Hospltal Value-Based Purchasing (VBP) Program

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

Overview of the FY 2023 HAC Reduction Program and Hospital Readmissions Reduction Program Presentation Transcript

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Maria Gugliuzza: Hello and welcome to today's webinar, *Overview of the FY 2023 Hospital-Acquired Condition Reduction Program and Hospital Readmissions Reduction Program*. My name is Maria Gugliuzza, and I am the Hospital Value-Based Purchasing Lead for the Outreach and Education Program Lead at CMS's Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be your moderator for today's event. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with a summary of the questions asked today, will be posted to the inpatient website www.QualityReportingCenter.com, in the upcoming weeks. If you registered for this event, a reminder email and a link to 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 our inpatient website www.QualityReportingCenter.com.

As a reminder, we do not recognize the raised-hand feature in the Chat tool during webinars. You can submit any questions, pertinent to the webinar topic, to us via the Chat tool. All questions received via the Chat tool during this webinar that pertain to this webinar topic will be reviewed and a Q&A transcript will be made available at a later date. To maximize the usefulness of the Q&A transcript, we will consolidate the questions received during this event and focus on the most important and frequently asked questions. These questions will be addressed in a questions-and-answers transcript, to be published at a later date.

My Gehrke is the HAC Reduction Program Lead at the DVIQR Program Support, DPS, Contractor. Kristanna Peris is the HRRP Program Lead at the DPS Contractor.

Today's event will provide an overview of the fiscal year 2023 HAC Reduction Program and HRRP, including program updates, methodology, Hospital-Specific Reports (HSRs), and the review and correction period.

Participants will be able to interpret the program methodology, understand your hospital's program results in your HSR, submit questions about your hospital's calculations during the HAC Reduction Program Scoring

Calculations review and correction period, and the HRRP review and correction period

I will now turn the call presentation over to our first speaker. Amy, the floor is yours.

Amy Gehrke: Thank you, Maria. My name is Amy Gehrke, and I am the HAC Reduction Program Lead for the Division of Value, Incentives, and Quality Reporting Program Support Contractor. Today, I am going to discuss background of the HAC Reduction Program and updates to the program for FY 2023, provide an overview of the scoring methodology for the program, and describe how hospitals can review their program results for the FY 2023 program year.

The HAC Reduction Program is a Medicare value-based purchasing program that reduces payments to hospitals based on their performance on measures of hospital-acquired conditions. The program reduces the overall Medicare payment by 1 percent for the worst-performing 25 percent of hospitals on hospital-acquired condition quality measures. The program encourages hospitals to implement best practices to reduce their rates of healthcare-associated infections and improve patient safety.

CMS evaluates overall hospital performance by calculating a Total HAC Score for each hospital, which is the equally-weighted average of their scores across measures included in the program. Hospitals with a Total HAC Score greater than the 75th percentile (the worst-performing quartile) of all Total HAC Scores will be subject to the 1-percent payment reduction.

The HAC Reduction Program includes all subsection (d) hospitals, which are broadly defined as general acute care hospitals paid under the Inpatient Prospective Payment System. A complete list of the excluded hospital types, such as critical access hospitals, can be found in the Frequently Asked Questions for the FY 2023 HAC Reduction Program, available on the Resources page of the QualityNet website.

Maryland hospitals are exempt from payment reductions under the HAC Reduction Program due to an agreement between CMS and Maryland. More information on the Maryland Total Cost of Care Model can be found on the CMS website.

The FY 2023 HAC Reduction Program includes six measures: one claims-based composite measure of patient safety, the CMS PSI 90, and five chart-abstracted or laboratory-identified healthcare-associated infection surveillance measures based on data that hospitals submit to the Centers for Disease Control and Prevention's National Healthcare Safety Network.

Next, I'll cover the updates to the program for the FY 2023 program year.

CMS did not change the scoring or measure methodology for the FY 2023 HAC Reduction Program. However, in response to the COVID-19 public health emergency, CMS paused all measures in the program and did not calculate measure scores or Total HAC Scores for any hospital in the FY 2023 program year. No hospital is subject to the 1-percent payment reduction in FY 2023. However, CMS will continue to publicly report CMS PSI 90 and HAI results on the Care Compare website to provide transparency to the public on important infection and patient safety metrics during the public health emergency.

For the FY 2023 program year, CMS is pausing the inclusion of the CMS PSI 90 measure in the FY 2023 HAC Reduction Program Hospital-Specific Reports. CMS will continue to report hospital HAI and CMS PSI 90 results via measure-specific reports and publicly report those results on the Care Compare website. Hospitals will have 30 days to preview the data and results prior to public display. The performance period for the five HAI measures includes all data submitted to NHSN for January 1, 2021, through December 31, 2021. As finalized in the FY 2022 IPPS/LTCH PPS Final Rule, CMS is excluding calendar year 2020 data from all program calculations for the HAC Reduction Program.

Next, I will review the scoring methodology for the program. As noted previously, there were no changes to the scoring methodology for the FY

2023 program year; however, several of the steps are not applicable this year because CMS is not calculating measure scores or Total HAC Scores.

In a typical year, the HAC Reduction Program scoring methodology consists of four high-level steps. The first step in the scoring methodology is to determine measure results for each of the measures included in the program. For the CMS PSI 90 measure, the measure result is the CMS PSI 90 composite value. For the HAI measures, the measure result is the SIR. Once measure results have been calculated, the next step in the scoring methodology is to calculate measure scores. CMS calculates a hospital's measure score as the Winsorized *z*-score using measure results for the given measure. Once measure scores have been calculated, these are used to calculate hospital Total HAC Scores. CMS calculates each hospital's Total HAC Score as the equally-weighted average of their measure scores. Once Total HAC Scores are calculated, CMS can use those scores to determine the worst-performing quartile. Hospitals whose Total HAC Score is greater than the 75th percentile Total HAC Score are in the worst-performing quartile. More information on the typical scoring methodology can be found in the HAC Reduction Program Scoring Methodology Infographic found on QualityNet or last year's presentation. As previously noted, CMS is not calculating any measure scores or Total HAC scores for any hospital. No hospital is ranked in the worst-performing quartile or subject to the 1-percent payment reduction.

For FY 2023, CMS is not including the CMS PSI 90 composite value or measure scores in the HAC Reduction Program HSRs. These will be reported as N/A. CMS is providing CMS PSI 90 results to hospitals through a measure-specific report at a later date. CMS is calculating HAI Standardized Infection Ratios, or SIRs, and including them in the HSR. CMS is not calculating Total HAC scores, so they will be reported as 0 for all hospitals. Finally, no hospitals will be subject to the 1-percent payment reduction because there will be no worst-performing quartile.

Next, I am going to discuss how hospitals receive their results via the Hospital-Specific Reports and how they can review those results and ask questions.

Each year, CMS provides hospitals with 30 days to review their program data, submit questions about calculations, and request corrections to their scoring, if appropriate. This is known as the Scoring Calculations review and correction Period. Hospitals have the opportunity to review their data and results via the HSRs and should use this to guide their scoring calculations review.

The HAC Reduction Program HSR provides hospitals the necessary information to review their program results. Along with the HSRs, CMS delivers an HSR User Guide, which can guide hospitals through the process of reviewing their data.

HSRs are accessible to users in your organization who have Basic Hospital Quality Reporting HQR System Managed File Transfer permissions and Auto-Route (IQR) permissions. An email notification indicating that HSRs are available is sent to users who have the necessary permissions. For those with the necessary permissions, the HSR and user guide will be in their MFT inbox. The HSR User Guide is also made publicly available on the QualityNet website. Hospitals that are having trouble accessing their HSRs should reach out via the Quality Question & Answer Tool on the QualityNet website.

The HAC Reduction Program HSR contains contact information for the program and additional resources. As a reminder, no hospital is being penalized in FY 2023. In the next set of slides, I will walk through information included in your FY 2023 HAC Reduction Program HSR.

This is an example of Table 1 in the FY 2023 HAC Reduction Program HSR. Table 1 normally contains the contribution of each measure to the Total HAC Score, along with the Total HAC Score, the actual 75th percentile Total HAC Score for the FY 2023 program, and the payment reduction status for this example hospital. Because CMS is not penalizing any hospital in FY 2023, the Total HAC Score is reported as 0 and all other values are reported as N/A in this table.

This is an example of Table 2 in the FY 2023 HAC Reduction Program HSR. Table 2 usually contains measure results for each of the measures along with the necessary information to calculate Winsorized *z*-scores. However, in FY 2023, only HAI measure results, that is the SIRs, are included, and all other values are reported as N/A.

This is an example of Table 3 in the FY 2023 HAC Reduction Program HSR. Table 3 in the HSR normally shows users the necessary information to reproduce their measure result for the CMS PSI 90 measure, the CMS PSI 90 composite value. The CMS PSI 90 is a composite measure that combines results from 10 component patient safety indicator measures, shown in the top row of the table. Each component patient safety indicator measure’s smoothed rate is weighted to form the composite value. All values in this table are reported as N/A; however, CMS will continue to collect, calculate, and confidentially report hospital CMS PSI 90 results via measure-specific HSRs. Hospitals will have 30 days to preview those data before CMS publicly reports them on the Care Compare website.

This is an example of Table 4 in the FY 2023 HAC Reduction Program HSR. Table 4 normally shows discharge-level information for the CMS PSI 90 measure. However, since CMS is not including the CMS PSI 90 measure result in the FY 2023 HAC Reduction Program HSRs, this table is blank.

This is an example of Table 5 in the FY 2023 HAC Reduction Program HSR. Table 5 shows hospital-level information for the five HAI measures. This includes the reported and predicted number of HAIs. The Standardized Infection Ratio, shown in row 4 of the table, is equal to the reported number of infections divided by the predicted number of infections.

The Scoring Calculations review and corrections period for the FY 2023 HAC Reduction Program begins on August 15, 2022, and ends on September 13, 2022. Hospitals have this 30-day period to review their data and submit questions about the calculation of their results.

CMS is only providing hospitals' HAI measure results in the FY 2023 HAC Reduction Program HSR. Hospitals cannot request corrections to the HAI measure result data, but they may ask clarifying questions.

Although there is no CMS PSI 90 data included in the FY 2023 HAC Reduction Program HSR to review and request corrections, this slide addresses correcting claims data in future years. Each year during the Scoring Calculations review and corrections Period, hospitals cannot add new or revise claims that are used to calculate CMS PSI 90 results. Hospitals already had the opportunity to review and correct those data. CMS takes an annual snapshot of claims data to perform measure calculations for claims-based measures for all of their hospital quality reporting and value-based purchasing programs. Corrections to underlying claims must be processed by the snapshot date and claim edits after that date are not reflected in program results. The next claims snapshot, for the FY 2024 program year, will occur around September 30, 2022.

As noted, hospitals cannot request corrections to underlying data during the Scoring Calculations review and corrections period. Hospitals already had the opportunity to review and correct those data. For the HAI measures, hospitals have the opportunity to submit, review, and correct HAI data within the NHSN system for four and a half months following the end of each reporting quarter. Immediately following this submission deadline, CDC takes a snapshot of the data for CMS to use in program calculations. CMS does not receive or use data entered after the NHSN submission deadline, and CMS expects hospitals to review and correct their data prior to the NHSN submission deadline.

As shown in the table below, the NHSN submission deadline occurs four and a half months following the end of each reporting quarter. For Quarter 1, the NHSN submission deadline is August 15. Likewise, the Quarter 2 submission deadline is November 15. The Quarter 3 deadline is February 15 of the following year, and the Quarter 4 deadline is May 15 of the following year. In all instances, if the 15th of the month falls on a Friday, Saturday, Sunday, or a federal holiday, the NHSN submission deadline is the following business day.

This image demonstrates the flow of the HAI data from submission to the NHSN through use in program scoring calculations and public reporting. Four and a half months from the end of the reporting quarter, CDC creates a snapshot of the data in NHSN to be used in CMS calculations. Hospitals can review their calculations during the Scoring Calculations review and corrections period before their HAC Reduction Program results are publicly reported on the Provider Data Catalog in the following January.

More information on the HSRs and Scoring Calculations review and corrections process is available on the QualityNet website. This includes the HSR User Guide and a mock version of the HSR. For more information on your hospital's results found in the HSRs, hospitals can submit any questions to the HAC Reduction Program Support Team via the Quality Question & Answer Tool.

In early 2023, CMS will release the publicly-reported version of the FY 2023 HAC Reduction Program results on the Provider Data Catalog. Because CMS is not calculating measure scores or Total HAC Scores for any hospital for FY 2023, only hospital SIRs will be reported on the PDC. Although CMS is not including CMS PSI 90 results in the FY 2023 HAC Reduction Program HSRs, CMS will continue to collect, calculate, and confidentially report hospitals' CMS PSI 90 results via measure-specific HSRs. CMS will publicly report those results on the Care Compare website after hospitals have 30 days to preview the data.

General information on the HAC Reduction Program can be found in the HAC Reduction Program section of the QualityNet website. This includes information on program scoring methodology, the Scoring Calculations review and corrections process, and additional resources such as frequently asked questions and program fact sheets.

As noted elsewhere, if you have questions about the HAC Reduction Program, you can submit them directly to the HAC Reduction Program Support Team via the Quality Question & Answer Tool. You do not need to register for an account to submit questions via this tool.

Now, I will pass it on to Kristanna to talk about HRRP.

Kristanna Peris: Thank you, Amy. As Amy stated, my name is Kristanna Peris. I am the HRRP Program Lead on the DPS contract. In this portion of the presentation, I will briefly discuss program background information, go through an example that explains the program methodology, and review the HRRP HSR.

The Hospital Readmissions Reduction Program, HRRP, is a Medicare value-based purchasing program that was established, beginning October 1, 2012, to reduce payments to hospitals with excess readmissions. HRRP supports CMS' goal of improving health care for Americans by linking payment to quality of hospital care. Under HRRP, hospitals are encouraged to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions. Hospitals with excess readmissions may receive payment reductions.

HRRP includes all subsection (d) hospitals with eligible discharges for any of the HRRP readmission measures. In general, HRRP hospitals are general acute care hospitals. CMS does not include non-subsection (d) units and hospitals in HRRP such as critical access hospitals, Veterans Affairs medical centers, and acute care hospitals in the US territories. CMS exempts Maryland hospitals from HRRP payment reductions because of an agreement between CMS and the state of Maryland. Although Maryland hospitals are exempt from HRRP payment reductions, CMS publicly reports measure results for Maryland hospitals and includes Maryland hospitals in the calculation of the excess readmission ratios, or ERRs.

HRRP includes the following condition- or procedure-specific 30-day risk-standardized unplanned readmission measures: AMI, COPD, heart failure, pneumonia, CABG, and elective primary total hip arthroplasty and/or total knee arthroplasty. As discussed in more detail on the next slide, the pneumonia measure is suppressed from payment reduction calculations for fiscal year 2023.

For FY 2023, CMS shortened the HRRP performance period due to the Extraordinary Circumstances Exception discussed in the FY 2022 IPPS/LTCH PPS Final Rule. CMS is not using claims data representing Quarter 1 and Quarter 2 2020, reflecting services provided January 1, 2020, through June 30, 2020, in its calculations for HRRP. The readmission measures identify readmissions within 30 days of each index stay; therefore, the performance period for HRRP will also not use claims data representing the 30 days before January 1, 2020. Therefore, the FY 2023 performance period for HRRP is July 1, 2018, to December 1, 2019, and July 1, 2020, to June 30, 2021. In addition, as finalized in the FY 2022 final rule, CMS is suppressing the pneumonia readmission measure in FY 2023 HRRP payment reduction calculations due to COVID-19's substantial impact on this measure. Because the pneumonia readmission measure is a claims-based measure, CMS is still receiving the claims needed to calculate the measure and will publicly report the measure results. However, the pneumonia measure results do not contribute to FY 2023 payment reduction calculations. CMS updated the specifications for the readmission measures to exclude Medicare beneficiaries with a principal or secondary diagnosis of COVID-19 coded as Present on Admission from the measure cohort and outcome. Additionally, each measure was updated to risk-adjust for patients with a clinical history of COVID-19 in the 12 months prior to the index admission.

From FY 2013 to FY 2018, CMS used a non-peer grouping methodology to assess hospital performance under HRRP. Under the non-peer grouping methodology, CMS used a threshold of 1, or the average ERR, for hospitals that admitted similar patients to assess hospital performance on each measure. Beginning in FY 2019, the 21st Century Cures Act directed CMS to use a peer grouping methodology to evaluate a hospital's performance. The peer grouping methodology assesses hospital performance relative to that of other hospitals with a similar proportion of stays for patients who are dually eligible for Medicare and full Medicaid benefits.

Dual-eligible status is an indicator of patients' social risk, and the approach of grouping hospitals holds all hospitals to a high standard while also making it so that the program does not disproportionality reduce payments for hospitals serving at-risk populations. The 21st Century Cures Act also requires that the peer grouping methodology produce the same amount of Medicare savings generated under the non-peer grouping methodology to maintain budget neutrality. The neutrality modifier in the payment reduction calculation satisfies the Cures Act requirements to maintain budget neutrality between the two methodologies.

The payment reduction is the percentage a hospital's payments will be reduced based on its performance in the program. The payment reduction is a weighted average of a hospital's performance across the HRRP measures during the performance period. In order to administer payment reductions, CMS transforms the payment reduction into the payment adjustment factor, or the PAF, and CMS applies the PAF to all Medicare Fee for Service base operating DRG payments during the fiscal year. The next few slides will walk through the steps involved in calculating the payment reduction in more detail. The slides will show the example calculations for a hospital using mock data. Throughout the example, an asterisk is applied to the pneumonia measure, since that measure is suppressed in fiscal year 2023 payment reduction calculations.

For Step 1, CMS calculates a dual proportion for each hospital and an ERR, or Excess Readmission Ratio, for each of the HRRP conditions and procedures. The ERR is a measure of a hospital's relative performance used in the payment reduction formula to assess whether a hospital has excess readmissions for each of the conditions or procedures included in HRRP. The ERR is the risk-adjusted ratio of the predicted readmission rate to the expected readmission rate. CMS calculates an ERR for each measure and each hospital included in the program. For the example hospital, it shows the calculations for taking the predicted readmission rate over the expected readmission rate. For the hip/knee measure, this hospital did not have any eligible discharges, so it did not have an ERR calculated for that measure. The dual proportion is also shown on this slide.

It is the proportion of Medicare Fee for Service and managed care stays in a hospital during the performance period in which the patient was dually eligible for Medicare and full Medicaid benefits. For the example hospital, it has 894 stays where the beneficiary was dually eligible for Medicare and full Medicaid benefits, and it has 3,389 total Medicare Fee for Service and managed care stays. For this hospital, the dual proportion equals 894 divided by 3,389 total stays, or 0.2638.

To calculate the payment reduction, CMS sorts hospitals into five approximately equal groups based on their dual proportions. Hospitals are sorted into one of five peer groups, ranging from peer group 1, which has the lowest dual proportions relative to other HRRP hospitals, to peer group assignment 5, which has the highest dual proportions relative to other HRRP hospitals. The example hospital, with a dual proportion of 0.2638, would be assigned to peer group 4 based on the dual proportion ranges for each of the peer groups. CMS then calculates a median ERR for each peer group and each measure. The peer group median ERR is the threshold CMS uses to assess excess readmissions relative to other hospitals within the same peer group. All hospitals in the same peer group will have the same peer group median ERR. The image on this slide shows an example of the peer group median ERRs for each of the peer groups.

For Step 4, CMS determines which ERRs will contribute to the payment reduction. For an ERR to contribute to the payment reduction, it must meet two criteria: First, the ERR must be greater than the peer group median ERR. Second, the hospital must have 25 or more eligible discharges for the measure. The table on this slide shows an example hospital and how measures will contribute to the payment reduction. In this case, the AMI and COPD measures meet both of the criteria and will contribute to the payment reduction calculation.

In Step 5, CMS calculates each measure’s contribution to the payment reduction. The slide shows an example of how that is calculated. The DRG ratio included in the calculations is the ratio of base operating diagnosis-related group, or DRG, payments for the measure cohort to base operating DRG payments for all discharges.

Since only AMI and COPD were determined to contribute to the payment reduction based off of Step 4, only these measures are included in the example calculations on this slide.

In Step 6, CMS sums the measure contributions to the payment reduction. If the sum of the measure contributions is greater than 3 percent, CMS will apply a cap because the maximum payment reduction allowed under the program is 3 percent. In this example, the hospital's payment reduction is 0.34 percent.

In Step 7, CMS calculates the payment adjustment factor, which equals 1 minus the payment reduction. The image on this slide shows an example for the hospital. Then, in Step 8, CMS applies the payment adjustment factor to payments for Medicare Fee for Service claims submitted, starting October 1 each year. In the example, it shows how the payment adjustment factor is applied to the total base operating DRG payment amounts and the resulting dollar amount of payments. In general, the base operating DRG payment amounts are the Medicare Fee for Service base operating DRG payments without any add-on payments, such as Disproportionate Share Hospital payments or Indirect Medical Education payments.

In this section of the presentation, we will review specific aspects of the HRRP HSR, or Hospital-Specific Report.

HSRs are reports that include hospital-level results and discharge-level data that CMS uses to calculate your hospital's payment reduction percentage and component results. The fiscal year 2023 HRRP HSR contains tabs that include the following hospital-specific information: your hospital's payment reduction percentage, payment adjustment factor, measure results and ERRs, the neutrality modifier, information used in the peer grouping methodology, discharge-level information for readmission measures, and contact information for the program. The first tab of the HRRP HSR workbook introduces the user to the HSR, identifies whether the hospital had an approved individual Extraordinary Circumstances Exception request and for which quarters, provides links to resources with detailed information on the program and the data in the HSR, as well as

information regarding where to direct questions via the QualityNet Question & Answer Tool. The user guide that accompanies the HSR includes more detailed information, including replication instructions to promote transparency into the calculations and data.

The second tab in the HRRP HSR workbook contains Table 1: Payment Adjustment, shown here. This table shows summary information for your hospital. The dual proportion, shown in the third column, is calculated as the number of dual eligible stays, shown in the first column, divided by the total number of stays, shown in the second column on this slide. Your hospital peer group assignment is shown in the fourth column. As noted, before, hospitals in peer group 1 have the lowest dual proportions relative to other HRRP hospitals. Hospitals in peer group 5 have the highest dual proportions relative to other HRRP hospitals. The ranges of the dual proportions for each peer group are included in the user guide. The neutrality modifier, shown in the fifth column, is applied in the calculation of the payment reduction to maintain budget neutrality with the non-peer grouping methodology. The payment reduction percentage, shown in the sixth column, shows the percentage your hospital's payments will be reduced, ranging from 0 percent to 3 percent. The last column in Table 1 shows the hospital's payment adjustment factor. The payment adjustment factor may be between 1.0, which means no reduction, and 0.97, which is the maximum payment reduction.

This slide shows the table in the third tab of the HSR: Table 2: Hospital Results. This table shows your hospital's measure-specific results. The sixth column, the ERR, shows the predicted readmission rate, shown in the fourth column, divided by the expected readmission rate, shown in the fifth column, for that measure. If a hospital performs better than an average hospital that admitted similar patients, the ERR will be less than 1. If a hospital performs worse than average, the ERR will be greater than 1. The penalty indicator, shown in the eighth column on this slide, will indicate if that measure will contribute to the payment reduction. The penalty indicator is Yes for a measure when your hospital has 25 or more eligible discharges and an ERR greater than the peer group median ERR

for that measure. The penalty indicator is No for a measure when your hospital has fewer than 25 eligible discharges or the ERR is less than the peer group median ERR for that measure. Each measure with a penalty indicator equal to Yes will contribute to your hospital's payment reduction and increase the size of the payment reduction. When a hospital has no eligible discharges for a measure, a value of NQ will be displayed in the Number of Eligible Discharges column to indicate that there are no qualifying cases for the measure. This will also cause the value of NQ to display in the Excess Readmission Ratio column for that measure. CMS cannot calculate an ERR without eligible discharges for a measure. The peer group median ERR and ratio of DRG payments per measure to total payments will display a value of N/A, and the penalty indicator will display No for the pneumonia measure for all hospitals, since the measure is suppressed in payment reduction calculations for fiscal year 2023.

The next six tabs in the HSR show Tables 3 through 8 with discharge-level information for each readmission measure. This slide shows the first eight columns that will appear in each of these tables with example discharge-level data. Each table shows discharge-level data for all Medicare Part A Fee for Service hospitalizations that occurred during the HRRP performance period where the patient was 65 years or older at the time of admission with a principal discharge diagnosis of either AMI, COPD, heart failure, pneumonia, or a procedure for CABG surgery, or primary elective total hip/knee, These tables indicate whether a planned or unplanned readmission for any cause followed the discharge within 30 days. HSRs include all discharges that meet the inclusion requirements for each measure. The cohort inclusion/exclusion indicator, shown in the table on this slide, is used to identify discharges that were excluded from the measure. The risk factors for each measure with their corresponding condition category are also included in these tables. The HSR includes a table for the pneumonia measure even though it is suppressed from payment reduction calculations in fiscal year 2023.

This slide and the next slide show the continuation of the data available in the discharge tabs. The HSR User Guide contains detailed descriptions for each of these columns.

These are more columns that you will see in Tables 3 through 8 of your HSR. The last two columns show your hospital's specific effect and the average effect. The Hospital Effect represents the underlying risk of a readmission at your hospital, after accounting for patient risk. The Average Effect represents the underlying risk of a readmission at the average hospital after accounting for patient risk.

This slide shows the table in the last tab of the HSR: Table 9: Dual Stays. This tab shows information for the stays that meet the criteria for the numerator of the dual proportion. As mentioned before, the numerator for the dual proportion includes stays for Medicare Fee for Service and managed care beneficiaries who were also eligible for full Medicaid benefits during the HRRP performance period.

Once hospitals receive their HSRs, the 30-day review and correction period begins. CMS distributes HSRs via the Hospital Quality Reporting System Managed File Transfer inbox at the beginning of the review and correction period. Hospitals can review the data in their HSRs and replicate their payment reduction percentage and component results. Hospitals can also submit requests for corrections to their payment reduction percentage and component results and submit questions about their result calculations during the 30-day review and correction period. The HRRP review and correction period for FY 2023 began August 8 and goes through September 7, 2022. HSR review and correction inquiries should be submitted to the QualityNet Q&A Tool. A link for this tool is available on this slide.

This slide lists what hospitals can and cannot submit calculation correction requests for during the HRRP review and correction period. Hospitals cannot submit corrections to the underlying claims data or add new claims to the data used for the calculations during this period.

Hospitals with at least 25 discharges will have the data elements listed on this slide publicly reported on the Provider Data Catalog website in early 2023.

In addition to public reporting on the Provider Data Catalog, CMS also reports hospital HRRP results along with the final rule. This slide shows the data elements that will be released in the IPPS/LTCH PPS final rule Supplemental Data File following the review and correction period.

More information on HRRP, HSRs, and readmission measures is available on the QualityNet website. The links on this slide can be used to navigate to specific web pages on QualityNet for further information on HRRP, as well as the HSR User Guide and a mock HSR.

Questions about HRRP should be submitted to the QualityNet Question & Answer Tool. The link for the tool is on this slide and can also be found on the QualityNet website. The table on this slide shows the program, topic, and subtopic to select when submitting your question, based on the subject of your question. This brings us to the end of the formal presentation. Thank you for your time. Now back to you, Maria.

Maria Gugliuzza: Thank you, Kristanna and Amy. It is now question time. If you have any questions at this point, please feel free to type them into the Chat box. As time allows, we will answer some questions. Okay. Let's get started. First question: If CMS is going to continue to collect, calculate, and publicly report results for PSI 90, when will hospitals receive those results?

Amy Gehrke: Thanks, Maria. Although CMS is not including the CMS PSI 90 measure result in the FY 2023 HAC Reduction program HSRs, CMS will continue to collect, calculate, and confident confidentially report hospital HAI and CMS PSI 90 results via measure-specific reports and publicly report those results on the Care Compare website to provide transparency to the public on important infection and patient safety metrics during the public health emergency. The timelines for measure-specific report delivery and public reporting have not been announced. These timelines will be communicated through the QualityNet Listserves.

If you are not signed up for the QualityNet Listserves, you can sign up for the email updates by going to the bottom of the QualityNet home page at QualityNet.CMS.gov and clicking Join Now.

Maria Gugliuzza: Thank you. Our next question: When or will patient encounter-level PSI data be available again in our HSR?

Amy Gehrke: As described in the FY 2023 IPPS/LTCH PPS Final Rule, CMS emphasizes the long-term importance of value-based care and incentivizing quality care tied to payment. The goal is to continue resuming the use of measure data for the purposes of scoring and payment adjustment beginning with the FY 2024 program year HAC Reduction Program HSRs. There are a couple of changes to the measures worth noting that will facilitate the resumption of the scoring and payment adjustment in the FY 2024 program year. First, for the CMS PSI 90 measure, beginning with the FY 2024 program year, the CMS PSI 90 measure software will include a COVID-19 diagnosis as a risk adjustment parameter, which will help the measure account for the impact of the COVID-19 public health emergency on calendar year 2021 and subsequent years of data. The FY 2024 performance period for the CMS PSI 90 measure will be January 1, 2021, through June 30, 2022. Next, for the HAI measures under the current data collection processes for the measures, we are not able to risk adjust for or otherwise account for a COVID-19 diagnosis; therefore, we must exclude data to account for the impact of the COVID-19 public health emergency on calendar year 2021 data. As finalized in the FY 2023 final rule, the exclusion of calendar year 2021 HAI data will result in an FY 2024 performance period for the HAI measures of January 1, 2022, through December 31, 2022.

Maria Gugliuzza: Okay. Great. Thank you. All right. Our next question: What is the difference between a measure score and a measure result?

Kristanna Peris: For the HAC Reduction Program, the measure result is a hospital's performance value for a given measure.

So, for the CMS PSI 90 measure, a hospital's measure result is its CMS PSI 90 composite value. For the HAI measures, a hospital's measure result is its Standardized infection Ratio for the given measure. Scores, on the other hand, are a calculation of hospital relative performance on the measure compared to other hospitals that are included in the HAC Reduction Program. Specifically, CMS calculates hospital measure scores for a given measure as the Windsorized z-score for their measure results. A negative measure score means that the hospital's measure result is below the national average and indicates better performance, whereas a positive measure score means that the hospital's measure result is above the national average and indicates worse performance. As previously discussed, no hospital is receiving a measure score for any measures for the FY 2023 program year.

Maria Gugliuzza: Excellent. Let's see if we have another question. Regarding the HAC program, how is the SIR calculated?

Kristanna Peris: For the HAI measures, CMS relies on calculations produced by the CDC. The CDC calculates the Standardized Infection Ratio, or the SIR, for each HAI measure as the ratio of a hospital's observed HAIs to its predicted HAIs. CDC determines predicted HAIs for each measure using a risk adjustment process based on hospital information submitted to NHSN. So, for the CLABSI and CAUTI measures, they are risk adjusted at the hospital- and the patient care-unit levels. SSI is risk adjusted at the procedure level, and the SSI measure is a pooled measure based on the number of SSIs following abdominal hysterectomy and colon procedures. Then, MRSA and CDI are risk adjusted at the hospital level.

Maria Gugliuzza: Thank you for that. It looks like we do have a few more minutes for some more questions. The next question: When will the pneumonia 30-day readmission measure data be reported on Care Compare?

Amy Gehrke: Thanks. Although CMS is not including the pneumonia readmission measure results in the fiscal year 2023 HRRP payment reduction calculations, CMS is still collecting, calculating, and confidentially reporting hospital pneumonia readmission measure results in measure-specific reports and will publicly report those results on the Care Compare website to provide transparency to the public on important infection or on important quality measures. The pneumonia 30-day readmission measure results included in your HRRP HSR will be reported on the Provider Data Catalog in early 2023. The timelines for measure-specific report delivery and public reporting on the main Care Compare website have not been announced yet. These timelines will be communicated through the QualityNet Listserve. If you're not signed up for the QualityNet Listserve, you can sign up for the email updates by going to the bottom of the QualityNet home page and clicking Join Now.

Maria Gugliuzza: Thank you. Let's see if we have another question. Let's go to here. All right. Next question: Just a clarification, does the elective THA and TKA readmission rates only include inpatient?

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

Maria Gugliuzza: Great. Next question: How does CMS know from the claim that a readmission is planned or unplanned?

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

For fiscal year 2023, CMS identifies planned readmissions using Version 4.0 2022 of its planned readmission algorithm. For more information, visit the Readmission Measures Methodology page on the QualityNet website.

Maria Gugliuzza: Thank you. Next question: Why are my pneumonia readmission measure results included in the HSR if the pneumonia readmission measure is suppressed in FY 2023?

Kristanna Peris: As finalized in the fiscal year 2022 final rule, the pneumonia readmission measure is suppressed in fiscal year 2023 HRRP payment reduction calculations due to COVID-19's substantial impact on this measure. The pneumonia readmission measure results are shown in the HSR for informational purposes only; the pneumonia readmission measure results do not contribute to the fiscal year 2023 HRRP payment reduction calculations. Additionally, the pneumonia readmission measure results will be publicly reported on CMS's Provider Data Catalog for transparency of the effects of the COVID-19 public health emergency.

Maria Gugliuzza: Okay. It looks like we have time for one more question. Why is the first part of the HRRP performance period only through December 1, 2019? Isn't it supposed to go through December 31 of 2019? It says that it goes through Quarter 4 of 2019.

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

Maria Gugliuzza: Again, thank you, Kristanna and Amy. That is all the time we have today for questions. If your question was not answered, there will be a transcript of all the questions asked today provided at a later date. Please check back again at our Quality Reporting Center website, as well as QualityNet. I would like to thank everybody for their participation and attending our event today. Have a great day.