Readmissions Reduction Program Analysis

-February 2018, Version 1-

Analysis Description

The Readmissions Reduction Program (RRP) Analysis is intended to provide detailed performance information on the readmissions measures that are currently evaluated under the Medicare Hospital Readmissions Reduction Program and to provide hospitals with an in-depth review of actual performance under the Federal Fiscal Years (FFYs) 2017 and 2018 programs. The analysis also projects potential exposure under the FFY 2019 Program based on data utilized for the FFY 2018 Program.

The specific measures analyzed (6 in total) represent the measures the Center for Medicare and Medicaid Services (CMS) has adopted for use in the FFYs 2017, 2018 and 2019 Hospital Readmissions Reduction Programs and include:

- Heart Attack (AMI)
- Heart Failure (HF)
- Pneumonia (PN)
- Hip/Knee Surgery (THA/TKA)
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Bypass Graft Surgery (CABG)

CMS calculates hospital readmissions rates on a rolling 3-year aggregate basis and updates are published on Hospital Compare annually as part of the Hospital Inpatient Quality Reporting (IQR) Program. These readmission rates reflect Medicare inpatient fee-for-service (FFS) patients only and do not include patients enrolled in Medicare Advantage (MA) Plans.

The readmission rates included in this analysis cover two update/publication periods as follows:

- 2nd Quarter 2016 update: July 2012 – June 2015
- 2nd Quarter 2017 update: July 2013 –June 2016

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This report provides a detailed review of hospital performance and the factors that drive performance under the Readmissions Reduction Program for FFYs 2017, 2018 and 2019, using actual and estimated data. The report includes tables and graphs to highlight exposure areas that drive payment penalties by year.

The “Estimated Program Penalties” section of this report provides the actual adjustment factors used to adjust inpatient rates for FFYs 2017-2018, as well as estimated impacts for those fiscal years. In addition, impacts are split among the individual readmission measures in order to better see how each condition area affects payments.

The “Performance Overview” section provides an overview of measure-specific readmission rates and resulting excess readmission ratios for each of the program years analyzed. The excess readmission ratios are used as part of the calculation of the adjustment factor for each program year. Excess readmission ratios are calculated as the hospital condition-specific prediction rate divided by expected rate.

- Predicted Rate: Hospital’s 30-day readmission rate for discharges in each time period with hospital-specific risk adjustments.
- Expected Rate: U.S. 30-day readmission rate for all hospitals participating in the Readmissions Reduction Program for discharges in each time period with hospital-specific risk adjustments.

When a hospital has fewer than 25 discharges attributable to a specific condition or rates were not available on Hospital Compare, “—“ will be displayed.

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The "Estimated Revenue by Condition" section of this report details estimated inpatient revenue for each condition, by applying program rules to the relevant three years of inpatient discharge data for each of the FFYs 2017-2018 program years (FFY 2019 held constant at FFY 2018 levels). Revenue used under the program represents Base Operating IPPS revenue, which excludes adjustments due to Disproportionate Share Hospital (DSH) payments, Indirect Medical Education (IME), capital, low volume, outliers, and quality performance.

This condition-specific revenue is multiplied by one minus each condition's corresponding excess ratio to determine the excess revenue used to calculate payment penalties. The total excess revenue is then divided by the relevant three years of total base operating revenue for ALL discharges to determine the annual adjustment factors applied to base operating IPPS payments (these factors are capped at 3.0%).

The result of the calculation is compared to the actual program factor published by CMS in the FFYs 2017-2018 Medicare IPPS final rules and used to adjust payments under the IPPS during those FFYs. The factors' estimated total impact on Medicare inpatient FFS operating payments is also shown. The use of slightly different hospital claims data is the cause of any difference between the actual and estimated factors.

FFY 2019 Interim Socio-Demographic Status Adjustment

The 21st Century Cures Act of 2016 required CMS to implement a Socio-Demographic Status (SDS) adjustment into the FFY 2019 program. In the FFY 2018 Inpatient Prospective Payment System (IPPS) final rule CMS adopted an interim SDS adjustment for FFY 2019 RRP. In this interim adjustment, hospitals will be grouped into quintiles based on their ratio of full-benefit dual eligible patients to total Medicare Fee-For-Service (FFS) and Medicare Advantage (MA) patients. Hospitals will then be compared to the condition-specific median excess ratio of all hospitals within their quintile. The adjustment will be budget neutral nationally. Final methodologies will be published in future rulemaking.

In the FFY 2019 SDS methodology, condition-specific revenue is multiplied by the condition-specific quintile median excess ratio minus each condition's corresponding excess ratio to determine the excess revenue used to calculate payment penalties. The total excess revenue is then divided by the relevant three years of total base operating revenue for ALL discharges and multiplied by a budget neutrality factor such that Medicare savings without the SDS adjustment and Medicare savings with the SDS adjustment are equal to determine the annual adjustment factors applied to base operating IPPS payments (these factors are capped at 3.0%).

Hospitals in the higher quintiles (higher percent of full-benefit dual eligible patients) will have a less stringent benchmark (median excess ratio) and hospitals in the lower quintiles (lower percent of full-benefit dual eligible patients) will have a more stringent benchmark (median excess ratio). Therefore, although the program is budget neutral nationally, there will be winners and losers within each quintile.

The approximate range of full-benefit dual eligible ratios for quintile distribution using CMS' RRP New Stratified Methodology Hospital-Level Impact File and the median excess ratio for each quintile per condition are as follows:

	Quintile 1 (0.000%-14.028%)	**Quintile 2** (14.029% - 19.037%)	**Quintile 3** (19.038% - 23.987%)	**Quintile 4** (23.988% - 32.439%)	**Quintile 5** (32.440%+)
AMI	0.9956	0.9964	0.9945	0.9971	1.0045
HF	0.9786	0.9863	0.9903	1.0064	1.0246
PN	0.9864	0.9783	0.9886	1.0015	1.0282
THA/TKA	0.9875	0.9910	0.9929	0.9997	0.9972
COPD	0.9926	0.9911	0.9922	0.9980	1.0099
CABG	0.9934	0.9946	0.9926	0.9944	1.0205

In this analysis FFY 2019 performance is held constant at the FFY 2018 level on the "Performance Scorecard" report and the SDS adjustment is incorporated into the estimated adjustment factor calculation. A full-benefit

dual eligible percent is provided for each hospital, as well as the corresponding quintile estimate, and quintile and condition specific median excess ratios.

This analysis also includes an "SDS Adjustment" report that shows the current RRP methodology compared to the interim FFY 2019 SDS methodology adjustment using FFY 2018 program specifications. Please note that for comparison purposes, the estimated budget neutrality factor calculated in this analysis uses the FFY 2018 calculated adjustment factors, not the actual factors.

CMS did not provide estimated full-benefit dual eligibility ratios and quintile assignments for some hospitals. Therefore these hospitals do not have an estimated SDS impact.

FFY 2017 and 2018 Data Sources

- Readmissions rates and information from the most recent Hospital Compare update (October 2017 update) at http://www.medicare.gov/download/downloaddb.asp
- Readmissions rates and information from previous Hospital Compare updates at https://data.medicare.gov/data/archives/hospital-compare
- Medicare inpatient claims data from the Medicare Provider Analysis and Review (MEDPAR) Files from FFYs 2012-2016
- Hospital payment data from the corrected FFY 2018 IPPS final rule correction notice Impact File available on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page.html
- FFYs 2017 and 2018 Readmissions Reduction Program Supplemental Data files available on the CMS Web site at:
    - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html
    - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page.html

SDS Data Sources

CMS will identify full-benefit dual eligible patients in the actual program using the State Medicare Modernization Act (MMA) file and the total number of Medicare patients as the total number of Medicare FFS and MA patients using MedPar. The full-benefit dual eligible ratios and quintile assignments in this analysis are from CMS' RRP New Stratified Methodology Hospital-Level Impact File at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html. In the actual FFY 2019 program, full-benefit dual eligible ratios will be calculated using the same three-year period as the program performance period (July 1, 2014 - June 30, 2017). Due to data availability, CMS's RRP New Stratified Methodology Hospital-Level Impact File calculates full-benefit dual eligible ratios using the three-year period from July 1, 2013 - June 30, 2016. Therefore, hospital quintiles in the actual FFY 2019 program may differ.

Median Excess Readmission Ratios are quintile specific and from CMS' RRP New Stratified Methodology Hospital-Level Impact File using the FFY 2018 program performance data.
CMS did not provide estimated full-benefit dual eligibility ratios and quintile assignments for some hospitals. Therefore these hospitals do not have an estimated SDS impact.

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