bases the 1% reduction on $960,000 (instead of $1,000,000).

Question 22: **When will the HRRP modifiers be posted in the IPPS Impact File and/or Table 15? Will that be August 1 as in past years or not until January as the slide indicates?**

After hospitals have been given an opportunity to review and correct their calculations for FY 2019, CMS will post Table 15 and the supplemental data file in early fall 2018 to display the final FY 2019 readmissions payment adjustment factors. The below links are found on *CMS.gov*:

FY 2019 IPPS/LTCH PPS Final Rule HRRP Supplemental Data Files: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Items/FY2019-IPPS-Final-Rule-Data-Files.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

Table 15: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Items/FY2019-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

Question 23: **Can you show the formulas for how the Winsorized z-scores are calculated, including the formula for the CMS PSI 90 composite value?**

Please refer to the replication instructions in the HAC Reduction Program HSR User Guide on *QualityNet* (Hospital-Inpatient > Hospital-Acquired Condition (HAC) Reduction Program > Hospital-Specific Reports) and in the scoring methodology infographic on *QualityNet* (Hospitals-Inpatient > Hospital-Acquired Condition (HAC) Reduction Program > Resources).

Question 24: **Is there a way we can determine our percentile ranking based on the Winsorized z-score?**

Hospitals cannot determine the percentile associated with their Winsorized z-score. However, Winsorized z-scores greater than 0 indicate the hospital performed worse than the mean across subsection (d) and Maryland hospitals; Winsorized z-scores below 0 indicate the hospital performance better than the mean.

The HSRs (made available to hospitals on July 27, 2018) include the 75th percentile Total HAC Score (0.3429). CMS does not post other Total HAC Score percentiles; however, hospitals can use the publicly reported data on *Hospital Compare* in January 2019 to approximate their Total HAC Score percentile.

Question 25: **What does Winsorized mean?**

The Winsorization process reduces the impact of extreme or outlying measure results and preserves hospital relative results. CMS calculates Winsorized measure results for each measure by adjusting hospital measure results as follows:

1. Hospitals with a measure result between the minimum and the 5th percentile will receive a Winsorized measure result equal to the 5th percentile value for the measure.
2. Hospitals with a measure result between and including the 95th percentile and the maximum will receive a Winsorized measure result equal to the 95th percentile value for the measure.
3. Hospitals with a measure result between the 5th and 95th percentile will receive a Winsorized measure result equal to their measure result.

CMS determines the 5th and 95th percentiles based on the distribution of the raw measure results from all subsection (d) and Maryland hospitals with sufficient data for each individual measure.

For more information on each of these steps, please refer to the HAC Reduction Program HSR User Guide on *QualityNet* (Hospital-Inpatient > Hospital-Acquired Condition (HAC) Reduction Program > Hospital-Specific Reports) or the HAC Reduction Program scoring methodology using Winsorized z-scores infographic on *QualityNet* (Hospitals-Inpatient > Hospital-Acquired Condition (HAC) Reduction Program > Resources).

Question 26: **When will the HRRP HSR be available?**

FY 2019 HRRP HSRs will be released in August 2018.

Question 27: **Is the surgical site infection (SSI) standardized infection ration (SIR) based on a combination of colon SSI and abdominal hysterectomy SSI?**

Yes, the HAC Reduction Program uses a “pooled” version of the SSI measure. The SSI measure is based on the number of SSIs following colon surgical procedures and total abdominal hysterectomy procedures.

Question 28: **Sometimes, there are patients with an inpatient claim (and they would be covered under this program), but then the inpatient claim is "denied" and only paid as an observation claim. Are the patients who are converted to observation/OP status removed from the population for calculation of the measure's PSI 90 component?**

If a claim is corrected in time, it should be excluded. CMS will take a snapshot of Medicare FFS claims data used for claims-based measures for FY 2020 on **September 28, 2018** for FY 2020.

Hospital results will only reflect edits that meet the time, reopening, and revision requirements outlined in the *Medicare Claims Processing Manual.* The manual's Chapter 1, General Billing Requirements, is found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf.

The manual's Chapter 34, Reopening and Revision of Claim Determinations and Decisions, is found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c34.pdf.

Medicare Administrative Contractors (MACs) must process all corrections to underlying Medicare FFS claims data by the snapshot date for FY 2020.

Question 29: **Will the national percentiles for the Total HAC Score be available soon?**

The HSRs (made available to hospitals on July 27, 2018) include the 75th percentile Total HAC Score (0.3429). CMS does not post other Total HAC Score percentiles; however, hospitals can use the publicly reported data on *Hospital Compare* in January 2019 to approximate their Total HAC Score percentile.

Question 30: **If the data period for the HAC Reduction Program includes discharges from January 1, 2016 through December 31, 2017 and the claims deadline is September 27, 2017, how is the fourth quarter of 2017 data included? I am confused.**

Under the HAC Reduction Program, Domain 1 and Domain 2 have different performance periods. Domain 1 (CMS PSI 90), which uses claims data, has a performance period of October 1, 2015 through June 30, 2017 for FY 2019.

Question 31: **Are the PSI technical specifications you mentioned in this webinar (version 8.0) the same as version 2018?**

No, version 2018 PSI specifications on the AHRQ website are not the same. Version 7.0 of the PSI technical specifications apply to the recalibrated version 8.0 of the CMS PSI software. A link to the version 7.0 PSI measure specifications can be found on the CMS PSI Resources page on *QualityNet.*

Question 32: **Can you explain dual-eligible?**

Dual-eligible refers to patients who are eligible for both Medicare and for full-benefits under Medicaid.

Question 33: **I thought ERR was observed (or actual) over expected. What is predicted?**

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 based on 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 based on average hospital performance given your hospital's case mix and the average hospital effect, provided in your hospital discharge-level data.

Question 34: **Is there a correlation with the ERR and Risk Standardized Readmission Rate (RSRR) and national rate?**

Yes, the ERR equals your hospital's predicted readmission rate divided by its expected readmission rate. For a given measure, multiplying your ERR by the national observed readmission rate for that condition will produce a number similar to your hospital's RSRR. CMS publicly reports RSRRs on *Hospital Compare*. There may be small differences in the estimated RSRR and your hospital's ERR and RSRR on *Hospital Compare* because CMS

uses a different group of hospitals to calculate the readmission measures for the programs.

Question 35: **Is there a place to see the exclusion codes for PSI 90?**

Version 7.0 of the PSI technical specifications apply to the recalibrated version 8.0 of the CMS PSI software and includes exclusions for each PSI. A link to the version 7.0 PSI technical specifications can be found on the CMS PSI Resources page on *QualityNet.*

Question 36: **Is this CMS PSI 90 methodology available for hospitals to replicate?**

Yes, there are replication steps included in the FY 2019 HAC Reduction Program HSR User Guide located on the *QualityNet* Hospital-Specific Reports: HAC Reduction Program webpage. You can also request an example replication (including calculations using the mock HSR) from hacrp@lantanagroup.com.

Question 37: **Currently chart-abstracted and healthcare-associated infection (HAI) measures are validated under the Hospital IQR Program. When will the validation of HAI measures switch to the HAC Reduction Program?**

This is addressed in the FY 2019 IPPS/LTCH PPS Final Rule which can be found on the FY 2019 IPPS/LTCH PPS Final Rule page on *CMS.gov*.

CMS is delaying removal of the National Healthcare Safety Network (NHSN) HAI measures from the Hospital IQR Program until the CY 2020 reporting period/FY 2022 payment determination. For this reason, CMS is also delaying adoption of the NHSN HAI measure validation processes into the HAC Reduction Program. The HAC Reduction Program's adoption of the Hospital IQR Program's NHSN HAI measure validation process will begin with third quarter 2020 discharges for FY 2023.

Question 38: **Does "dual-eligible" represents the patient population that is eligible for both Medicare FFS and Medicare Advantage and NOT Medicare FFS and Medicaid?**

"Dual-eligible" refers to patients that are eligible for Medicare and Medicaid. For HRRP, CMS identifies full-benefit dual patients as Medicare

FFS and managed care (also known as Medicare Advantage) hospital inpatient stays if the patient has full-benefit dual status for the month the beneficiary was discharged from the hospital. Managed care inpatient stays are included due to variation in hospitals' managed care population. CMS uses this information to calculate a hospital's dual proportions. The dual proportion is the proportion of patients that are dually eligible for Medicare and full-benefit Medicaid among all Medicare FFS and managed care stays.

Question 39: **The FY 2019 IPPS proposed two scoring options for the HAC Reduction Program. The preferred proposal used equal measure weights and removed domains. The alternative used variable domain weights based on the number of NHSN measures. This presentation doesn't reflect either methodology. Does this presentation reflect a final decision to not change the domain scoring methodology as proposed?**

CMS finalized adopting the Equal Measure Weights scoring option for the FY 2020 HAC Reduction Program.

This is addressed in the FY 2019 IPPS/LTCH PPS Final Rule which can be found on the FY 2019 IPPS/LTCH PPS Final Rule page on *CMS.gov*.

Question 40: **Please explain again what makes a full-benefit, dual-eligible patient.**

Full-benefit Medicaid refers to Medicaid coverage for comprehensive health services. Some states offer limited benefit packages that only cover some services (e.g., emergency services). For HRRP, CMS identifies full-benefit dual status (i.e., numerator) using data from the MBSF, which it sources from the State MMA files. Dual-eligible means that a patient is eligible for both Medicare and Medicaid.

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 41: **What hospital discharge period of PSI indicators the new AHRQ PSI version 2018 will affect?**

The FY 2019 HAC Reduction Program uses recalibrated version 8.0 of the CMS PSI software for CMS PSI 90. Version 7 of the PSI technical specifications applies to version 8.0 of the CMS PSI software. The CMS PSI

90 performance period was October 1, 2015 through June 30, 2017. CMS has not finalized future versions of the CMS PSI software.

Question 42: **If you are above the ERR for one HRRP measure, is your payment adjusted for all CMS claims?**

If a hospital is above the peer group median ERR for one ERR, the hospital may be subject to a penalty. The ERR will enter the payment adjustment factor formula to calculate the penalty. If the hospital is penalized (has a payment adjustment factor less than 1), CMS applies the payment adjustment factor to all Medicare FFS base operating DRG payments for discharges in the applicable fiscal year, regardless of the condition.

Question 43: **Why use dual eligibility as the peer group assignment?**

The 21st Century Cures Act requires HRRP to assess penalties based on a hospital's performance relative to other hospitals with a similar proportion of dual-eligible patients.

Question 44: **What are the benefits of performing the replications for the HAC Reduction Program and HRRP?**

CMS grants hospitals 30 days to review their HSR data and submit corrections and findings. During this period, hospitals can review the data in their HSRs and replicate their results for verification.

Question 45: **Where can I submit questions regarding HRRP?**

Please submit all HRRP-related questions to hrrp@lantanagroup.com.

Question 46: **How do we use the data in Table 3 to calculate the penalty cost?**

To estimate the dollar amount of penalties, you will need the payment adjustment factor in Table 1 of the HSR and information on your hospital's base operating DRG payments. CMS applies the payment adjustment factor to all Medicare FFS base operating DRG payments for discharges in the applicable fiscal year, regardless of the condition. CMS does not publish the

base operating DRG payments, but your hospital may be able to estimate using internal data.

To estimate the total penalties, first determine the percentage of your hospital's payment reduction by subtracting the payment adjustment factor from 1.0000. If the adjustment factor is 1.0000, then your hospital will not receive a payment reduction. If your hospital will receive a payment reduction, the dollar amount is approximately equal to the payment reduction multiplied by your hospital's base operating DRG payments for all Medicare FFS discharges in the fiscal year, regardless of condition.

Question 47: **Are readmissions only counted for the six HRRP measures?**

HRRP measures include the following six 30-day risk-standardized readmission measures: acute myocardial infarction (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), total hip arthroplasty/total knee arthroplasty (THA/TKA), and coronary artery bypass graft (CABG).

CMS uses administrative claims to identify unplanned readmissions among all Medicare FFS patients that occur within 30 days of discharge from the hospital. Although the initial discharge must be for one of the six conditions/procedures in the program, CMS takes an all-cause approach for identify readmissions. This means that CMS considers unplanned readmissions for any reason in the calculation of a hospital's ERR.

For more information about the methodology for identifying readmissions, please refer to *QualityNet* (*QualityNet*.org > Hospitals-Inpatient > Claims-Based and Hybrid Measure > Readmission Measures > Measure Methodology.

Question 48: **Can a hospital have an ERR greater than 1 with a penalty indicator of "Y" and not get a reduction based on stratification?**

Beginning in FY 2019, CMS assesses hospital performance relative to the peer group median. The peer group median replaces 1 in the previous formula as the threshold for assessing excess readmissions and varies depending on the measure and peer group. Hospitals with an ERR greater than the peer group median and at least 25 eligible discharges will have a penalty indicator of "Y" for that measure.

A hospital can have an ERR greater than the peer group median and not be penalized. A penalty indicator of "Y" indicates that the ERR enters the payment adjustment factor formula. The final payment adjustment factor is rounded to four decimal places. Due to rounding in the formula, a small number of hospitals will have a measure enter the payment adjustment factor formula but will not be penalized. In this case, a hospital would still show "Y" as the penalty indicator, but it will have a payment adjustment factor of 1.0000.

Question 49: **Will CMS release the detailed hospital information in each peer group? I'm not asking for the peer group assignment for our hospital. We would like to know what other hospitals are in our assigned group.**

Yes, CMS will report the payment adjustment factor and component results (which includes the peer group assignment) for all hospitals in the FY 2019 IPPS/LTCH PPS Final Rule after the Review and Correction Period. Visit the following link for FY 2019 Final Rule data files: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Items/FY2019-IPPS-Final-Rule-Data-Files.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

Question 50: **Are Medicare Advantage patients included in HRRP?**

For HRRP, Medicare FFS and managed care stays are used to calculate the dual proportion. The dual proportion is determined as the ratio of dual-eligible patents among all Medicare FFS and manage care stays during the FY 2019 HRRP applicable period (i.e., stays from July 1, 2014 through June 30, 2017).

Question 51: **What is the difference between expected and predicted readmission rates?**

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 based on 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 based on average hospital performance given your hospital's

case mix and the average hospital effect, provided in your hospital discharge-level data.

Question 52: **Are the discharge dates for the HAC Reduction Program different than they are for HAC reduction in the Hospital VBP Program? My Hospital VBP Program domain weighting document shows dates from January 1, 2017 to December 31, 2017, but this shows from January 1, 2016 to December 31, 2017.**

Yes, the Hospital IQR Program and Hospital VBP Program use a one-year reporting or performance period for NHSN HAI measures. The HAC Reduction Program uses a two-year performance period.

Question 53: **We understand that managed care/Medicare Advantage claims will be included in the dual proportion calculation. Are those claims included in the ERR calculation?**

CMS does not include Medicare managed care (also known as Medicare Advantage) claims in the ERRs due to limitations in the available data for these patients. ERRs reflect the ratio of predicted-to-expected readmissions for Medicare FFS patients only.

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.

Question 54: **Please clarify which patients are in the numerator. Is it only patients who are dual-eligible for Medicare and Medicaid and not patients with Medicare only?**

Correct, the numerator includes only stays where a patient was dually eligible for Medicare and full-benefit Medicaid.

Question 55: **Even though Medicare Advantage is used to determine peer groups, is the penalty just applied to Medicare FFS?**

Correct, payment reductions are applied to all Medicare FFS base operating DRG payments for the fiscal year.