New Stratified Methodology Hospital-Level Impact File User Guide

Hospital Readmissions Reduction Program

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I. Overview

This document is intended to serve as a tool to help hospitals understand changes to the methodology CMS will use to assess hospital performance in the Hospital Readmissions Reduction Program (HRRP) in FY 2019, and the New Stratified Methodology Hospital-Level Impact File being posted on cms.gov in November 2017. Beginning in FY 2019, as required by the 21st Century Cures Act, the HRRP will use new stratified methodology that evaluates hospital performance relative to other hospitals with similar proportions of patients that are dually eligible for Medicare and full-benefit Medicaid. The Hospital-Level Impact File is designed to provide hospitals information on estimated performance in the HRRP under the new stratified methodology using data from FY 2018. This file also includes hospital-level dual proportion and peer group assignment information. This document provides details on how to understand and use the information included in this file.

- **Section II** provides a brief background of HRRP and the new stratified methodology
- **Section III** provides a detailed description of the contents of the new stratified methodology Hospital-Level Impact File and how hospitals can use the file
- **Section IV** provides information on who to contact for additional resources

II. Background

The Hospital Readmissions Reduction Program

Section 3025 of the 2010 Affordable Care Act (P.L. 111-148) required the Secretary of the Department of Health and Human Services to establish the Hospital Readmissions Reduction Program (HRRP) and reduce payments to Inpatient Prospective Payment System (IPPS) hospitals for excess readmissions, beginning October 1, 2012 (FY 2013). Starting with FY 2015, hospitals payments can be reduced by a maximum of 3 percent. The program supports the national goal of improving healthcare for Americans by linking payment to the quality of hospital care. The Centers for Medicare & Medicaid Services (CMS) includes measures of conditions and procedures that significantly affect the lives of large numbers of Medicare patients. Prior research has shown that hospital readmission rates for these patients vary across the nation, indicating an opportunity to improve the quality of care and save taxpayer dollars by incentivizing providers to reduce excess readmissions. Changes to the program occur through rulemaking and are published annually with the IPPS/LTCH PPS Final Rule following a public comment period.

For FY 2018 the HRRP includes six measures:

- Acute myocardial infarction (AMI)
- Chronic obstructive pulmonary disease (COPD)
- Heart failure (HF)
- Pneumonia
- Coronary artery bypass graft (CABG)
- Elective primary total hip and/or knee arthroplasty (THA/TKA)

21st Century Cures Act

In December 2016, the 21st Century Cures Act (Cures Act) was signed into law. The legislation requires that CMS assess penalties based on a hospital's performance relative to that of other hospitals with a similar proportion of patients that are dually eligible for Medicare and full-benefit Medicaid. The legislation further requires that estimated payments under the new methodology equal payments under the old design, also known as budget neutrality.

Old Methodology (FY 2018)

CMS measures hospital performance in the HRRP by calculating excess readmission ratios (ERRs) for each of the six program measures. An ERR is the ratio of predicted-to-expected readmissions for a given measure. Under the old methodology, measures with 25 or more eligible discharges and an ERR greater than 1.0 enter the payment adjustment factor formula. The threshold of 1.0 is applied to all hospitals, and an ERR greater than 1.0 indicates that a hospital performed worse than the average performance of all hospitals. The payment adjustment factor formula is used to calculate the size of the penalty reduction or penalty. Starting in FY 2015 penalty reductions were capped at 3% (i.e. a minimum payment adjustment factor of 0.97).

The formula to determine a hospitals penalty reduction is:

$$P = 1 - \min\left\{.03, \sum_{dx} \frac{Payment(dx) * \max\{(\mathrm{ERR(dx)} - \mathbf{1.0}), 0\}}{All\ payments}\right\},$$

where *dx* is any one of the six measures (AMI, COPD, HF, Pneumonia, CABG, and THA/TKA), payments refer to base operating DRG payments, and the ERR is a hospital's performance on that measure.[1]

[1] The ERR is the reliability-adjusted number of readmissions predicted at the hospital over the number of readmissions expected based on patient risk factors at the level of performance of an average hospital.

III. New Stratified Methodology and Hospital-Level Impact File

Under the new stratified methodology, hospital performance is assessed relative to the performance of hospitals within the same peer group. Hospitals are stratified into five peer groups, or quintiles, based on proportion of dual eligible. A hospital's dual proportion is the proportion of Medicare fee-for-service (FFS) and managed care stays where the patient was dually eligible for Medicare and full-benefit Medicaid. Under the new stratified methodology, the median ERR of hospitals within the peer group is used as the threshold to assess hospital performance on each measure. The median peer group ERR varies by measure and replaces the 1.0 threshold used to assess hospital performance under the old methodology. Measures with 25 or more eligible discharges and an ERR above the peer group median ERR enter the payment adjustment factor formula. The payment adjustment factor formula is used to calculate the size of the penalty reduction or penalty. The penalty reduction is capped at 3% (i.e. a minimum payment adjustment factor of 0.97).

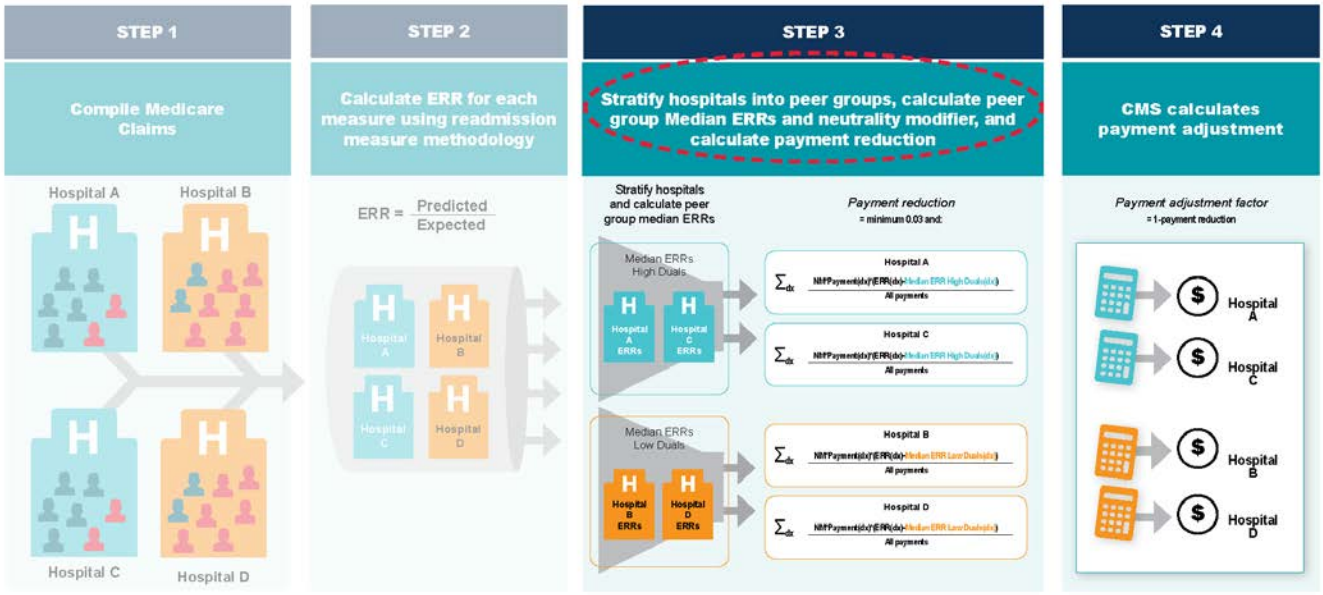
The new stratified methodology also applies a neutrality modifier to comply with the requirements of the Cures Act. To calculate the neutrality modifier, CMS estimates total Medicare savings across all hospitals under the old method as well as under the new stratified methodology (in the absence of a modifier). CMS then identifies the neutrality modifier, which is the multiplicative factor that, when applied to hospital payment adjustment factors, equates total Medicare savings under the old and new methodologies.

This formula shows how payment adjustment factors will be calculated under the new stratified methodology:

$$\mathrm{P} = 1 - \min\left\{ .03, \sum_{\mathrm{dx}} \frac{NM_M \,\mathrm{Payment\,(dx)} * \max\{(\mathrm{ERR\,(dx)} - \boxed{\mathrm{Median}}\ \ \mathrm{peer\ \ group\ \ ERR\,(dx)}), 0\}}{\mathrm{All\ \ payments}} \right\}$$

where *dx* is any one of the six measures (AMI, COPD, HF, Pneumonia, CABG, and THA/TKA), payments are base DRG payments, and the ERR is a hospital's performance on that measure. The box around "median" indicates that the median ERR for the hospital's peer group is put in place of 1.0 in the old payment adjustment factor formula.

Comparison of Old and New Stratified Methodology



This figure shows how the stratified HRRP payment adjustment factor methodology accounts for hospitals proportion of dual eligible patients.

Step 1 and Step 2 are not changing under the stratified methodology. Hospitals submit claims to Medicare and CMS calculates ERRs for the six measures included in the program.

However, as shown in Step 3, under the new stratified methodology, hospitals are stratified into peer groups based on their dual proportion and CMS calculates median ERRs for each peer group. For each measure, hospital performance is assessed relative to the peer group median ERR when calculating the payment adjustment factor.

The New Stratified Methodology Hospital-Level Impact File applies the new stratified methodology to hospital results from the FY 2018 performance period (discharges from July 1, 2013 to June 30, 2016). The purpose of the file is to provide hospitals a preview of how their performance will be assessed under the new stratified methodology. **The new stratified methodology will not be implemented until FY 2019 and will use discharge data from July 1, 2014 to June 30, 2017; thus, this file does not reflect nor, will it be used to assess hospital penalties in FY 2018 or in FY 2019**.

Hospitals are listed in the New Stratified Methodology Hospital-Level Impact File by the CMS Certification Number (CCN). The file provides information on your hospital's dual proportion and peer group assignment under the new stratified methodology (See **Table 1** for a full list of variables in the file and their descriptions).

The file also includes the following information for each of the six measures (AMI, COPD, HF, pneumonia, CABG, THA/TKA):

- ERR
- Number of eligible discharges
- Peer group median ERR
- Penalty indicator

Table 1. Variable list

Variable	Description
Hospital CCN	Hospital's CMS Certification Number
Dual Proportion	Proportion of Medicare fee-for-service (FFS) and managed care stays in a specific hospital, where the patient was dually eligible for Medicare and full-benefit Medicaid during the FY 2018 HRRP performance period (July 1, 2013 to June 30, 2016). Full-benefit dual status (numerator) is identified using data from the Medicare Beneficiary Summary File which is sourced from the State Medicare Modernization Act (MMA) files. Stays for full-benefit dual patient are stays where the patient was identified as full-benefit dual status for the month the beneficiary was discharged from the hospital. Hospital Medicare FFS and managed care stays were identified using the FY 2013 to FY 2016 MedPAR files.
Peer Group Assignment	Hospital's assigned Peer Group. Hospitals are stratified into five peer groups, or quintiles, based on the dual proportion. Hospital peer group assignment is numbered 1 through 5. Hospitals in the first peer group (i.e. peer group assignment = 1) have the lowest dual proportion and hospitals in the 5th peer group (i.e. peer group assignment = 5) have the highest dual proportion. Under the new methodology, a hospital's performance on the six measures (excess readmission ratios [ERRs]) are assessed relative to the performance of hospitals within the same peer group.
ERR	Ratio of the predicted readmission rate to the expected readmission rate for a given measure. The ERR is the measure of hospital performance used to assess excess readmissions when determining the payment adjustment factor.
Number of Eligible Discharges	The number of eligible discharges for a given hospital during the FY 2018 performance period (discharges from July 1, 2013 through June 30, 2016). Eligible discharges are identified based on the FY 2018 readmission measure methodology. Hospitals with fewer than 25 eligible discharges are not eligible to be penalized and their ERR will not enter the payment adjustment factor formula.
Peer Group Median ERR	The median ERR for the hospital's peer group for the measure. This is used as the threshold to assess hospital performance relative to other hospitals within the same peer group. All hospitals in the same peer group will have the same median ERR.

Variable	Description
Penalty Indicator	Indicates whether a hospital is subject to a penalty for a given measure. Hospitals are subject to a penalty for a given measure (i.e. the penalty indicator equals 1) if they have 25 or more eligible discharges and an ERR greater than the peer group median. If your hospital does not have at least 25 eligible discharges or if your hospital's ERR for the measure is less than the peer group median ERR for that measure, then the penalty indicator will be equal to 0. When the penalty indicator equals 1, the ERR will enter the payment adjustment factor formula and your hospital may be subject to a penalty reduction.

IV. Additional Resources

More Information about the Hospital Readmissions Reduction Program and CMS Readmission Measures

For program questions, please contact the HRRP Program Support team at HRRP@lantanagroup.com.