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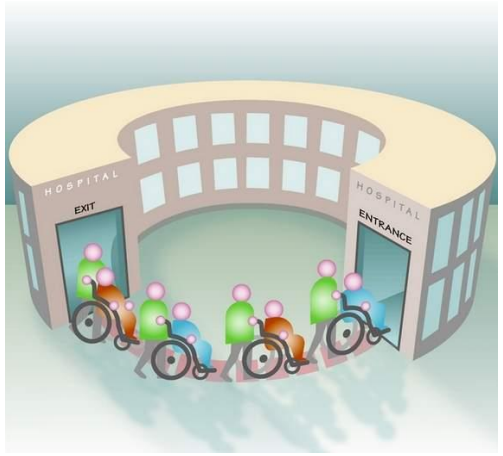
Hospital Readmissions Reduction Program

Nebraska Hospital Association

Feb. 8, 2024

What is the HRRP?

- CMS penalty program mandated by the 2010 ACA
- Hospitals with “excess” readmissions within 30 days of hospital discharge have their base inpatient Medicare payments reduced by:
  - 1 percent in FY 2013, 2 percent in FY 2014, 3 percent in FY 2015 and beyond
- Uses 30-day readmissions measures for a total of six conditions:
  - FY 2013: AMI, HF, PN
  - FY 2015: Elective hip/knee, COPD
  - FY 2017: CABG
- Peer grouping by proportion of dual-eligible Medicare patients began in FY 2019
  - Mandated by 21st Century Cures Act of 2016
  - Budget neutral (that is, aggregate penalties must be same as non-peer group adjusted approach)



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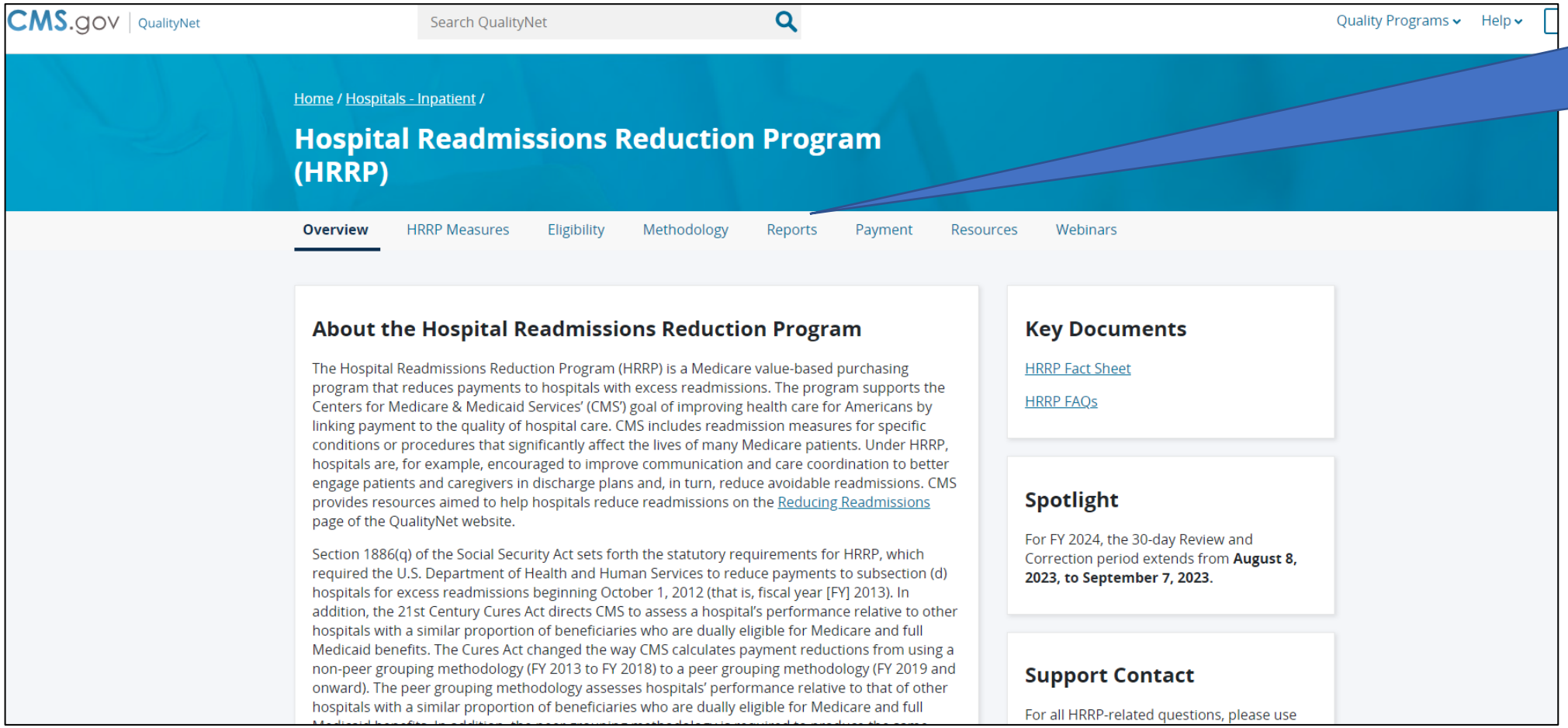
Helpful Resources from CMS - QualityNet



Hospital Specific Reports (HSRs) previewing your perormance generally available in July/Aug of each year

https://qualitynet.cms.gov/inpatient/hrrp

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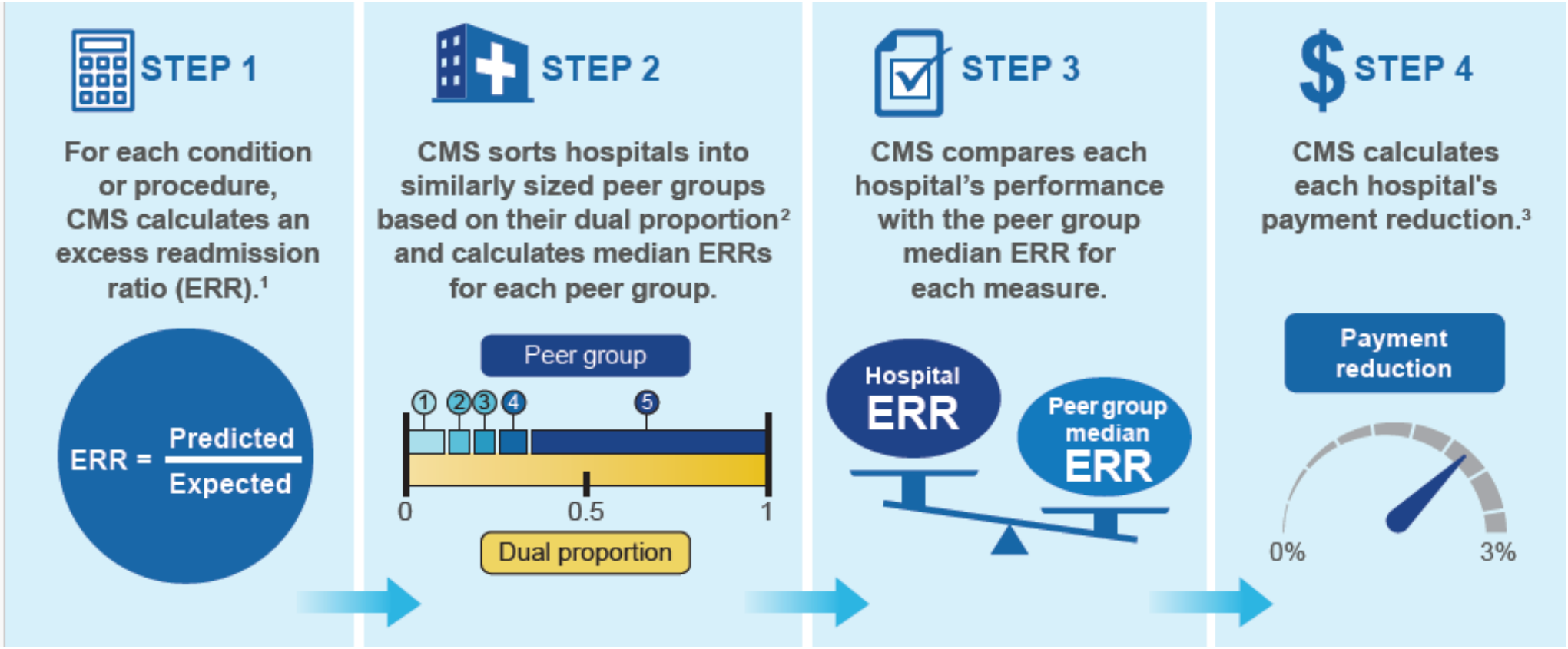
Multi-Step Process to Calculate Performance and Payment Adjustments



Source: CMS QualityNet, HRRP FY 2024 Fact Sheet
https://qualitynet.cms.gov/files/64cbd7532292b9001c2434c3?filename=FY2024_HRRP_FactSheet.pdf

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Breaking down the Excess Readmissions Ratio

$$ERR = \frac{\text{predicted readmission rate}}{\text{expected readmission rate}}$$

- Underlying readmission measures uses statistical risk adjustment technique to account for patient-level factors that may influence likelihood of being readmitted

- The predicted readmission rate is the predicted 30-day readmission rate for a hospital, based on that hospital's performance for its specific patient case mix
  - Mathematical term is the "hospital-specific effect," reported in its discharge-level data
  - Hospital-specific effect includes blend of both hospital's own data and national data distribution

- The expected readmission rate is the expected 30-day readmission rate for a hospital, based on readmission rates at an average hospital with a patient case mix similar to that hospital's
  - That is, if patients with the same characteristics had been treated at an average hospital rather than at that individual hospital

*Graphic from CMS QualityNet FAQ for Risk-Standardized Outcome and Payment Measures.

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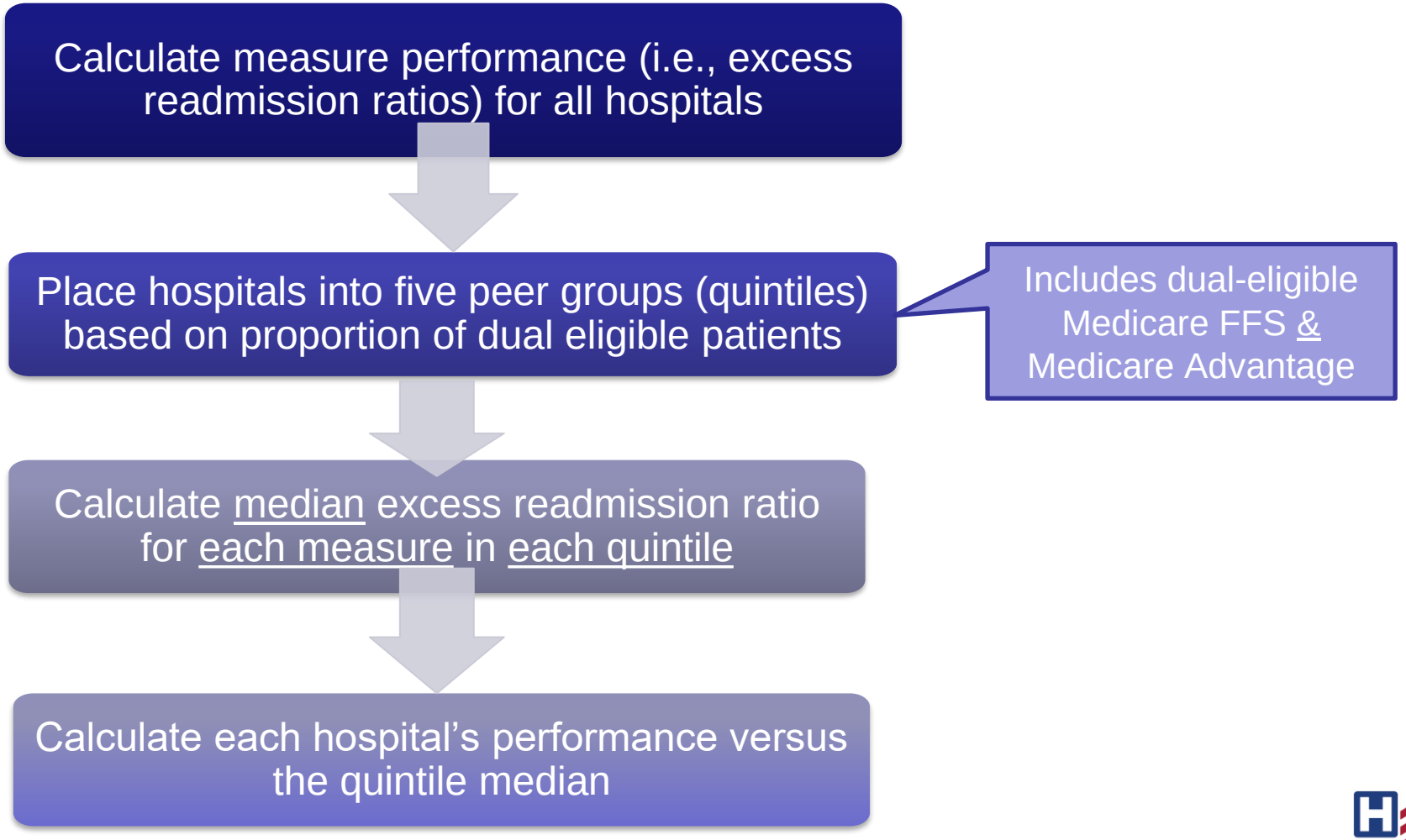
HRRP Peer Grouping Approach



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Sample Calculations: ERR and Duals Proportion

Example dual proportion calculation for **Hospital A**:

Hospital A has **894** stays in which the beneficiary was dually eligible for Medicare and full Medicaid benefits.

Hospital A has **3,389** total Medicare FFS and managed care stays.

$$\textit{Dual proportion} = \frac{894}{3{,}389} = 0.2638$$

Example ERR calculations for **Hospital A**:

AMI ERR: $\frac{0.1898}{0.1850} = 1.0259$

COPD ERR: $\frac{0.1649}{0.1574} = 1.0476$

HF ERR: $\frac{0.1349}{0.1251} = 1.0783$

Pneumonia* ERR: $\frac{0.1659}{0.1459} = 1.1371$

CABG ERR: $\frac{0.1883}{0.1995} = 0.9439$

THA/TKA ERR: $\frac{NQ}{NQ} = NQ$

Hospitals with no eligible discharges for a measure will not have an ERR calculated for that measure.

Source: CMS QualityNet

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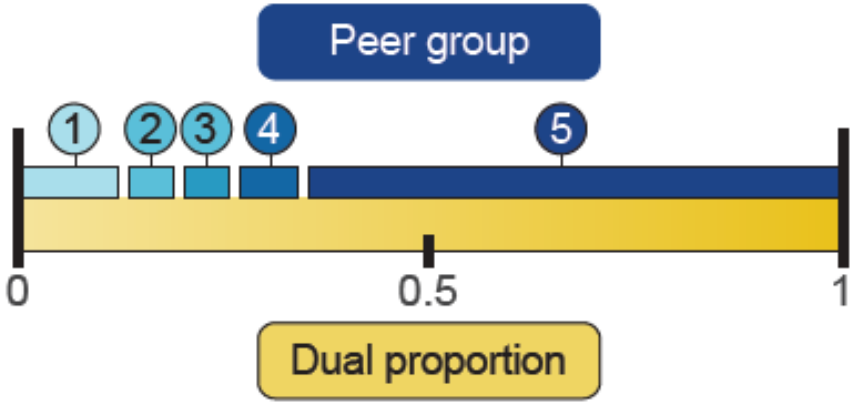
Using the ERR to Put Hospitals into Peer Groups

Sort hospitals into peer groups

Sort hospitals into 1 of 5 similarly sized peer groups (i.e., quintiles) based on hospitals' dual proportions.



The yellow line represents the range of dual proportions and the blue bars represent the dual proportions of the hospitals included in each of the similarly sized peer groups.

Example peer groups:

Peer group	Minimum dual proportion	Maximum dual proportion
1	0	0.1347
2	0.1348	0.1832
3	0.1833	0.2316
4	**0.2317**	**0.3083**
5	0.3084	1

Hospital A's dual proportion = **0.2638**
Hospital A is in **Peer Group 4**

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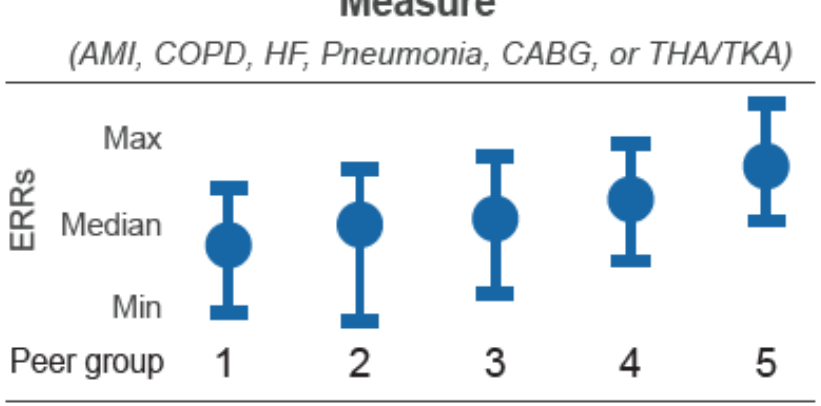
Calculating Peer Group Median ERRs

Identify the peer group median ERRs for each condition or procedure

Identify the median ERR for each condition or procedure within each peer group.



The lines represent the range of ERRs and the circle represents the median ERR for a single measure.

Example peer group median ERRs:

Peer group	AMI	COPD	HF	Pneu-monia	CABG	THA/ TKA
1	0.9941	0.9943	0.9848	0.9842	0.9804	0.9841
2	0.9961	0.9944	0.9865	0.9927	0.9961	0.9969
3	0.9964	0.9956	0.9894	0.9968	0.9979	0.9901
4	**0.9970**	**0.9954**	**1.0077**	**1.0021**	**1.0093**	**1.0073**
5	1.0093	1.0104	1.0258	1.0243	1.0157	0.9989

Source: CMS QualityNet, HRRP Infographic
https://qualitynet.cms.gov/files/64cbd7992292b9001c2434c9?filename=FY2024_HRRP_Infographic.pdf

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Measures with ERR > 1 Contribute to Payment Reduction

Example determination of measures contributing to the payment reduction for Hospital A:

Measure	ERR	Peer Group 4 median ERR	ERR > Peer Group 4 median ERR	Eligible discharges	Eligible discharges ≥ 25
AMI	**1.0259**	**0.9970**	✓	**42**	✓
COPD	**1.0476**	**0.9954**	✓	**38**	✓
HF	1.0783	1.0077	✓	22	X
Pneumonia	1.0007	1.0021	X	23	X
CABG	0.9439	1.0093	X	25	✓
THA/TKA	NQ	1.0073	X	0	X

The **AMI** and **COPD** measures will contribute to Hospital A's payment reduction.

For a measure to "count" towards HRRP performance, must have minimum of 25 discharges meeting the measure inclusion criteria

Source: CMS QualityNet, HRRP Infographic
https://qualitynet.cms.gov/files/64cbd7992292b9001c2434c9?filename=FY2024_HRRP_Infographic.pdf

Translating Performance into a Payment Adjustment

Payment reduction for measure = NM x DRG ratio x (ERR – peer group median ERR)

The **neutrality modifier** is the calculated value that makes the total savings to the Medicare program generated under the peer grouping methodology† roughly equal to the total savings generated under the non-peer grouping methodology.‡

The **DRG ratio** is the ratio of base operating diagnosis-related group (DRG) payments for the measure cohort to base operating DRG payments for all discharges.

†The peer grouping methodology, implemented in FY 2019 in response to the 21st Century Cures Act, compares hospitals' ERRs with the peer group median ERRs.

‡The non-peer grouping methodology, used from FY 2013 to FY 2018, compared hospitals' ERRs with 1.0 (that is, the national average ERR).

Example calculations of measures' contributions to the payment reduction for Hospital A:

Neutrality modifier		DRG ratio		ERR		Peer Group 4 median ERR		Contribution
0.9458	x	0.0648 AMI	x	1.0259 AMI	–	0.9970 AMI	=	0.0018 AMI
0.9458	x	0.0331 COPD	x	1.0476 COPD	–	0.9954 COPD	=	0.0016 COPD

Source: CMS QualityNet, HRRP Infographic
https://qualitynet.cms.gov/files/64cbd7992292b9001c2434c9?filename=FY2024_HRRP_Infographic.pdf

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Translating into a Penalty Amount

Calculate the payment reduction

1. Sum the measure contributions to the payment reduction:

Sum of measure contributions = *AMI contribution* + *COPD contribution* + *HF contribution* + *Pneumonia contribution* + *CABG contribution* + *THA/TKA contribution*

2. Apply the 3% cap if the sum of the measure contributions to the payment reduction is > 0.03.

Example calculation of the payment reduction for **Hospital A**:

Measure contributions	Sum of measure contributions	Apply the 3% cap
0.0018 AMI	0.0034	0.0034
+		
0.0016 COPD		

Hospital A's payment reduction is 0.34%.

Calculate the payment adjustment factor (PAF)

The PAF is the form of the payment reduction CMS uses to reduce hospitals' payments.

Payment adjustment factor = 1 – payment reduction

Example calculation of the payment adjustment factor for **Hospital A**:

Hospital A's payment adjustment factor = 1 – 0.0034 = 0.9966

PAF x Total Base Operating DRG Payments = HRRP Penalty Amount

Source: CMS QualityNet, HRRP Infographic
https://qualitynet.cms.gov/files/64cbd7992292b9001c2434c9?filename=FY2024_HRRP_Infographic.pdf

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Hospital Specific Reports (HSRs) and Annual Review / Corrections Period

- HSRs generally available by Jul/Aug of each year, with an accompanying 30-day review/corrections period
- HSR User Guide includes step-by-step instructions to replicate CMS's calculations
- Hospitals CAN use review / corrections period to ask questions / identify potentially misattributed patients or incorrect calculations of measures, payment amounts, etc.
- Hospitals CANNOT use review/corrections to change underlying claims data or add new claims to calculate performance

https://qualitynet.cms.gov/inpatient/hrrp/reports#tab1

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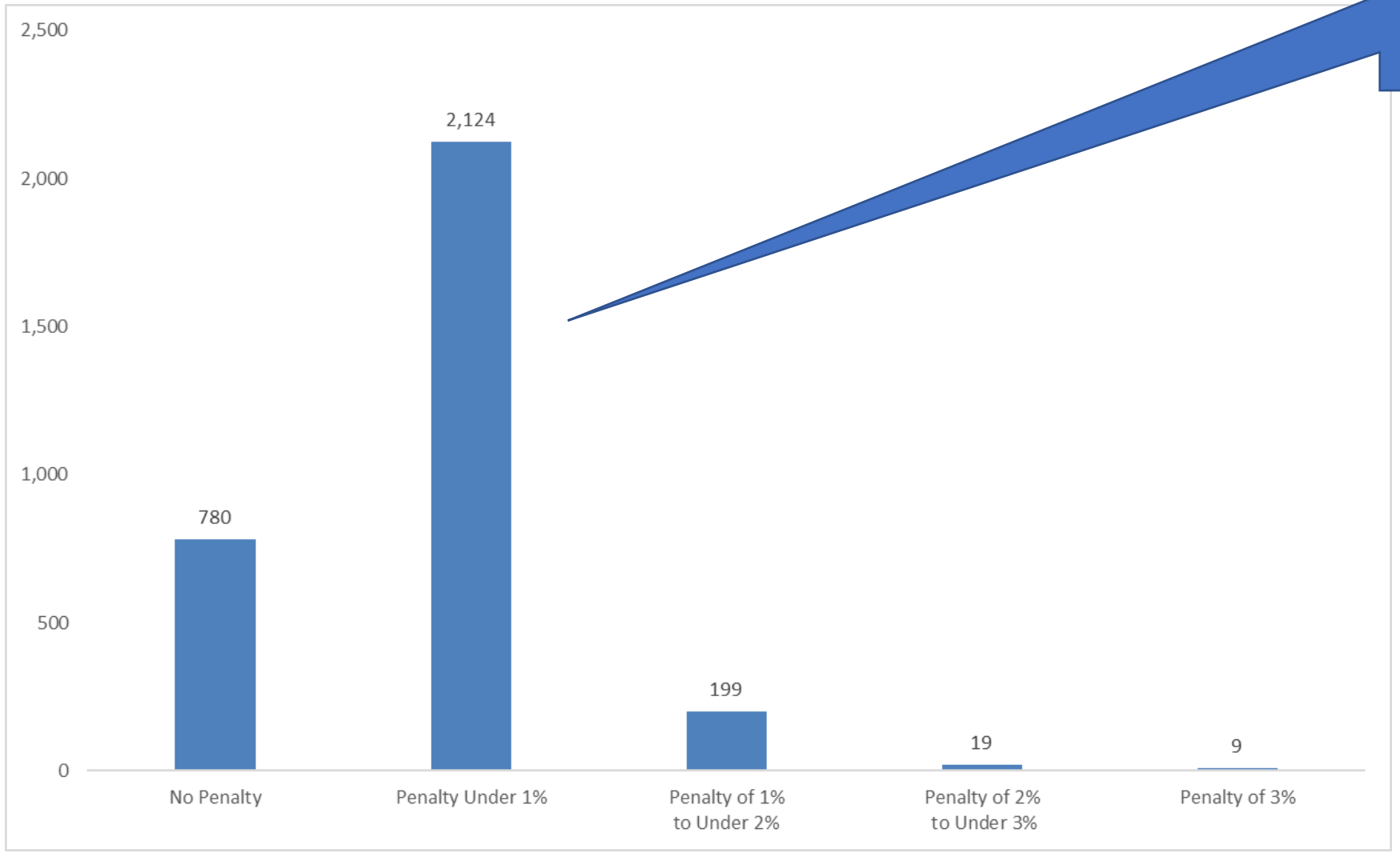
FY 2024 Readmission Results

~75% of hospitals received a penalty, vast majority under 1%



Source: AHA Analysis of IPPS Final Rule, FY 2024

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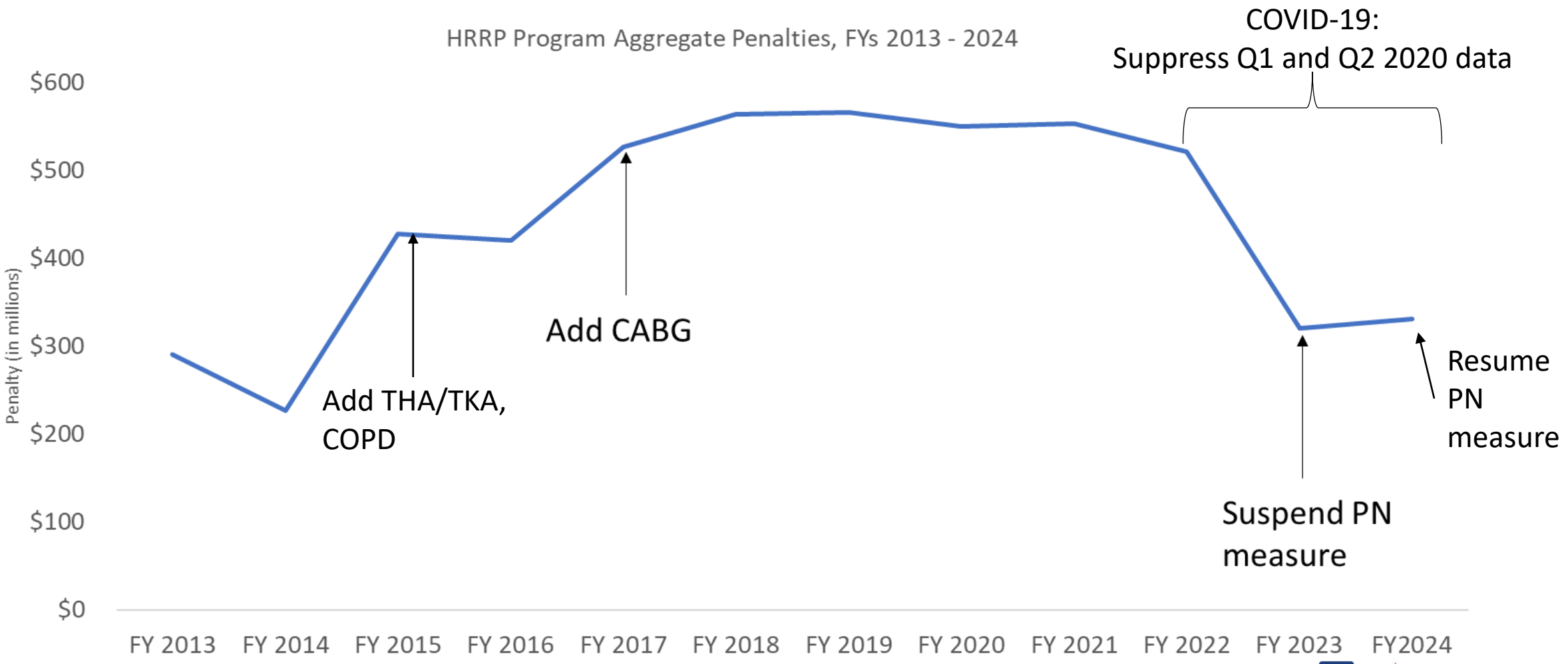
Readmission Penalty Trends



Source: CMS and AHA Analysis of IPPS Final Rules, FYs 2013-2024

~$5.2 billion in penalties since FY 2013 (and counting…)

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Grappling with Impact of COVID-19 PHE

- During PHE, CMS adopted “measure suppression” policy used to exclude certain data and time periods affected by COVID-19 in calculating performance
  - HVBP payment adjustments were neutral for FYs 2022 and 2023
  - No HAC Reduction Program penalties FY 2023
- CMS also adopted risk adjustment for prior COVID-19 diagnosis for readmissions and other measures effective w/ FY 2023 program
- Coding changes also allowed better differentiation of COVID-19 and pneumonia
  - CMS suspended PN readmit measure for FY 2023 then brought back for FY 2024

HRRP Performance Periods

	Performance Period	
	Start	End
FY 2020	Jul. 1, 2015	Jun. 30, 2018
FY 2021	Jul. 1, 2016	Jun. 30, 2019
FY 2022	Jul. 1, 2017	Jun. 30, 2020
FY 2023	Jul. 1, 2018	Jun. 30, 2021
FY 2024	Jul. 1, 2019	Jun. 30, 2022
FY 2025	Jul. 1, 2020	Jun. 30, 2023
FY 2026	Jul. 1, 2021	Jun. 30, 2024

A Few Longer-Range Policy Issues

- What is the “optimal” readmission number that our current measures allow us to capture?
  - It’s not zero with current measures, but where’s the plateau?
- Approach to accounting for social risk factors
  - Dual-eligible peer grouping a start, but statute gives CMS flexibility to explore other approaches
- What measures?
  - CMS considered adding hospital wide readmission measure several years ago but backed off because of statutory constraints
  - 2023-24 pre-rulemaking list includes EDAC measures – same statutory problems
- Penalty multiplier approach may inadvertently provide disincentive to improve
  - MedPAC 2013 report

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Hospital Readmissions Reduction Program

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